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Inner North East London Joint Health Overview and Scrutiny Committee

Date: **MONDAY, 25 JULY 2016**

Time: **7.00 pm**

Venue: **HACKNEY TOWN HALL**

Members: Wendy Mead
Revd Dr Martin Dudley

Enquiries: **Philippa Sewell**
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John Barradell
Town Clerk and Chief Executive

AGENDA

1. **ELECTION OF CHAIR AND VICE CHAIR FOR 2016/17**
(Pages 1 - 2)

2. **APOLOGIES FOR ABSENCE**

3. **URGENT ITEMS ORDER OF BUSINESS**

4. **DECLARATIONS OF INTEREST**

5. **MINUTES OF THE PREVIOUS MEETING**
(Pages 3 - 16)

6. **NHS NORTH EAST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN**
(Pages 17 - 28)

7. **TRANSFORMING SERVICES TOGETHER - UPDATE**
(Pages 29 - 54)

8. **ANY OTHER BUSINESS**

Inner North East London
Joint Health Overview and Scrutiny Committee (INEL JHOSC)

Membership 2016-17

The Committee comprises 3 members each from Hackney, Newham and Tower Hamlets and 1 member from the City of London.

Borough	Members
Hackney	Cllr Ann Munn (L)
	Cllr Ben Hayhurst (L)
	Cllr Clare Potter (L)
Newham	Cllr Susan Masters (L)
	Cllr Anthony McAlmont (L)
	tbc (L)
Tower Hamlets	Cllr Clare Harrisson (L)
	Cllr Sabina Akhtar (L)
	Cllr Muhammad Ansar Mustaquim (I)
City	Common Councilman Wendy Mead OBE (I)

L=Labour; I- Independent

Only named substitutes are allowed to substitute for a Member should there be a vote. One named substitute has been notified:

City of London: Revd. Dr Martin Dudley

The London Borough of Waltham Forest is a Member of the Outer North East London JHOSC but their Scrutiny Chair(s) are also invited to attend INEL meetings, as observers, when there are items of mutual interest.

The officer contacts are:

Hackney: Jarlath O'Connell jarlath.oconnell@hackney.gov.uk
Tower Hamlets: Daniel Kerr Daniel.kerr@towerhamlets.gov.uk
Newham: Michael Carr Michael.carr@newham.gov.uk
City: Neal Hounsell Neal.hounsell@cityoflondon.gov.uk

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Inner North East London Joint Health Overview and Scrutiny Committee 25 July 2016 **Minutes of the previous meeting**	Item No **5**

OUTLINE

Attached please find the draft minutes of the meeting held on 26 October 2015. There are no matters arising.

ACTION

The Committee is requested to agree the minutes as a correct record.

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MINUTES OF A MEETING OF THE INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MONDAY 26 OCTOBER 2015

Meeting held at 7.00 pm at City of London Corporation, Guildhall, London EC2P 2EJ

Committee Members present:

City of London
Common Councilman Wendy Mead OBE

Hackney Council
Cllr Ann Munn (Chair)
Cllr Ben Hayhurst
Cllr Rosemary Sales

Newham Council
Cllr Susan Masters (substituting for Cllr Walls)
Cllr Winston Vaughan

Member apologies:

Tower Hamlets Council
Cllr Amina Ali
Cllr Shahed Ali
Cllr Dave Chesterton

Newham Council
Cllr Anthony McAlmont
Cllr Dianne Walls OBE (Vice Chair)

Officers in attendance:

***City of London Corporation*:**
Farrah Hart (Health & Wellbeing Policy Manager)
Philippa Sewell (Committee & Members' Services Officer)

Hackney Council
Jarlath O'Connell (Overview & Scrutiny Officer)

Also in attendance:

Barts Health NHS Trust
Alwen Williams (Chief Executive)
Professor Jo Martin (Interim Chief Medical Officer)
Jan Stevens (Chief Nurse)
Claire Hogg (TST Out-of-Hospital Programme Manager)
Jo Carter (Stakeholder Relations Manager)
Jamie Whitburn

NHS North & East London Commissioning Support Unit
Dr Kate Adams (GP and TST Clinical Lead for Out-of-Hospital Programme)
Don Neame (Director of Communications)
Alex Smith (Assistant Director of Transformational Change)
Jessica Brittin (Programme Director, WELC Integrated Care)

Newham CCG
Dr Prakash Chandra (Chair)
Steve Gilvin (Chief Officer)
Satbinder Sanghera (Director of Partnerships and Governance)

Waltham Forest Council

Cllr Richard Sweden (Chair, Social Care Scrutiny Committee)

2 members of the public

1. APOLOGIES FOR ABSENCE

1.1 Attendees were welcomed to the meeting and introductions were made.

1.2 It was noted that Cllr Susan Masters from Newham was substituting for Cllr Dianne Walls.

1.3 The Chair stated that he had received apologies from the three Members from Tower Hamlets. Apologies were also received from Neil Kennett-Brown from the CSU.

1.4 It was noted that the Health and Social Care Scrutiny Chairs from London Borough of Waltham Forest had been invited to this meeting as observers and that this was customary when there were items relating to Barts Health NHS Trust. The Chair welcomed Cllr Richard Sweden (Chair, Social Care Scrutiny Committee) to the meeting.

2. MEMBERSHIP OF THE COMMITTEE

2.1 Members were invited to note the revised membership of the Committee. It was noted that three new members had been appointed from Tower Hamlets.

RESOLVED:	**That the membership of the committee for 2015/16 be noted.**

3. DECLARATIONS OF INTEREST

3.1 Cllr Hayhurst stated that he was a member of the Council of Governors of Homerton University Hospital NHS Foundation Trust.

4. MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING

4.1 The minutes of the meeting held on 27 May 2015 were agreed as a correct record and the matters arising were noted.

5. BARTS HEALTH NHS TRUST IMPROVEMENT PLAN

5.1 The Chair welcomed for this item the following from Barts Health NHS Trust: Alwen Williams (**AW**) (Chief Executive), Professor Jo Martin (**JM**) (Interim Chief Medical Officer) and Jan Stevens (**JS**) (Chief Nurse).

5.2 Members' gave consideration to the following reports/presentations:
(a) *Safe and Compassionate* – presentation
(b) *Safe and Compassionate – Our Improvement Plan* – full report

And two tabled items:

(c) *Safe and compassionate Progress Report: Oct 2015* - newsletter
(d) *Safe and compassionate – our plan for improving services* - leaflet

5.3 In introducing the reports AW stated that Barts Health was fully committed to delivering high quality care and in mid-September they had published their major improvement plan 'Safe and Compassionate' which had set out the various priorities. Tangible improvement on these would only be delivered within the individual hospital sites she added. The October newsletter, as tabled, was an attempt to produce frequent updates for all stakeholders on progress. The Improvement Plan was underpinned by strengthened governance arrangements and a strong governance framework which had been agreed with the Regulators. This was mirrored at each site and there was also a Quality Improvement Committee. The Trust Oversight and Assurance Group would in addition include representation from the CCGs the CQC and Health Education England and this would be mirrored at site level.

5.4 JM added that the key priority was to change the culture of the organisation so that the problems in the past would not recur. A practical example included the introduction of the 'Safety Huddles', where ward staff met daily to review the past 24 hrs and plan for the next 24 hours by for example establishing what patients had specific problems (e.g. a mental health issue or an end of life care plan) and which would require special attention. In addition, JM stated that they had implemented further training on the Mental Capacity Act and on Deprivation of Liberty Safeguards (DoLS) assessments. The Trust had also benchmarked their processes and procedures and had looked, for example, at how UCLH used safety dashboards. The Trust had also developed a new App for antibiotic prescribing and had also done much work on early warnings of cardiac arrest.

5.5 JS added that one heartening thing arising from the CQC reviews was the acknowledgement that staff had been caring. Nevertheless, there was also a requirement for a full staffing review to set the ward establishment levels appropriately. They were investing a further £20m into increasing the funded nursing establishment by 500 and this would be very challenging. There was also focused investment in the Band 7 super-numerary grade as part of an increased focus on training and development. Another issue which had been addressed was streamlining the documentation which nurses have to deal with and this had been benchmarked against other similar Trusts. There were also now in place a different set of processes for responding to complaints focused on looking at the root causes. The Trust received 350 formal complaints per month but much progress was being made in getting these numbers down. In relation to workforce they were still heavily reliant on bank and agency staff and this was not good for either staff or patients. There were c.900 nursing vacancies. While this seemed high it had to be considered in the context of the size of the Trust, which was the largest in the country and that similar situations prevailed nationally. Nursing establishment numbers had been increased everywhere post the Francis Report. In addition to these pressures many nurses were now also working outside the NHS, thus creating a 'perfect storm' in terms of recruitment. She added however that despite these pressures and the Trust having been placed in special

measures many people still wanted to come and work at Barts Health and they were taking on 100 newly qualified nurses the following week, for example. Another aspect requiring attention was staff turnover and the shortage of Emergency Department doctors in the middle grades. As for End of Life Care they had replaced the Liverpool Care Pathway with a new process and new documentation had been introduced relating to 'Do Not Resuscitate'. 70% of actions required in the CQC report on the Margaret Centre had also now been completed. Finally, another challenge was training and the need to quickly implement training for several thousand staff at once.

Questions and answers

5.6 With reference to p.45 Cllr Hayhurst asked about the 9 'never events' between Nov 2013 and Jan 2015, asking if there had been any since Jan 2015 and what type these were.

5.7 JM replied that there had been 5 additional 'never events' since January 2015. 4 had involved naso-gastric tube misplacements and one an incorrectly sized hip-socket. The Root Cause Analysis of these established that failure to follow protocols was the reason. In only one of the cases was it one of the contributing factors to a death. She added that unfortunately initial safeguards which had been put in place had not been sufficient to prevent the latest incident and the situation was of course being reviewed again.

5.8 Cllr Vaughan asked what departments would receive the increased funded nursing establishment of 532. He further asked for clarification on the vacancy rate, the fill rate and the aspiration to get to 90% of established capacity.

5.9 JS replied that they were spread across the Trust with roughly 148 at Whipps Cross, 200 at Royal London and the remainder at Barts and Newham. The allocations were based on a review of the staffing establishment. The fill rate was 85% and the aspiration was to get to 90%.

5.10 Mrs Mead asked about the challenges in recruiting specialist cancer nurses and Cllr Vaughan also asked whether there were enough bank staff in place.

5.11 JS replied that with the newly set establishment there was an acknowledgement of the need also for longer training and the need to increase the capacity for training within these posts. On bank staff it was noted that good bank staff would be preferable to agency as they were the Trust's own staff and could be trained more easily. The NHSE cap on agency spend was proving a further challenge as was the limits on foreign recruitment with the need to put nurses into the 'protected occupations' category. They recently had recruited, for example, 45 critical care nurses from the Philippines.

5.12 Cllr Sweden (Waltham Forest) stated that a major impediment to finding nursing staff was the need to find suitable affordable accommodation for them and he was concerned that in the emerging proposals for developing Whipps

Cross there were plans to sell off the old nurses home. He asked therefore whether the redevelopment plans included any accommodation for nurses. He noted that while he was aware that the plans for disposal of assets had been put on hold the plans for re-development had not.

5.13 AW replied that they were working closely with Waltham Forest Council and other partners on developing options for the Whipps Cross site. In any property disposal plans that would be put in place there would have a strong interest in looking at housing options for staff and they needed to find innovative ways forward with the local authority to resolve this.

5.14 Cllr Sweden stated that the Margaret Centre was held in much esteem locally and he was concerned that the CQC had noted that safeguards on the improper use of the site had not been adhered to.

5.15 JS replied that in addressing the points raised by the CQC it was being made clear what the proper use of the site would entail.

5.16 Mrs Mead commented that the proposed new ward structures appeared to indicate a return of 'Ward Sisters'.

5.17 JS replied that it did and that the loss of a single sister-in-charge had been a mistake. The problem had been that those in that role had also been expected to also carry their own caseload of patients and this was not viable. There was a need to establish the Ward Sister role as many in the meantime had lost some of the necessary skills.

5.18 Cllr Sales stated that she had read with some concern reports in the press about the number of Employment Appeal Tribunal cases against the Trust which had been won by staff and this had raised concerns about staff morale and a culture of bullying.

5.19 AW replied that they had made significant changes in recent months on improving staff structures which should address this problem. Each hospital site would have a Managing Director, a Director of Nursing and a Director of Operations. There were still a number of HR related issues which needed to be focused on. Under investment in IT systems had put constraints in the workplace which engendered much frustration, for example. Also the Trust had instigated staff engagement programmes which had been tried and tested elsewhere in the NHS. There were now for example 40 clinical projects which were being led by staff and the aim of this was to engender a shared leadership culture across the organisation. In November and December 25 different 'Big Conversations' session were taking place. JS added that when she joined in March she had been impressed with the very good guardianship programmes which were in place and on the good staff dynamic overall. The 'Speak in Confidence' programme involved putting in place 12 senior managers who could be contacted in confidence by any staff who were experiencing problems. JM added that Health Education England had commended the Trust for this programme and at the undergraduate level it

was heartening to see that the training sessions were uncovering fewer incidents of staff having these concerns.

5.20 Mrs Mead raised a concern about the level of debt overall of the Trust whilst it had to invest so much more currently in nursing staff for example.

5.21 AW replied that it was an ongoing major concern and the Trust was spending over and above its deficit. The investment in new nursing posts however was an 'invest to save' initiative as it would reduce dependence on bank and agency staff. It was important now she added that the new structures remained in place for at least a 2 or 3 year period while the organisation stabilised and hopefully after that time they would be able to go back to a less intensive level of senior executive support. They would be in a negative financial positon for a number of years and sustainability was the key because also so much was changing in the overarching health economy.

5.22 Cllr Hayhurst asked if the Trust was on course for its budgeted deficit. He also asked if the documents such as those tabled could in future distinguish between aspirations and achievements so it would be clearer to the reader where the Trust stood.

5.23 AW replied that the budgeted deficit was £135m and they were not on plan. A key factor was medical staffing issues and agency spend and they were catching up on the efficiency programme. A rigorous recovery plan was in place and she explained that while the aspiration was to reach 100% of the planned deficit target, 90% would be a more likely figure.

5.24 Cllr Hayhurst asked what would happen to the Trust if it couldn't catch up.

5.25 AW replied that she could not quote a figure but could come back later in the year on it. It was not their intention to exceed the financial deficit but there were significant financial challenges facing all the NHS. They had moved to a site based management in the hospitals to bring more rigour to the finances.

5.26 Cllr Masters raised the issue of down banding of staff grades which had been referred to in the CQC report. She expressed concern that on the bullying issue there had been no mention in the improvement plan of working with trade unions and commented that unions appeared quite weak in the Newham site.

5.27 JS stated that she couldn't comment on the previous staffing plan. 500 extra nurses were being brought in based on a rigorous benchmarked assessment. AW added that the Trust had strong partnerships with the unions. There was a staff partnership trust and site based staff partnership forums.

5.28 Cllr Sales asked whether the various monitoring committees would be permanent and for an assessment of when senior management was expecting to reach these targets.

5.29 AW replied that this was about organisational turnaround and it would be carefully monitored. There was a real commitment to site based running. They now had produced the first monthly update on the Improvement Plan. At the end of each chapter of the Plan the expected outcomes were detailed and the monthly reports would feed in to this process. JS commented that in a previous role she had been the Healthcare Assessment Programme Manager for the national programme to tackle rates of MRSA and it had taken at least 12 months to get the numbers decreasing, so there was a need to persevere with these plans.

5.30 The Chair made reference to the Committee's disquiet at the two CCGs responses to the CQC inspection reports and asked the CCG reps present what outcomes they were expecting from the Trust in one year's time.

5.31 SG replied that the challenge for the two local CCGs was to strike the correct balance between holding the Trust to account and at the same time supporting the clinicians who were shown to be caring and providing good levels of care. Often it was the case that staff were trying hard within systems which were failing and it was important to bear in mind that these were three very different hospitals with three very different sets of issues. The difficulties in Newham were medical care related and because that was rated inadequate it had affected the overall rating. Improvements in quality must take place because this wasn't good enough but again those trying to improve things needed to be supported. He added that some areas of outstanding practice such as the 'Gateway' service at Newham had been acknowledged. They had also of course instigated monthly meetings with GPs to monitor progress on the improvement plan. He added that from Newham CCGs point of view he was very pleased with the new operating model and this was allowing GPs to gain some traction in helping to improve matters. Overall the role of the CCGs was to provide challenge on the pace and ambition of the Plan but to acknowledge that it was happening in the context of serious financial challenges.

5.32 Cllr Hayhurst asked whether, in the context of the new discussions on Devolution, whether Barts Health was too big?

5.33 AW replied that many NHS organisations were actually looking to the system in Barts as a way forward. The last thing Barts Health needed now was more change and stability was what was required. The Transforming Services Together programme had aspirations to deliver care close to home and the Trust needed to be part of the leadership on this programme.

5.44 The Chair thanked the senior officers from Barts for their reports and for their attendance.

RESOLVED:	**That the reports and discussion be noted.**

6. 'TRANSFORMING SERVICES TOGETHER' – UPDATE

6.1 The Chair stated that the Committee had last discussed the proposals at its meeting on 12 February and she welcomed to the meeting groups of officers from the CSU, from Barts Health and from Newham CCG.

6.2 Members gave consideration to the report "Transforming Services Together – update".

6.3 In introducing the report Steve Gilvin (SG) stated that east London had been identified as one of the most challenged health economies. The plan envisaged savings of 50% on productivity and 50% on estates and workforce. The plan did not involve any major closing of departments. The programme was being delivered in the context of the major challenges now facing the NHS. He highlighted that Newham now had the fastest growing young population in the Europe and it was anticipated that there would be an additional 5000 births per year across the three CCGs. In relation to the timetable, a draft strategy had been released in July and there was a need to complete the full detail in this document. More had to be done on the finance and estates elements for example. Obviously, he added, the financial challenge facing Barts Health NHS Trust had also to be factored in. They were hoping to publish the Strategy at the end of November.

6.4 Claire Hogg (CH) stated that in relation to the TST Programme's Out-of-Hospital workstream, there was a need to strengthen the leadership model around the overall strategy. One focus was to ensure that enough people were able to focus on the strategic delivery and able to leave aside the operational delivery for this period. TST was part of Barts Health's own sustainability plan and it had strong leadership. A key element of the programme was the creation of specialist hubs for elective surgery and the success of the Gateway centre in Newham was a good beginning. It focused on orthopaedic surgery. She was currently working on developing the obstetric hub for example.

6.5 Dr Kate Adams (KA) stated that the key to Out-of-Hospital transformation was on care being delivered closer to home. The aim was to treat people out of hospital whenever possible and to leave hospitals for the acute work which they were better at delivering. This change was dependent on expanding integrated care and reform of urgent care was a current challenge. It would involve improving the tools for self-care and the capacity for digital response for example. The challenges here included changing the culture whereby most people will default to A&E. As regards End of Life Care too many people were dying in hospitals when their choice would have been to die at home. Transforming Primary Care was the key and yet east London was short 175 GPs. Furthermore, 28% of GPs in Newham were over 65 years old. Another challenge was to make better use of pharmacists. In terms of the "Enabler" workstreams here, they would look closely at both IT and workforce issues and address barriers such as the poor record of sharing data, use of over testing and use of over ordering in the system. Supporting greater access to Primary Care was the key part of the TST Programme.

Questions and answers

6.6 Mrs Mead asked if Barts Health was struggling to recruit nurses, as it was, how could more community nurses be recruited in this climate?

6.7 KA replied that there was a need to be more proactive in nursing recruitment, in particular going outside London and of course the two groups needed to work together as both were facing shortages. Steve Gilvin (SG) added that a key barrier was that affordable housing wasn't affordable and conversations were taking place with the Mayor of London on designating housing for nurses as well as health and social care professionals. Mrs Mead commented that the NHS had however taken a decision that it no longer wanted to house nurses. SG acknowledged that the NHS had not been very good at being a housing provider in this context but there was now a responsibility on the NHS to work with others to achieve solutions to this problem.

6.8 Cllr Vaughan asked why there appeared to be no clear plan on estates.

6.9 SG replied that there were two different aspects here: hospital estates and primary care estates. As part of this programme they were looking at the plans to develop the old London Chest Hospital site as well as looking to regenerate the Whipps Cross site. In terms of primary care they would reduce the number of sites. Each CCG was required to develop an Estates Plan by the end of December and the plan was to produce a strategic document for TST by March. There was also a need for the NHS to have a voice in the London Land Commission, which was led by the Mayor of London.

6.10 Cllr Vaughan asked about the succession plans for the many older GPs.

6.11 SG replied that no steps were being taken to reduce the number of GPs overall despite the ageing profile and the many who were now reaching retirement age. To partly ease the problem each CCG was putting in place a pilot study on getting Pharmacists to work more closely with GP Practice and they were also looking at additional roles which Health Care Assistants might be able to play.

6.12 Cllr Masters asked how the huge savings which needed to be made in Public Health budgets over the next four years were being factored in to the TST programme.

6.13 SG replied that all local authorities were having major funding difficulties and there were obvious pressures therefore in both adult social care and in public health. He was also worried about the £22bn in net savings also required of the NHS. They all recognised that there was a need to work more closely with public sector partners to be more innovative. As an example of this joint working there were projects in Newham to address the fact that Year 6 children had levels of obesity which if not tackled would lead to diabetes. KA added here that if a child was overweight at 11 years old they had in fact

missed the boat with them. This was proving a huge challenge but they acknowledged too the huge funding problems facing all public sector partners. Don Neame (DN) added that there were representatives from the councils feeding in to all the workstreams of TST, this included councillors, senior public health staff and directors of adult social care.

6.14 Cllr Hayhurst asked about the progress being made on Devolution and how this would impact on TST. Could the integrated vision be achieved by pooling Public Health, Adult Social Care and CCG budgets? He also asked for further clarity on the amount of cost savings being envisaged in the Programme and if the Programme was working towards an ideal number of GP Practices in each borough, what was this number?

6.15 SG replied that integration in out-of-hospital care was primarily for the boroughs and the Better Care Fund programme had made a good start on this. In terms of larger devolution programmes nationally, everyone was looking closely at Manchester to see what might be learned from their pilot. There would be a need to look at pooling of budgets and Health and Wellbeing Boards would need to give impetus to this work. He concluded that the TST vision couldn't be delivered without integration. On the issue of costs, they were not ready as yet to come back with a costed plan. On the configuration of services, they needed to look at how much they might pay on a Payment by Results tariff as opposed to other options. A key driver of this work was to ensure that decisions on the future of Barts Health were kept in local hands and that another Lewisham situation did not develop.

6.16 CH added on TST costs, that it was important to avoid an alternative to TST which would be the need, down the line, to spend the money on building another hospital or another midwifery unit. There was a need to re-design the whole system and to better develop the workforce and care pathways. In obstetrics for example having more high risk patients' leads to more complex care pathways and higher costs so there was a need for more prevention and early intervention. There was a need to ensure for example more capacity at Birthing Centres. In terms of the reforms in Tower Hamlets, known as the Integrated Provider Partnership, it was in the vanguard having a single block contract budget. A move to capitated budgets i.e. assessing how much you need to deliver for a set population, needed further exploring. The problem up to now with Payment By Results tariffs had been that they didn't incentivise the right kinds of things within the system. The aim was fewer hospital admissions and more care closer to home.

6.17 KA added that solo GP Practices were no longer really fit for purpose. Primary Care needed to be delivered by teams in larger settings but this did not necessarily mean losing the link to a familiar family doctor. Newham in particular has many smaller or solo Practices.

6.18 Dr Prakash Chandra (PC), Chair of Newham CCG, added that it was important not to look at these issues in isolation. There was a need for the enabler sites to get off the ground as the quality of premises in Newham for

example were very poor. Because of the large number of small or solo Practices, capacity was limited and training was limited.

6.19 Cllr Hayhurst asked what would be a target number of GP centres for a borough? Would it be 10?

6.20 KA replied that many Practices currently had 10-15K patients each and some merged Practices could go up to 30k for example. This could be achieved in a confederation model but this was a long journey and they were just beginning. SG added that the model of Primary Care going forward needed to be layered and rather than focusing on an optimal size they needed to be ensuring that there was a more consistent quality of care across the system. There was no doubt however that in 18 months' time the configuration of Primary Care would likely be very different.

6.21 The Chair thanked all the officers for their briefings and for attending to answer the Members' questions. She suggested to SG and KA that it would be appropriate to bring the TST plan back to the Committee only when they had worked up a full Case for Change. SG replied that they would return in due course with a costed strategy.

RESOLVED:	**That the briefings and discussion be noted.**

7. ANY OTHER BUSINESS

7.1 The Chair stated that a date for the next meeting would be set to fit in with the requirements of the next stage of the TST 'case for change'.

7.2 The Chair stated that Hackney had the Chair of the JHOSC for two years now and she would be stepping down in May and there was a need for the other boroughs to consider how they would be supporting this Committee from now on. Support to the JHOSC was a cost in terms of officer time and while all boroughs were undergoing major cost savings programmes, this burden needed to be equally shared. Finding the resource to support a JHOSC, on occasions when it is required, should be reflected upon on further in each of the boroughs she added.

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Inner North East London Joint Health Overview and Scrutiny Committee 25 July 2016 **NHS North East London Sustainability and Transformation Plan**	Item No **6**

OUTLINE

Attached please find a briefing on the development of the NHS North East London Sustainability and Transformation Plan. The STP is an iterative process and a draft plan was submitted to NHSE on 30 June.

Attending for this item will be:

Jane Milligan, Chief Officer, Tower Hamlets CCG and Lead Officer for the NEL STP

Others tbc

ACTION

The Committee is requested to give consideration to the briefing and the discussion.

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North East London Sustainability and Transformation Plan Briefing for INEL Joint Health Overview and Scrutiny Committee

Closing the gaps: working together to deliver improved health and care for the people of north east London

25 July 2016

Background

Across north east London, the health and care system - clinical commissioning groups (CCGs), providers and local authorities - are working together to produce a Sustainability and Transformation Plan (STP). This will set out how the NHS Five Year Forward View will be delivered: how local health and care services will transform and become sustainable, built around the needs of local people. The plan will describe how north east London (NEL) will:

- meet the health and wellbeing needs of its population
- improve and maintain the consistency and quality of care for our population
- close the financial gap.

The STP will act as an 'umbrella' plan for change: holding underneath it a number of different specific local plans, to address certain challenges. Crucially, the NEL STP will be the single application and approval process for transformation funding for 2017/18 onwards. It will build on existing local transformation programmes and support their implementation. These are:

- Barking and Dagenham, Havering and Redbridge: devolution pilot (accountable care organisation)
- City and Hackney: Hackney devolution in part
- Newham, Tower Hamlets and Waltham Forest: Transforming Services Together programme
- The STP is also supporting the improvement programmes of our local hospitals, which aim to supports Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust out of special measures

In accordance with national guidance a draft Sustainability and Transformation Plan (STP) for north east London was submitted to NHS England on 30 June. It is being seen as a 'checkpoint' to form the basis of a conversation with NHS England in July.

Developing the submission

The NEL STP Board and Partnership Steering Group meet regularly and is attended by both health and local authority colleagues. We have been working with Martin Esom (Chief Executive of LB Waltham Forest) as the overall local authority STP lead who sits on the NEL STP Board, as well as your local health and social care colleagues who are actively engaged in the process. In addition to a meeting which was held for local authority chief executives in June, updates are being shared at each health and wellbeing board. Local authority elected Members have also been given the opportunity to meet with Jane Milligan the overall NEL STP lead.

The involvement of patients, staff and communities is crucial to the development of the STP. We want it to be based on the needs of local patients and communities and command the support of clinicians, staff and wider partners. Where possible, we will build on existing relationships, particularly through health and wellbeing boards and patient panels and forums.

In addition, we are taking account of recent public engagement on the transformation programmes outlined above and where relevant the outputs are being fed into the STP process; this will ensure that the views of residents from each local authority area are incorporated into the draft submission. In addition, a specific session was held for Healthwatch and patient engagement forum chairs to discuss the STP and how they would like to be engaged, and discussions are ongoing.

Draft vision

- To measurably improve health and wellbeing outcomes for the people of north east London and ensure sustainable health and social care services, built around the needs of local people.

- To develop new models of care to achieve better outcomes for all; focussed on prevention and out of hospital care.

- To work in partnership to commission, contract and deliver services efficiently and safely.

To implement this vision we have developed a common framework that will be consistently adopted across the system through our new model of care programmes. This framework is built around our commitment to person centred, place based care for the population of NEL.
The focus throughout our work is to:

1. Promote prevention and personal and psychological wellbeing
2. Support people to access care closer to home
3. Improve quality of secondary care for those who need it

The following **enablers** have been identified to support our work.

- **Workforce**: recruitment and retention of a high calibre workforce, including making NEL a destination where people want to live and work, ensuring our workforce is effectively equipped to support delivery of new care models, caring for the workforce and reduction in use of bank/agency staff.

- **Infrastructure:** considering the best use of our estates across the system. We recognise that estates are a crucial enabler for our system-wide delivery model. We need to deliver care in modern, fit-for-purpose buildings and to meet the capacity challenges produced by a growing population. The STP will establish appropriate system leadership to ensure that people think about estates at an NEL level whilst building on local priorities.

- **Communications and engagement:** ensuring stakeholders, including local people, understand and support the need to deliver the Five Year Forward View.

- **Technology:** considering the best use of technology to support and enable people to most effectively manage their own health, care and support, and to ensure a technology infrastructure which supports delivery of new care models.

- **Finance:** access and use of non-recurrent fund to support delivery of the plan, delivering financial sustainability across NEL.

Draft priorities

Initial discussions have led us to identify the six key priorities that we need to address as a system. Details of the draft priorities and actions we propose to address them is set out in the table below.

Next steps

Following the submission of the draft STP on 30 June 2016, further discussions regarding it are due to take place with NHS England on 14 July. We will be developing and sharing a summary of the draft NEL STP with our stakeholders following these discussions. The summary document will be used to facilitate meaningful engagement on the NEL STP over the coming months, enabling us to gather feedback, test our ideas and strengthen our STP. For more information go to http://www.nelstp.org.uk or email nel.stp@towerhamletsccg.nhs.uk

DRAFT: Summary of the actions we are going to take in response to each priority

1. Channel demand with appropriate capacity

Issue	Actions
Our population is projected to grow at the fastest rate in London (18% over 15 years to reach 345,000 additional people) and this is putting pressure on all health and social care services. Adding to this, people in NEL are highly diverse. They also tend to be mobile, moving frequently between boroughs and are more dependent on A&E and acute services. If we do not make changes, we will need to meet this demand through building another hospital. We need to find a way to **channel the demand for services** through **maximising prevention**, supporting self-care and innovating in the way we deliver services. **It is important to note that even with successful prevention, NEL's high birth rate means that we may need to increase our physical infrastructure.**	To meet the fundamental challenge of our rapidly growing, changing and diverse population we are committed to: • Shifting the way people using health services with a step up in prevention and self-care, equipping and empowering everyone, working across health and social care; • Ensuring our urgent and emergency care system directs people to the right place first time, with integrated urgent care system, supported by proactive accessible primary care at its heart; • Establishing effective ambulatory care on each hospital site, to ensure our beds are only for those who really need admission, so we don't need to build another hospital; • Ensuring our hospitals are working together to be productive and efficient in delivering patient-centred care, with integrated flows across community and social care; and • Ensuring our estates and workforce are aligned to support our population from cradle to grave.

2. Transform delivery models to support self-care, deliver better care close to home and high quality secondary care

Issue

Transforming our delivery models is essential to empowering our residents to manage their own health and wellbeing and tackling the variations in quality, access and outcomes that exist in NEL. There are still **pockets of poor primary care quality and delivery.** We have a history of innovation with two of the five **devolution pilots (see appendix for detailed plans)** in London, an Urgent and Emergency Care (UEC) vanguard and a Multispecialty Community Provider (MCP) in development. However, we realise that these separate delivery models in each health economy will not deliver the benefits of transformative change. Crucially, we must **establish a system vision** that leverages community assets and ensures that residents are **proactive** in managing their own physical and mental health and receive coordinated, quality care in the right setting.

Actions

We have a unique opportunity to bring alive our system-wide vision for better care and wellbeing. We are already working together on a system-wide clinical strategy; this will build on our two devolution pilots in BHR and CH, and the TST programme (which is being implemented already in WEL). At its core we are committed to:

- Transforming primary care and addressing areas of poor quality/access, this will include offering accessible support from 8am to 8pm (seven days a week), with greater collaboration across practices to work to support localities, and address workforce challenges; and
- Addressing hospital services: streamlining outpatient pathways, delivering better urgent and emergency care, coordinating planned care/surgery, maternity choice and encouraging provider collaboration. This will allow us to meet all of our core standards including those relating to RTT and A&E, and enable the planned ED closure of King George Hospital.

3. Ensure our health and social care providers remain sustainable

Issue

Many of our health and social care providers face challenging financial circumstances; this is especially true with Bart's Health and BHRUT being in special measures. Both are currently being re-inspected to ensure that all necessary recommendations are embedded. Although our hospitals have made significant progress in creating productivity and improvement programmes, we recognise that medium term provider-led cost improvement plans cannot succeed in isolation: our providers need to collaborate on improving the costs of workforce, support services and diagnostics. Our challenge is to create a roadmap for viability that is supported at **a whole system level** with NEL coordinated support, transparency and accountability.

Actions

Our health and social care providers are committed to working together to achieve sustainability. Changes to our NEL service model will help to ensure fewer people either attend or are admitted to hospitals unnecessarily (and that those admitted can be treated and discharged more efficiently):

- We have significant cost improvement plans, which will be complimented by a strong collective focus on driving greater efficiency and productivity initiatives. This will happen both within and across our providers (e.g. procurement, clinical services, back office and bank/agency staff);
- The providers are now evaluating options for formal collaboration to help support their shared ambitions; and
- Devolution pilots in BHR and CH are actively exploring opportunities with local authorities, which will be set out in their forthcoming business cases.

4. Transform specialised services

Issue

NEL residents are served by a number of high quality and world class specialist services; many of these are based within NEL, others across London. We have made progress recently in reconfiguring our local cancer and cardiac provision. However, the quality and sustainability of specialist services varies and we need to ensure that we realise the benefits of the reviews that have been carried out so far. Our local financial gap of £134m and the need for **collaboration** both present challenges to the transformation of our specialised services. We need to move to a more collaborative working structure in order to ensure high quality, accessible specialist services for our residents, both within and outside our region, and to realise our vision of becoming a truly world class destination for specialist services.

Actions

We will continue to deliver and commission world class specialist services. Our fundamental challenge is demand and associated costs are growing beyond proposed funding allocations. We recognise that this must be addressed by:

- Working collaboratively with NHS England and other STP footprints, as patients regularly move outside of NEL for specialised services; and
- Working across the whole patient pathway for our priority areas from prevention, diagnosis, treatment and follow up care – aiming to improve outcomes whilst delivering improved value for money.

5. Create a system-wide decision making model that enables placed-based care and clearly involves key partner agencies

Issue	Actions
Our plans for proactive, integrated, and coordinated care require changes to the way we work in developing system leadership and transforming commissioning. We have plans to **transform commissioning** with capitated budgets in WEL, a pooled health and social care budget in BHR and in CH. Across NEL, we recognise that creating accountable care systems with integrated care across sectors will require joining previously separate services and close working between local authorities and other partners; our plans for **devolution** (see appendix) have made significant progress in meeting the challenge of integration. New models of system leadership and commissioning that are driven by real time data, have the ability to support delivery models that are truly **people-centred and sustainable** in the long term.	We are committed to establishing robust leadership arrangements, based on agreed principles that provide clarity and direction to the NEL health and wellbeing system, and can drive through our plans. For us, involving local authority leaders is the only way to create a system which responds to our population's health and wellbeing needs. Building on our history of collaboration, we have agreed a set of principles which our leaders will be accountable for, including a commitment to making NEL-wide decisions as opposed to local decisions whenever appropriate. This will help us to deliver the scale of change required at pace to deliver place-based care for our population.

6. Maximise the use of our infrastructure so that it supports our vision

Issue	Actions
Delivering new models of primary and secondary care at scale will require modern, fit-for-purpose and cost-effective infrastructure. Currently, our workforce model is outdated as are many of our buildings; Whipps Cross, for example, requires £80 million of critical maintenance. This issue is compounded by the fact that some providers face significant financial pressures stemming from around **£53m remaining excess PFI cost**. Some assets will require significant investment; others will need to be sold. The benefits from sale of resources will be reinvested in the NEL health and social systems. **Devolution** will be helpful in supporting this vision. **Coordinating and owning a plan** for infrastructure and estates at a NEL level will be challenging; **we need to develop approaches to risk and gain share that support our vision.**	Infrastructure is a crucial enabler for our system-wide delivery model. We need to deliver care in modern, fit for purpose buildings and to meet the capacity challenges produced by a growing population. We are now working on a common estates strategy which will identify priorities for FY16/17 and beyond. This will contain a single NEL plan for investment and disposals, utilisation and productivity and managing PFI, with a key principle of investing any proceeds from disposals in delivering the STP vision.

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Inner North East London Joint Health Overview and Scrutiny Committee 25 July 2016 **'Transforming Services Together' update**	Item No **7**

OUTLINE

Attached please find an update on the *Transforming Services Together* programme. The Committee has had a number of items on this change programme over the past few years, the most recent being on 26 October 2015. The minutes of that meeting are included in this agenda.

Officers were asked to return to the Committee with a briefing on the issues which emerged from recent public engagement on the subject.

Attending for this item are:

Neil Kennett-Brown, Programme Director for NEL Sustainability & Transformational Plan, NHS NEL CSU

Other members of the Transforming Services Together Team to be confirmed.

ACTION

The Committee is requested to give consideration to the briefings and the discussion.

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Transforming Services Together

Report of engagement

July 2016

What is Transforming Services Together?

- A partnership between Newham, Tower Hamlets and Waltham Forest CCGs and Barts Health NHS Trust involving multiple other organisations and stakeholders
- Aims to deliver safe, sustainable, high-quality services to improve the local health and social care economy in east London – in line with the challenges of the NHS Five Year Forward View and the established case for change
- 13 high priority initiatives which are an important part of the CCGs' commissioning strategy

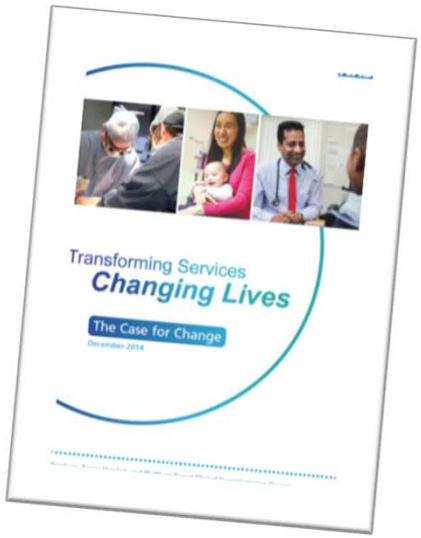
NHS Waltham Forest Clinical Commissioning Group
NHS Newham Clinical Commissioning Group
NHS Tower Hamlets Clinical Commissioning Group
Barts Health NHS Trust

The case for change

Our population is growing rapidly: we expect another 270,000 people on top of the existing 861,000 over the next 15 years

Without change, this would:

- Require over 25% (550) more beds and 1 million more primary care appointments
- Burden us with a £400m+ financial shortfall
- Continue the variable quality of care (some world class services, but also significant challenges)
- Fail to address life expectancy and health inequalities challenges
- Result in continued workforce challenges



Because of population growth and growing demand, closing an A&E/maternity unit is not an option. Building 550 beds is not an option either. We need to manage with the existing bed base

High impact initiatives

Care close to home	Improve access, capacity and coordination in **primary** care
	Expand **integrated care** to those at medium risk of hospital admission
	Put in place an integrated model of **urgent care**
	Improve **end-of-life care**
Strong sustainable hospitals	Establish planned care **surgical hubs**
	Establish **acute care hubs** at each hospital
	Increase the proportion of **natural births**
Working across organisations	Reduce **unnecessary testing**
	Transform the **patient pathway and outpatient services**
	Develop a strategy for the future of **Mile End Hospital**
	Develop a strategy for the future of **Whipps Cross Hospital**
	Deliver **shared care records** across organisations
	Explore the opportunity that **physician associates** may bring

A culture of health, and empowered citizens

There will be better use of technology, diagnostics and medicines

Both investment and payment innovation will be required

Organisational and supporting **processes**

The whole system will work to help people stay well and manage their health better

Staff will increasingly work across care settings and organisation -al boundaries

Engaged, informed individuals and carers, including through third sector

Support to self care

Prevention

Person-centred coordinated care

Health and care professionals working together in partnership

Person-centred care plans will be in place to help people stay in control of their long term condition

Quicker access to specialist advice when required

Whole system working to ensure:
High quality, safe and sustainable services across east London

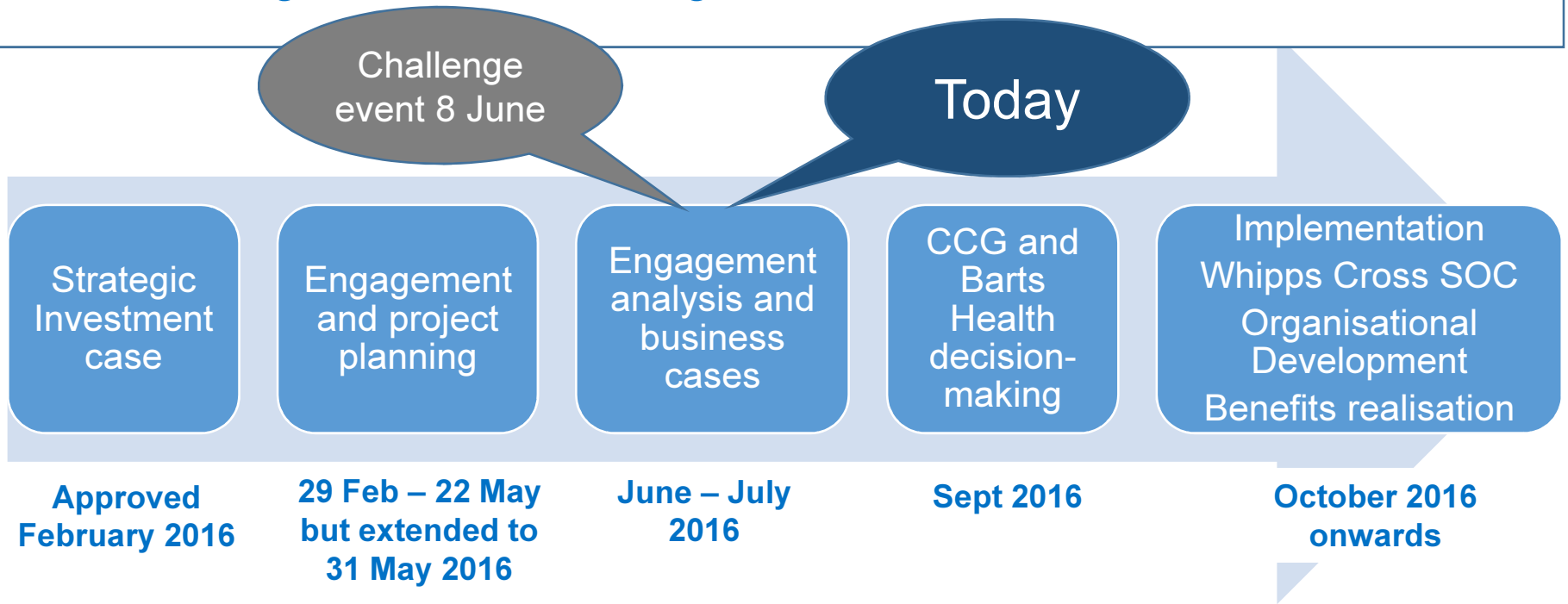
People will stay in hospital shorter amounts of time

People will only travel to hospital when it is absolutely necessary

Timeline

The TST programme will:

- ✓ plan across the health system and geographical area for the future
- ✓ work collaboratively to provide integrated and coordinated care – patients move across boundaries
- ✓ focus on system savings and joint accountability: moving away from which organisation or borough 'wins/loses'



Our engagement

- Advertisements in local papers and articles (for example, Evening Standard feature focusing on reduced outpatient appointments, Skype GP consultations and impact of proposals)
- Dedicated TST website with links from CCG and Barts Health
- Social media
- Barts Health and CCGs publicised the engagement in staff newsletters, staff bulletins, on intranets and at staff meetings
- Emails to more than 5,000 people/organisations offering a meeting to discuss the proposals
- Leaflets/documents in libraries, hospitals and council offices

Our engagement

- Public and staff drop-in sessions in Newham, Tower Hamlets and Waltham Forest and in Barts, Royal London, Newham and Whipps Cross
- Discussions at patient meetings including CAMHS event, patient participation groups, health and social care meetings, locality meetings, primary care workshops, end of life survey and focus groups on surgery
- Discussions at Overview and Scrutiny Committees; Health and Wellbeing Boards; hospital management boards, partners such as NELFT, ELFT, Redbridge, West Essex and City and Hackney CCGs, and Local Medical Committees

- Around 100 people attended a feedback and challenge event to mark the end of the engagement period
- More than 1,000 people engaged with us overall.

What we asked

Is the strategy correct?

The strategy

- The vision was embraced by most respondents but there was concern that the plans did not show a clear link and solution for the whole health economy.

No-one can deny the good intentions of the schemes

Tower Hamlets Local Medical Committee

It is clear we have to make changes to cope with the population growth, I think this is a good programme but everyone involved needs a 'we can' attitude to deliver this. There is a lot to do and we need to do this together.

Newham patient and public drop in session

Although the full impact of TST will not be felt for some years, we know you are making progress with some of the key building blocks. Specifically, there are work programmes in IT including an integrated care record, workforce and care pathways that we are keen to remain aware of and tap into when it makes sense to do so.

West Essex CCG

The strategy: our proposed response

What we heard	What we propose to do
• Almost all respondents were supportive of the proposals	• We will develop business cases, taking account of the responses
• The strategy is stronger on the challenges than deliverables	• Agreed. We are developing business cases which will set out how the challenges are to be addressed
• It is difficult to assess the plan without knowing the whole picture. The 13 initiatives do not make it easy to understand	• The business cases will be developed in the context of the whole health economy • The Sustainability and Transformation Plan (STP) will address key gaps (specialised commissioning and productivity)
• Lack of plans for improving mental health	• Continue to work closely with mental health colleagues on needs analysis and the development of crisis concordant plans • Consideration of the incidence of people with mental health needs attending A&E

What we asked

Is the investment case correct?

The investment case

- There was concern that the plans were unachievable.

According to the transforming documentation, the population is expected to increase by 270,000 over the next 15 years. An increase of population of that scale would normally require, in the next 10 years, 550 additional hospital beds, a million more GP appointments, 195 additional GPs and 92,000 additional A&E attendances. Moreover King George Hospital A&E is due to close, and social care budgets have been decimated. It is simply not credible that, in this context, the TST programme can achieve 180,000 fewer outpatient appointments, keep A&E attendances at existing levels, and make overall savings of between £104m and £165m over five years.

Joint Response of Newham and Waltham Forest Save our NHS and Tower Hamlets Keep our NHS Public

A lot of changes are needed at Whipps Cross so there are not delays to appointments, unnecessary prescriptions and tests. These changes need investment, but the NHS is in a dire financial situation. Patient records need to be handled more efficiently between departments and organisations.

Whipps Cross Hospital drop-in session

The investment case: our proposed response

What we heard	What we propose to do
• It is unclear why these proposals are going to succeed • How are you going to change hearts and minds of the public, stakeholders, clinicians and staff; bring down the artificial walls between professions and the real barriers between organisations • Too much ambition and too many efficiencies needed • There will be a time lag between capitated income and the need for expenditure • Too little time means the proposals are unrealistic • Good patient care at home is not cheap	• We recognise the NHS often struggles with delivery, but in east London we have always risen to the challenges. For instance in improving stroke and trauma care, blood pressure and cholesterol management, 7 day-a-week Adult Respiratory Care and Rehabilitation Service in Tower Hamlets, care home support reducing admissions in Newham and WF and a 20% reduction in hospital admissions at Whipps Cross. The NHS is much better than 10 years ago. • The changes are 'whole system', involving all partners – all of which have committed time and resources to improve • We recognise that some plans may not be fully achieved but we should still aim high • We will regularly review the plans so we can instigate changes if necessary

What we asked

Are the 13 high impact initiatives correct?

The 13 high-impact initiatives

- Overall support, however respondents felt some concern over travelling for surgery, and that there was insufficient focus on organisational development and workforce planning, mental health, prevention and self-care.

I am very interested to hear that you will be looking at recruitment as it's something most professions are experiencing difficulty with and it is easy to say but hard to achieve. My own practice is finding it hard to recruit.

Newham Health and Social Care Network meeting

We would not support the proposals as they were previously presented. Why couldn't the specialist teams travel, rather than patients and relatives. We are worried about vulnerable groups having to travel longer distances.

Tower Hamlets Healthwatch

It saved time instead of bouncing from one place to another.

Ambulatory care pilot patient at Whipps Cross Hospital

It is not worth waiting for a long time in the hospital for a consultation when the appointment only takes a few minutes. Anything that seeks to make the process more efficient is to be welcomed.

Drop in engagement event in Tower Hamlets

What we heard: Care Close to Home

What we heard	What we propose to do
• There is insufficient focus on prevention and self-care	• Prevention and self-care are at the heart of the strategy. We are working with partners to develop initiatives which will also be in our Sustainability and Transformation Plan
• The plans will fail if there is no integration of social, primary and secondary care budgets	• Integrate health and social care by 2020 • We have integrated care plans for over 30,000 people and plans for 35,000 more this year
• Insufficient focus on workforce e.g. GP recruitment /staff accommodation	• We have expanded the physician associates initiative – one of a range of approaches – to include a broader range of workforce issues
• Primary care hubs/federations welcomed, but transport is a concern. There is insufficient detail for all GPs to sign up	• We will develop case studies of success and more evidence
• One urgent care point of access may not suit everyone	• Plan to tailor single points of access to local requirements
• End of life care must be 24/7. Not everyone wants to die at home	• Providing 24/7 care is key to implementation • Business case being developed to ensure 24/7 care is provided in the community

What we heard: Strong Sustainable Hospitals

What we heard	What we propose to do
• There needs to be better investment in information and communications e.g. projections for non-obstetric births are too ambitious as women will not make these choices without better knowledge.	• Across all workstreams, we will fully develop our communications plans so that patients are well-informed and able to make the best choices possible • East London has recently been selected as a pioneer to improve maternity services – part of which includes better information provision • Intensive information sharing within primary care partners is being planned
• Hospital can be a far more attractive prospect than living alone in an empty, cold, unadapted home with no primary or social care. Need to ensure care in the community is a) better and b) ready for any shift.	• Our plans involve using a Multi-Disciplinary Team (MDT) approach to holistically view each person's needs and to ensure that all partner agencies proactively assess those needs at every aspect of a patient's recovery
• Administration is always poor. Clinics run late or get everyone to turn up at the same time.	• Agree. This is partly addressed by the outpatients workstream and the Barts Health outpatient improvement groups

What we heard: working across organisations

What we heard	How we propose to respond
• Need to encourage greater third sector involvement. Insufficient focus on patient engagement, poor use of existing knowledge; little feedback	• We will seek to develop a tri-borough approach to working with the third sector and patient engagement across providers and commissioners
• Appointments online are essential. Shared care records must be under the control of patients but may increase the inequality gap if the NHS doesn't provide support	• Implementation of shared care records integral to all workstreams • Work on sharing records with pharmacies under way
• There is a lack of evidence. There needs to be clear monitoring to check whether things are going to plan	• We have established a joint steering group to objectively assess proposals and monitor their implementation
• Physician associates were not seen as a high impact initiative. There needs to be greater focus on other workforce issues	• Case study to be produced on how physician associates will work • Other workforce issues being considered at an event in August
• Plans for Whipps Cross welcomed. The strategy must be real – work on the possible not what would be nice. Need to build on TST models of care	• Barts Health establishing a programme including patient involvement to develop a strategic outline case, which will take this into account

Surgery proposals

Engagement with staff has been positive. The idea of centralising surgical procedures of certain types onto fewer sites as a means of improving quality was originally suggested by surgical consultants. Having tested this more widely among clinicians and other staff across all sites it is clear there is strong support.

Public engagement has shown some concern from residents in Tower Hamlets regarding travel, but overriding support for better surgery and shorter waiting times, particularly if the NHS:

- works to improve transport
- ensures that patients are informed about their right to choose (which has often not happened in the past)
- provides assurance with regard to the quality of service provision at alternative sites that would be less familiar to patients
- honours the commitment that other aspects of services (e.g. outpatient and diagnostics, in particular post operative appointments) would continue to be offered at the patient's local hospital (again this has often not happened in the past).

Surgery proposals

To ensure improved quality our proposals (which will be considered by the local NHS in September) are:

- **Colorectal surgery**

Expand capacity at Newham through increased theatre efficiency and more staff so that around 100 more operations per year could be done there instead of at RLH or Whipps Cross. Patients would still be able to choose to have their operations at any of the three hospitals. Currently there are around 4,400 day cases a year (500 at RLH; 2,500 at WXUH; and 1,400 at Newham).

- **Urology surgery**

Use increased medical staff and underutilised theatre capacity at Whipps Cross so that around 400 operations could be done there instead of at RLH. Patients would still be able to choose to have their operations at any of the three hospitals. Currently there are around 3,200 day cases a year (1,600 at RLH; 500 at WXUH; and 1,100 at NUH).

- **ENT, adenoid surgery and tonsillectomies**

Use unused theatre capacity at Whipps Cross so that the c.100 operations we do each year could be done there instead of at RLH. RLH would retain ability to perform this surgery but would not routinely offer it.

Newham and WF Save our NHS and Tower Hamlets Keep our NHS Public response

Whilst many comments are included earlier, the following provides a summary of their concerns:

- proposals present a shift in demand from hospitals to primary care and cuts to provision in hospitals that represent a threat to future health and well-being
- proposals amount to a major reorganisation of services
- cuts in government funding will mean that there are operational failures as demand increases
- consultation is flawed as it has not been properly advertised. Drastic changes are lost in the documents
- proposals threaten A&E and maternity services at Whipps Cross and Newham
- specific proposals lack overall coherence and timescales are unrealistic
- proposals take no account of social care cuts and the impact on carers
- impact of disability, mental health, substance abuse and socio-economic effects have not been taken into account when developing self management proposals
- reliance on IT to drive change is misplaced given previous IT failures and raises data protection issues
- proposed inter-hospital transport, especially at night makes 'stabilise and transfer' proposals problematic and there will be no consultant supervision of acute hubs for up to 10 hours a day
- estates should not be sold without proper public consultation, that sold land should be used for the benefit of the community, and that any sale should be subject to independent scrutiny

We would agree with many of the aspirations expressed in the plans. However, to try to implement them with budgets cut, and to unrealistic time-scales, will put an already stretched and stressed workforce under even greater pressure, is likely to further destabilise struggling services, and put patients at risk.

Next steps

- Initial findings presented to CCGs, Barts Health and JOSCs during July.
- August: develop the full report on engagement and a paper on how TST will respond, looking at, for instance:
  - Do CCGs accept the outcome of engagement?
  - Has anything changed since the start of engagement that would make us change our plans e.g. STPs?
  - Have we heard anything in the engagement that means we should change our plans?
- September: Bring back the engagement report and the TST response to CCG boards and Barts Health for decision.

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