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

THURSDAY, 20TH NOVEMBER 2014

Meeting held at 7.00 pm at Tower Hamlets Council Offices, Mulberry Place, 5 Clove Crescent, East India Dock, E14 2BG

Committee Members Present:	**Cllr. Ann Munn (Chair), Cllr. Mahbub Alam, Cllr. David Edgar, Cllr. Ben Hayhurst, Common Councilman Wendy Mead, Cllr. Rosemary Sales**
Apologies:	**Cllr. Dianne Walls OBE (Vice Chair), Cllr. Asma Begum, Cllr. Anthony McAlmont and Cllr. Winston Vaughan**
Officers in Attendance:	**Tahir Alam (Strategy, Policy and Performance Officer, Tower Hamlets), Dr Somen Banerjee (Interim Director of Public Health, Tower Hamlets),, Neal Hounsell (City of London Corporation) and Jarlath O'Connell (Overview and Scrutiny Officer, Hackney)**
Also in Attendance:	**Karen Breen (Director of Delivery and Improvement, Barts Health), Mark Graver (Head of Stakeholder Relations and Engagement, Barts Health), Sarah Mcilwaine (Senior Consultant, NHS NEL CSU), Common Councilman Dhruv Patel (City of London Corporation) and Dr Steve Ryan (Medical Director, Barts Health),**

1 Welcome and introductions

1.1 Introductions were made and the Chair welcomed to the meeting Dr Somen Bannerjee (Interim Director of Public Health, Tower Hamlets Council).

2 Apologies for absence

2.1 Apologies for absence were received from Cllrs Vaughan, Walls and McAlmont. The Chair sent the Committee's best wishes to Cllr Vaughan who was in hospital.

2.2 An apology was also received from Mr Neil Kennett-Brown (Programme Director – Transformational Change, NHS NEL CSU) for item 6.

3 Urgent items/ Order of business

3.1 There were no urgent items and the order of business was as on the agenda.

4 Declarations of Interest

4.1 There were none.

5 Minutes of the previous meeting and matters arising

5.1 The minutes of the meeting held on 11 September 2014 were agreed as a correct record subject to the following amendment:

Page 8, point 4 referring to Cllr Hayhurst "...by virtue of a conflict of interest arising from his career as a barrister, and undertook to leave the room…" to read "by virtue of having met with those conducting the judicial review with a view to assisting them, and undertook to leave the room…"

5.2 Under matters arising the Committee noted the response from Neil Roberts of NHSE to the Chair's letter to them concerning the MPIG issue. The Chair added that she has asked NHSE London to keep the Committee informed when the new Carr-Hill funding formula would be agreed.

RESOLVED:	**That the minutes of the meeting held on 11 September 2014 be agreed subject to the amendment above and that the matter arising be noted.**

6 Improving specialist cancer and cardiovascular services - update on implementation

6.1 Members gave consideration to a report providing an update on the implementation of the changes to specialist cancer and cardiovascular services which had been requested by the Chair. The Committee had given consideration to this formal case for change proposal on 20 November 2013 and NHS North East London Commissioning Support Unit had been invited back to present a short update.

6.2 The Chair welcomed to the meeting Sarah Mcilwaine (Senior Consultant, NHS NEL CSU) who took Members through the report. Ms Mcilwaine added that the Commissioners would only give final sign-off on the moves when all the services involved were deemed safe and quality assured.

6.3 Ms Mcilwaine and Dr Steve Ryan (Medical Director, Barts) responded to detailed questions from Members and in the responses the following points were noted:

(i) The three JHOSCS who considered the Case for Change were all broadly supportive of the proposal. Issues had been raised for example by clinicians on the impact on clinician training. Dr Ryan pointed out that at Barts they had engaged with 'The Deanery' on updating the curriculum for their brain-cancer surgeon training to take account of the changes.

(ii) Dr Ryan pointed out that concerns by neuro-surgeons about sufficient cover at the Trauma Centre at the Royal London (following movement of brain cancer surgeons to Queen's Square) were one of the many quality assurance issues taken on by Barts' Unification Board, which had the job of implementing the changes within their Trust. This Board had senior cancer surgeons on it and checks were made on all treatment gateways and ensuring that trauma services were safe. No moves would be signed off until the Operational Steering Group, led by senior clinicians, were assured that all systems remained safe.

(iii) In relation to the metrics being set to judge the performance of the new system, Dr Ryan pointed out that for Barts these would include the results from the National Cancer Survey, reductions in waiting times and reaching the benchmarks for England, Europe and the World on outcomes.

(iv) Across all the changes 'gateway 6' would be the key milestone and it would assess how long after the switch round could benefits be realised. The focus here would be on the whole pathway not just on trauma. The key focus overall was to reduce late diagnosis of cancer and CVD.

(v) The changes were cost neutral but resources would move around within the system. The vast majority of care would remain where it was currently provided. In terms of Barts own Cancer Centre, this represented a large investment and there would be analyses of when a surplus could be made on that long term investment.

(vi) The claims made for how the changes would impact on early diagnosis and prevention related to the fact that in large trusts such as Barts, the whole pathway was being looked at. The organisation was called 'Barts Health' not 'Barts Hospitals' and the focus was in saving lives through general health improvements not just by putting in place a state of the art cancer centre. The Trust took an active interest in issues such as improving air quality and diet and worked with the Mayor and the boroughs on these. The changes would enhance specialisation and the world class work being done needed to be promoted locally as part of a wider public health campaign directed at not just GPs but also at local communities. The focus started from the fact that given the high calibre of staff and equipment outcomes were still not good enough e.g. 30% of cancers being diagnosed at A&E. The Chair commented that one advantage of the changes would be that Trusts would be in a better position to gather data.

(vii) In relation to transport issues the focus all along was that patients would only have to travel for the specialist part of their treatment but the majority of the treatment would continue to be provided locally.

(viii) Another element of the proposals was to give patients more choice in treatment pathways as often there was no black and white solution on

offer. People could decide on waiting out for one aspect of their treatment or on having an element of it delivered more locally but it was important that, with very specialist robotic surgery for example, that this be concentrated in fewer locations so clinicians could gain more experience and thus improve outcomes.

(ix) Members continued to stress to Dr Ryan that a crucial part of implementing these changes was to ensure that the follow-up care pathways worked properly and that, for example, medical notes were transferred efficiently. Dr Ryan replied that the intention was to make this process as paperless as possible (using Cloud storage) and that they were examining innovative solutions here.

(x) In relation to whether the NHS's assurance processes have sufficiently robust data to pick up important demographic information, Ms Mcilwaine stated that they were currently limited in terms of what data was being collected. Data on disability had not been collected and this had posed a problem in relation to the transport planning aspect of the changes. She undertook to take up this issue with the Academic Health Partners.

6.4 The Chair thanked Ms Mcilwaine and the CSU for its update report.

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

ACTION:	**Ms Mcilwaine to raise with the Academic Health Partners, the issue of improving demographic data collection as part of the implementation of the specialist cancer and cardio changes.**

7 Improving quality at Barts Health NHS Trust

7.1 The Chair stated that Barts Health issues generally came to INEL because their services crossed all of the 4 boroughs as well as Waltham Forest. She stated that there were ongoing concerns about quality issues at the Trust and reminded Members that City and Hackney CCG had written to the Trust during the summer raising serious concerns about quality standards and since then there has been the publication of the National Cancer Patient Survey where the Trust did not do well.

7.2 Members gave consideration to the "Update Report from Barts Health" and the Chair welcomed to the meeting Dr Steve Ryan (Medical Director), Ms Karen Breen (Director of Delivery and Improvement) and Mr Mark Graver (Head of Stakeholders Relations and Engagement).

7.3 Dr Ryan and colleagues took Members through their report. It was noted that Ms Breen was the new COO for the Trust and that improving data and IT system would be an important priority for her.

7.4 Dr Ryan and colleagues replied to detailed questions from the Members and during the discussion the following points were noted:

Problems with appointment systems

(i) The Clinical Support Services CAG in the Trust had taken on the outpatient quality issues. Issues of concern ranged from the appointment follow-up system, multiple letters being issued, patients being booked in to sites on days when a clinic wasn't operating, or patients receiving two appointments on the same day at different sites. The processing time for patients was at 14 days and reducing as were the number of missed appointments and the phone waiting times. At Royal London the out-patients service had been successfully moved to a new building which had also helped.

(ii) Major problems experienced at Whipps Cross over the summer, when a serious incident had to be declared, were now being addressed in the new 'Millennium' IT system. The quality of the estate at Whipps for out patients also needed addressing and a lot more work needed to be done.

(iii) The problem of multiple letters arose from lack of sufficient staff training on the new system and the need to respond robustly when patients changed their appointment times more than once. The Chair commented that it appeared that sufficient testing did not appear to have been carried out on the new system before it had gone live. It was agreed that the new problem was a transformational change one and not just an IT issue.

National Surgical Audit Results

(iv) In relation to the issue of some surgeons not carrying out optimal numbers of particular surgical procedures, the Trust now had fewer vascular surgeons, going down from 13 to 5, who were highly specialised clinicians and the outcomes had improved significantly. With stroke patients for example surgeons could now intervene at an earlier stage of a clot and thus prevent the stroke from developing. This team were also working on this issue with clinicians at the Homerton.

Concerns from C&H CCG on quality

(v) Dr Ryan had attended the September Board meeting of City and Hackney CCG to discuss their concerns in detail. Other CCGs had also been raising similar concerns. A key area of focus was to reduce the Referral to Treatment times down from the 18 week maximum. The critical measures were the '18 week admitted pathway' and ensuring no more than 8% waiting longer than this. Noted that because of complexity of some cases this target would never reach 100%.

(vi) There were significant data quality issues and the Board was determined to tackle the confidence issues arising from these and to ensure that they had robust practices in place to ensure there would be no harm caused arising from delays.

(vii) As an illustration of the challenge the Trust currently had 13000 waiting for surgery and this number should be c. 7000 therefore the Trust needed to maximise every opportunity to treat people in whatever way possible.

Use of private providers

(viii) As part of this they were maximising their relationships with private providers and working with them to get waiting times down. The National Tariffs here worked against Trusts and in effect compromised their business model, in that if they treated a particular category of patients beyond the tariff threshold, they would only receive 30% of the tariff. The Trust operated within a very tight margin so often it was in their interest to have patients treated privately so as to avoid tariff sanctions. The challenge with going outside however was to balance quality vs risk.

(ix) The response was to maximise what they did internally. Sometimes it was in the patients' interests to be treated by them via private providers but for some patients e.g. complex cases it would not be appropriate and they would wait to be seen by the Trust's consultants. Generally though they found no reduction in patient satisfaction for those using a private provider. They were monitoring performance here closely since they stared using private providers in September.

(x) In terms of safety, Dr Ryan was the GMC designated 'Responsible Officer' in the Trust and would ensure any private provider would have a similar post in place. Noted that Great Ormond Street Children's Hospital success had been underpinned by their use of private providers to complement their work. It was noted that the main use of private providers at Barts was for dermatology and ophthalmology.

(xi) In relation to bed capacity in the new Cardiac Centre, this represented an increase in a capacity overall. A Member expressed a concern that the state of the art equipment in the new centre was not being used to its optimum while there were NHS waiting lists.

Discharge problems and length of stay

(xii) A key challenge was in responding to numbers coming in via A&E and the difficulty of predicting or planning for this.

(xiii) Across the three main sites the patient profile varied. In Whipps Cross the length of stay had risen significantly. Whipps had not seen an

increase in admissions but the pressure instead caused by length of stay.

(xiv) That numbers overall had not increased sharply was testament to the improved partnership working between the CCG and the Council on initiatives to keep people out of A&E but generally patients were older and with more complex needs and so discharge plans were complicated. The discharge process currently included a 40 page assessment form, such was the complexity…

(xv) The Royal London's length of stay rate had increased and pressure continued on tertiary services. Peaks in trauma admissions which happened on occasion put great pressure on managing capacity. Despite Royal London being a major trauma centre, a night with 8 trauma calls or multiple stabbings can seriously throw out the performance figures and blockages can back up through critical care.

National Cancer Patient Survey Results

(xvi) On the Trust's poor performance in the National Cancer Patient Survey it was noted that the Board and the Quality Committees in the Trust had spent much time studying these findings. The challenge was to manage the holistic needs of the patients.

(xvii) Outcomes were best when patients had a Clinical Nurse Specialist in place. Noted that in the past the Trust often had over complicated the treatment pathway and had 30-line action plans when the cause of the problem might have been more fundamental.

(xviii) Noted that the Friends and Family test is ward specific which did provide some more granular data. At present a large focus was on inpatient support and on A&E. A Member pointed out that a key area of concern was linking services in the hospital with local services and this pathway had not been effective at Whipps Cross. Also for the more common cancers much of the treatment was at local sites rather than at Barts and the pathways needed to be robust at each site.

(xix) Noted that Ocular cancer surgery was not being decommissioned at Barts. Barts would lead with specialist treatment at their site with additional support from Moorfields. High quality scans could be shared electronically between the two sites now avoiding the need for patients to travel between sites.

MRSA and CD

(xx) There had been 7 recent cases of MRSA which was to be regretted. They were aware of the causes which include hand cleaning, keeping environment clean, proper handling of drips and screening patients fully. A common factor in the cases here was that drips were not being used properly. Regular audits of wards were now taking place to

ensure there were no lapses in procedures and disciplinary procedures were instigated against those who were not complying fully with the proper procedures.

(xxi) On Clostridium Difficile there was good news to report and there had only been 2 cases this year. They were doing root cause analyses to understand why results on CD had been good while those on MRSA had been poor.

(xxii) There had been negligence payments in the past 12 months relating to MRSA and CD but some of these claims went back some time because the more complicated cases took a long time to settle. The overall trend however on the number of claims was stable.

7.5 The Chair asked if INEL members could visit the new Cardiac Centre and officers agreed to liaise with the Overview and Scrutiny Officer to set this up. It was noted it would need to take place before Christmas to avoid some further building work which would be taking place.

ACTION:	**O&S Officer to fix date for site visit to Barts Cardiac Centre in mid-December.**

7.6 The Chair thanked Dr Ryan, Ms Breen and Mr Graver for their report and for attending to answer their questions. She commended the level of detail in the report and their constructive engagement with the work of the Committee.

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

8. Any other business

Duration of the meeting: 7.00 - 8.30 pm

Signed

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Chair of Committee

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