

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

THURSDAY, 12 FEBRUARY 2015

Meeting held at 7.00 pm at Room 3, Assembly Hall, Hackney Town Hall, Mare St, London E8 1EA

Committee Members Present: Cllr Ann Munn (Chair), Cllr Dianne Walls OBE (Vice Chair), Cllr Mahbub Alam, Cllr David Edgar, Cllr Ben Hayhurst, Common Councilman Wendy Mead, Cllr Rosemary Sales and Cllr Winston Vaughan

Member apologies: Cllr Asma Begum and Cllr Anthony McAlmont
Other apologies from Cllr Emmerson (Waltham Forest), Common Councilman Dhruv Patel (City of London Corporation) and Terry Huff (Chief Officer, Waltham Forest CCG).

Officers in Attendance: Tahir Alam (Strategy, Policy and Performance Officer, Tower Hamlets), Nina Bhakri (Policy Officer, City of London Corporation) and Jarlath O'Connell (Overview and Scrutiny Officer, Hackney)

Also in Attendance: Dr Sam Everington (Chair, Tower Hamlets CCG), Dr Steve Ryan (Medical Director, Barts Health NHS Trust), M Neil Kennett-Brown (Transformation Director – Newham, Tower Hamlets and Waltham Forest CCGs), Dr Zuhair Zarifa (Chair, Newham CCG), Deborah Kelly (Deputy Chief Nurse – Patient Care and Experience, Barts Health NHS Trust), Mr Steve Millington (Consultant Orthopaedic Surgeon, Barts Health NHS Trust), Jo Carter (Stakeholder Relations Manager, Barts Health NHS Trust), Satbinder Sanghera (Director of Partnerships and Governance, Newham CCG), Don Neame (Director of Communications NHS NE London Commissioning Support Unit), Claire Lynch (Communications Manager, Transforming Services Together, NHS NEL CSU)

1. WELCOME AND INTRODUCTIONS

- 1.1 The Chair welcomed everyone and introductions were made. There were no Substitute Members.
- 1.2 The Chair stated that Cllrs Emmerson and Sweden, the Chairs of the Health and Adult Social Care Scrutiny Committees in Waltham Forest were both

invited to this meeting. This was customary when there were items relating to Barts Health NHS Trust.

2. APOLOGIES FOR ABSENCE

- 2.1 Apologies for absence were received from Cllr Begum from Tower Hamlets and Cllr McAlmont from Newham.
- 2.1 Other apologies were recorded from Cllr Emmerson from Waltham Forest, Dhruv Patel from Corporation of City of London and Terry Huff (Chief Officer, Waltham Forest CCG).

3. DECLARATIONS OF INTEREST

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

4. MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING

- 4.1 The minutes of the meeting held on 20 November 2014 were agreed as a correct record at the matters arising on page 3 were noted.

5. TRANSFORMING SERVICES CHANGING LIVES PROGRAMME – A CASE FOR CHANGE AND NEXT STEPS

- 5.1 The Committee gave consideration to a report from NHS North and East London Commissioning Support Unit on the latest stage of the Transforming Services Changing Lives Programme now known as 'Transforming Services Together'.
- 5.2 The Chair welcomed to the meeting Dr Sam Everington (Chair, Tower Hamlets CCG), Dr Steve Ryan (Medical Director, Barts Health NHS Trust), Mr Neil Kennett-Brown (Transformation Director – Newham, Tower Hamlets and Waltham Forest CCGs), Dr Zuhair Zarifa (Chair, Newham CCG), Ms Deborah Kelly (Deputy Chief Nurse – Patient Care and Experience, Barts Health NHS Trust), Mr Steve Millington (Consultant Orthopaedic Surgeon, Barts Health NHS Trust), Ms Jo Carter (Stakeholder Relations Manager, Barts Health NHS Trust), Mr Satbinder Sanghera (Director of Partnerships and Governance, Newham CCG), Mr Don Neame (Director of Communications NHS NE London Commissioning Support Unit) and Ms Claire Lynch (Communications Manager, Transforming Services Together, NHS NEL CSU)
- 5.3 Members also gave consideration to a presentation "*Transforming Services Together – Delivering a world-class healthcare service in east London*" which

was jointly presented by Drs Everington, Ryan and Zarifa as well as Mr Millington and Mr Kennett-Brown. Each introduced a section of the presentation as follows:

- a) Dr Everington explained that the area is experiencing an increase in population and an increase in the prevalence of Long Term Conditions. 5% of patients are now managed in an integrated team. Many patients can now opt to die at home and there is also a great awareness of the need for the system to be more efficient. The vision they were working towards was that in 10 years time there would only be half the number of attendees at outpatients as there was now. They were utilising the latest 'Apps' to improve how they worked and to improve care pathways. The condition of NHS estates was also a serious problem. On diabetes for example they were now managing nearly all cases in a GP setting. The drive towards centralisation of specialisms was an important factor in improving patient outcomes as clinicians could have impact over a wider area and yet be available on a mobile phone. Much work was being done on joining up care pathways. Secondary care could only be responsible for 15-20% of people's health and wellbeing. The role that other stakeholders play must be emphasised as schools, for example, have a much greater opportunity to be engaged with the mental, social and physical health of children. The local health economies faced very significant challenges with savings of £28m required in Tower Hamlets and £53m in Newham in 2015/16. The advent of Social Prescribing was to be welcomed and had great potential. Typically a GP had 60 consultations per day. The system also needed to connect better with the voluntary sector. There was a need to look at different ways of segmenting the population. Taking advantage of IT need not necessarily be a problem for older people and there were examples of octogenarians happily using Skype technologies for example. The key issue was support and encouragement.
- b) Dr Zarifa described the work in Newham on improving the service provided to young diabetics where only 11% of young people had been safely controlling their conditions. In the past clinics had been scheduled to suit clinicians rather than the patients. After surveying patients they adopted new ways of working including use of texting to provide quick advice to those attending their clinics and for the first time children and teenagers were appointed as patient champions and contributed to the re-commissioning plans for the diabetes service.
- c) Dr Ryan stated that a key part of the change programme was on improving staff attitudes and their Older People Services Programme had made progress here. He also outlined their 'Great Expectations' maternity services programme and the 'Stepping into the Future' programme which was being rolled out at Whipps Cross. As part of the latter much progress had been made in improving the pathways for renal dialysis patients. Overall the levels of complaints were going down and they soon hoped to match the outstanding performance here of the Homerton. Cancer waiting times continued to be a challenge. They had just seen a first draft of the

latest CQC report on Whipps Cross, which would be published in March. It would be very challenging particularly in relation to staff attitudes and they were working on an action plan in response. On staff attitudes much was being done in response to the Francis report such as improving the whistleblower policies and having zero tolerance for bullying. It was important too to talk about the successes in the Trust's services and they could be proud of the collaborative work at Newham Community Health Services and the success of their stroke patient pathways. The success of the major trauma unit at Royal London was double edged though in that it had a knock on effect on waiting times for elective surgery. He reiterated that this was a "here and now" programme and incremental changes were being made rather than adopting a big bang approach. It would not be possible to make the levels of savings required through salami slicing and there was a need for major restructures to start happening now.

- d) Mr Millington stated that it was important for Members to be aware of the scale of the problems nationally facing the NHS. East London was nationally one of the most challenged sectors for meeting the '18 week wait' target. In the area of Orthopaedics, East London would require 100 more orthopaedics consultants now in order to meet current government targets. At the Royal London they saw the same number of orthopaedic patients as in the other three hospitals in the Trust put together and the Trauma Centre did put pressure on the capacity for elective surgery. He stated that much progress had been made at Newham and they now had a surgical gateway centre there also to improve patient flows. They were working on pre re-habilitation programmes and on Enhanced Recovery Programmes to improve the follow up treatment. They were centralising specialist functions while ensuring that patients could get follow up outpatient services closer to home and this had greatly reduced the length of stays. Rapid improvements in medical care were also impacting on patient flows. For example an individual recovering from knee replacement surgery now could be up and walking the following day. Much progress was also being made at Newham with the specialist children's out-patients site there and they were now seeing 20K more patient episodes there. Out patients facilities could grow there because of easy access and good parking provision for the public. Dr Ryan added that allied to this, specialist children's surgery would be focused on the Royal London so that patients could get a dedicated children's surgery service.

- 5.4 The Committee gave consideration to a tabled joint statement from the Healthwatch organisations covering City, Hackney, Newham, Tower Hamlets and Waltham Forest. Mr Kennett-Brown responded to it on behalf of the NHS partners present stating that the Transforming Services Together programme was about focusing on the impact on the wider health system of changes to the acute system and social care. There were 9 'clinical workstreams' and 5 'enabler workstreams'. He stated that this programme wasn't about a system shock with one or two huge changes. There were a number of strands that the NHS could get on with and were doing so including making progress on the diabetes project in Newham or in maternity services in relation to

improving clinical protocols around caesareans. The Consultant Midwife working on this part of the programme was looking at issues around home birthing or on having more birthing beds in the system. Some work was needed across the whole system however and this would involve not just the 3 CCGs in the programme but the wider cohort of 7 CCG in east London.

5.5 The NHS representatives then answered detailed questions from Members and during the discussion the following points were noted:

- a) Mr Kennett-Brown commented that the NHS did not need to consult on every small element of the programme but, if there were significant proposals for change, then those would be part of a consultation. Members took issue with this pointing out that a site strategy on changes as complex as this would need full consultation. They asked if the timeline chart relating to Jan-Mar 2016 (p.10 of the presentation), could be amended by replacing the words “consultation if applicable” to “consultation where applicable”. Officers agreed to this.
- b) Members asked if it was possible to get a breakdown and cost analysis across the 9 clinical and 5 enabler workstreams of the programme with an indication of the expected savings on each. This would allow Members to provide some challenge from an accountability and transparency point of view. Officers undertook to provide this.

ACTION	<ul style="list-style-type: none"> a) The CSU/Programme Director to prepare for the next meeting a breakdown of what is hoped to be achieved and a cost analysis of potential savings for each of the 9 clinical workstreams and the 5 enabler workstreams in the <i>Transforming Services Together</i> Programme. b) That the timeline document for the programme be amended to read “Consultation where applicable” instead of “if applicable”.
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- c) Dr Everington pointed out that the asset strategy element of the programme had great potential and that one aim was that hospitals should have a GP Practice on their sites. In response to a question on finances, he replied that the current fiscal situation was making decision making more challenging, giving an example of Tower Hamlets CCG having to go all the way to a Health Minister for a decision about a site in Tower Hamlets as NHS Property Services had been unable to make a decision.
- d) Members expressed a concern that there appeared to be no role for Councils in the projected governance structures. Mr Kennett-Brown replied that local authorities were represented on the *Transforming Services Together* Board. The Chairs of local Health Scrutiny committees, the Chairs of Health and Wellbeing Boards, the Directors of Public Health and Directors of adult social services from the participating boroughs in the programme were all involved in meetings. It was also noted that local authorities were also involved in

strategic estates discussions as they had a great interest in key worker housing, in particular relating to nurses housing.

- e) The work on youth diabetes involved a borough by borough strategy across east London and prevention work was key. Getting young people involved in sport was an important factor in tackling childhood obesity, a major causal factor in diabetes, which was proving to be a health 'time bomb'. Another aspect was limiting the amount of fast food shops located near to school premises. Dr Everington added that getting diabetic children back to normal weight has an astonishing impact on reducing and even eliminating their condition.
- f) Members asked how confident the financial modelling for the programme could be considering the levels of borrowing at Barts Health. Mr Kennett-Brown replied that they would evaluate all these factors from a financial perspective. He re-iterated that overall however the programme was clinically led.
- g) In relation to older people with complex needs there was a need to improve the co-ordination of services and for the NHS to improve how it shared data. The move towards 7 day working in trusts should help address this as there was a concern about life expectancy rates being worse at the weekends. Generally, hospitals were not healthy places for frail older people to be, Dr Everington added. On the issue of data, Dr Everington pointed out that matters were not being helped by the current care.data debacle. He was involved in a pilot project whereby 50% of patients in his group now had direct access to their medical notes online.
- h) In relation to delayed transfers of care, it was noted that in Hackney the CCG had given an additional £4m to the Council for care packages. The officers pointed out that there would be movements in both directions and the Better Care Fund was all about such integration.
- i) It was noted that the NHSE, Monitor and the NTDA had employed McKinsey's to carry out a review of 12 challenged health economies nationally and east London was one of these. The *Transforming Services Changing Lives* programme had actually commenced before the 'challenged health economies' report had been produced. Financial challenges in East London had been clearly identified but with the significant increase in population in the area it had become increasingly obvious that it would not be possible to close any service such as an A&E in the area because that need would have to be replaced. Dr Everington added that the traditional approach in the health service had been to create more bed spaces but this was no longer practical and there was a need instead to do things in a different way, hence the focus on aiming to reduce outpatients visits by 50% and enabling more patients for example to die at home should they choose to.
- j) A concern was expressed about what would happen to City residents who might go outside the WEL CCG areas for treatment. Mr Kennett-Brown replied that City and Hackney CCG had to focus on what was provided in the

community rather than on what hospital patients might choose to attend. Overall the NHS in East London had to deliver a system that worked best for them. It was noted that UCL Partners had done work on how patient flows worked across the system and indeed the recent changes to specialist cancer and cardio services had very much been driven by research on patient flows across the whole system. Dr Ryan added that Barts Health was working on having a single IT system with Primary Care across Tower Hamlets, Newham and the City.

- k) In response to a concern about the urgency of getting the savings programme back on track Dr Ryan stated that they now had the best processes in place that they ever had. Both Referral to Treatment rates and Patient Tracking Lists were showing improvements.
- l) Average stays in Orthopaedics were now down to one week. Nurses were seeing high volumes of patients and once patients were physically ready the focus was to ensure their discharge was not delayed. Mr Millington added that in Orthopaedics they had to liaise with 11 different local authorities on getting discharge schemes sorted out.
- m) Dr Everington pointed out that a key point with discharge was to help patients on their journey and to ensure that people felt that their local hospital was 'their hospital'. Patients instinctively had a massive loyalty to their local hospital. Having said that the stroke and cancer-cardio centralisations were really saving lives and the new cardiac centre at Barts would do the same. Mr Millington added that if patients had their outpatient appointments at their local hospital and had continuity of care this allayed their fears.
- n) Members expressed concerns about the operation of the marginal tariff on emergency care and how for a Trust like Barts it was cheaper for them if they were able to outsource some patients to the private sector because of the perverse incentives in the operation of the tariff system. Dr Ryan explained that they negotiated deals with private providers so the Trust didn't lose out. The aim however was to end this practice within a year or so. There would also be a focus to get the numbers of patients waiting longer than 52 weeks down. As part of the process they obviously assessed the risk of harm to patients who might have to wait more than 18 weeks.
- o) On the issue of bullying and the forthcoming CQC report Dr Ryan stated that they worked on the principle of collaboration between stakeholders so there should be no surprises when CQC reports came out. The latest CQC report on Whipps would be challenging however. It would also raise issues about waiting times. On the bullying issue the Board was taking a lead on pushing through improvements here. Dr Ryan stated that as Medical Director he himself had taken serious action against bullying cases and cases where patients were shown incivility or disrespect. In terms of employee morale it was important that staff also respected each other and understood better the pressures colleagues were under.

- p) A Member pointed out that the 2013 CQC report had highlighted bullying then but no progress appeared to have been made. Dr Ryan stated that Professor Duncan Lewis had carried out an external report and the recommendations were being acted upon. He cautioned that this would take more than a year to start delivering results. He noted that the CQC itself had bullying issues within its own organisation. Large change management programmes required training of all staff and the Older Persons Services Programme had cost £1m to implement, for example, as every member of staff had to be taken off wards for a week.
- q) Ms Kelly stated that staffing was a national issue and was a central focus of their work. Transport links to some of their sites meant that it was often difficult to recruit staff and there was an added housing challenge for student nurses for example. There were also challenges in recruiting to specialist areas. The changing pace of work, the increase in acuity of patients put a strain on staff. The impact of working in the trauma team long term was a concern and working on the front line of nursing now was much different than when she had first trained. A lot needed to be done to get the culture right and to make the roles attractive and to ensure there is enough support was in place for staff. She added that up to now nurses were greatly encouraged to specialise but now there was a need for nurses to be able to work across a wider range of care pathways. It was difficult to recruit cancer nurse specialists she added. There was a need to think about re-creating generic roles in nursing but to maintain the integrity of these roles. Dr Everington added that there was a need to develop nurses' roles and to bring in new skills. There was often great talent among staff who didn't possess formal qualifications for example and there was a need to rethink career pathways.

5.6 The Chair thanked the NHS representatives for their presentation and for their attendance. Mr Kennett-Brown stated that the next stage would be to come back to INEL around July to present the next phase of the Programme. The Chair stated that she looked forward to seeing how the programme would develop and that a date would set for this closer to the time.

RESOLVED:	That the reports and discussions be noted.
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ACTION:	Overview and Scrutiny Officer to convene a meeting of INEL in late July to take forward the next stage of the consultation on <i>Transforming Services Together</i> programme.
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