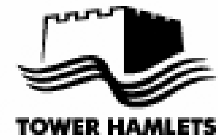

Meeting of the

INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

Friday, 25 May 2012 at 3.30 p.m.

A G E N D A

VENUE
C1, 1ST FLOOR, TOWN HALL, MULBERRY PLACE

If you require any further information relating to this meeting, would like to request a large print, Braille or audio version of this document, or would like to discuss access arrangements or any other special requirements, please contact:

tracey.anderson@hackney.gov.uk 0208 356 3312

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LONDON BOROUGH OF TOWER HAMLETS

INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

Friday, 25th May 2012

3.30 p.m.

PARTICIPATING LOCAL AUTHORITIES

MAP OF LOCATION

1. APPOINTMENT OF CHAIR AND VICE-CHAIR

2. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

3. DECLARATIONS OF INTEREST

Any Member of the Committee or any other Member present in the meeting room, having any personal or prejudicial interest in any item before the meeting is reminded to make the appropriate oral declaration at the start of proceedings. At meetings where the public are allowed to be in attendance and with permission speak, any Member with a prejudicial interest may also make representations, answer questions or give evidence but must then withdraw from the meeting room before the matter is discussed and before any vote is taken.

4. MINUTES (Pages 5 - 20)

To agree the minutes of the meeting held on 15th July 2012.

5. URGENT CARE SERVICE

A presentation from Helen Brown, Director Performance and Delivery and Sarah Mcilwaine, Senior Programme Manager, Urgent Care from NHS North East London and the City. Updating on implementation of national programme making changes to urgent care services.

6. BARTS HEALTH NHS TRUST (Pages 21 - 44)

Presentation from Dr Steve Ryan, Medical Director and Professor Shona Brown, Director of Organisational Development from Barts Health NHS Trust. Updating on the current position of the merger project.

7. NORTH EAST LONDON COMMISSIONING SUPPORT (Pages 45 - 52)

Presentation by Andrew Ridley, Managing Director Commissioning Support Services from NHS North East London and the City. Update on the development of the commissioning support organisation to support CCGs in North East London.

8. INEL JOSC TERMS OF REFERENCE AND PROCEDURE RULES (Pages 53 - 60)

A discussion about the draft terms of reference and procedure rules, for a standing joint committee for Inner North East London.

9. ANY OTHER ORAL OR WRITTEN ITEMS WHICH THE CHAIR CONSIDERS URGENT

[Each written report on the public part of the Agenda as detailed above:

(i) was made available for public inspection from the date of the Agenda;

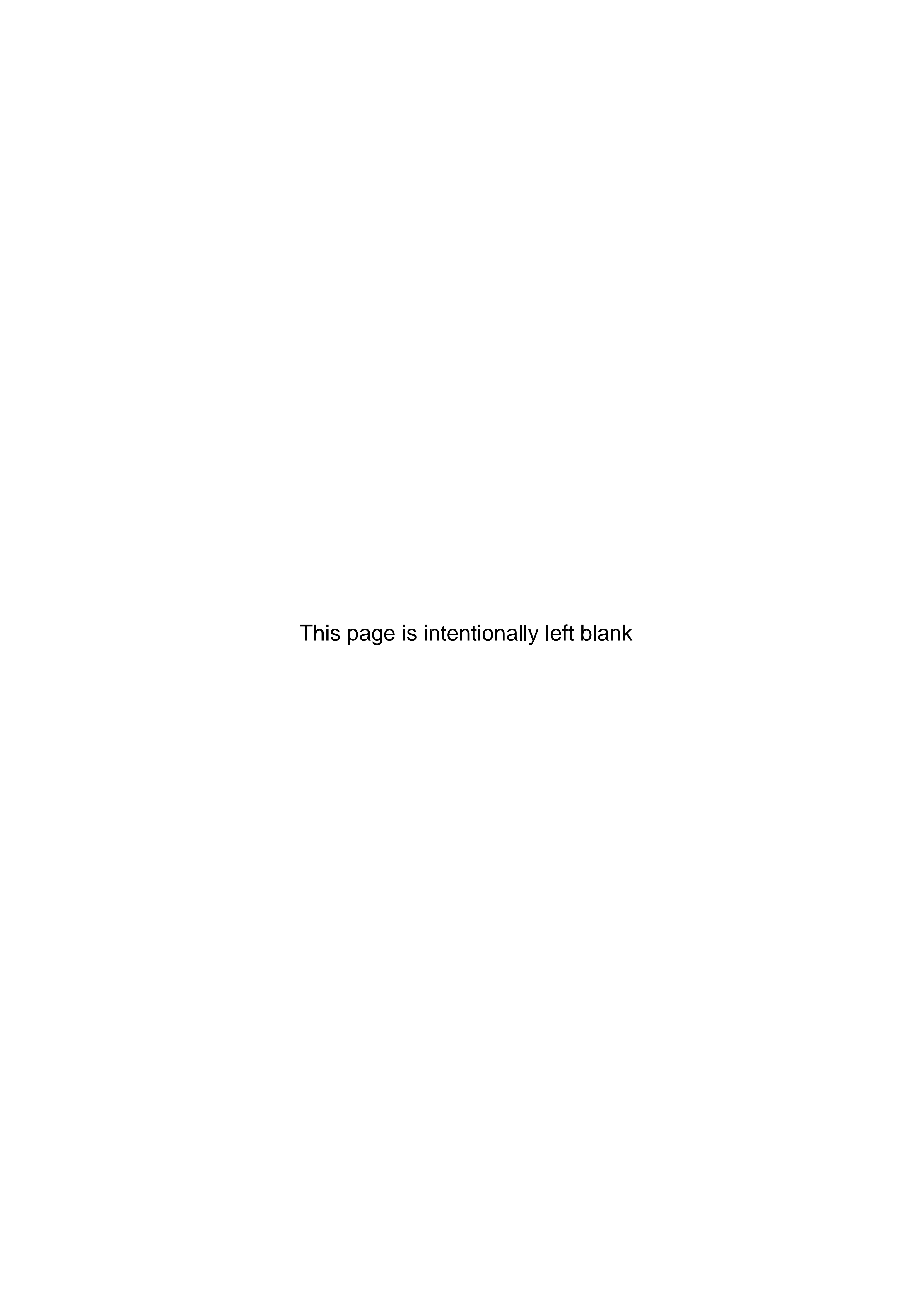
(ii) incorporates a list of the background papers which (i) disclose any facts or matters on which that report, or any important part of it, is based; and (ii) have been relied upon to a material extent in preparing it. (Relevant documents which contain confidential or exempt information are not listed.); and

(iii) may, with the consent of the Chairman and subject to specified reasons, be supported at the meeting by way of oral statement or further written report in the event of special circumstances arising after the despatch of the Agenda.]

Exclusion of the Press and Public

There are no matters scheduled to be discussed at this meeting that would appear to disclose confidential or exempt information under the provisions Schedule 12A of the Local Government (Access to Information) Act 1985.

Should any such matters arise during the course of discussion of the above items or should the Chairman agree to discuss any other such matters on the grounds of urgency, the Committee will wish to resolve to exclude the press and public by virtue of the private nature of the business to be transacted.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PARTICIPATING AUTHORITIES

Authorities	Appointed Member
The City of London Corporation	Common Council Man Vivienne Littlechild
London Borough of Hackney	Cllr Luke Akehurst
	Cllr Ann Munn
	Cllr Benzion Papier
London Borough of Newham	Cllr Ted Sparrowhawk
	Cllr Winston Vaughan
	Cllr Leanora Cameron
London Borough of Tower Hamlets	Cllr Rachel Saunders
	Cllr Denise Jones
	Cllr Lesley Pavitt

Please Note: *Membership for each borough is currently being reviewed and may change resulting with attendance at the meeting being different.*

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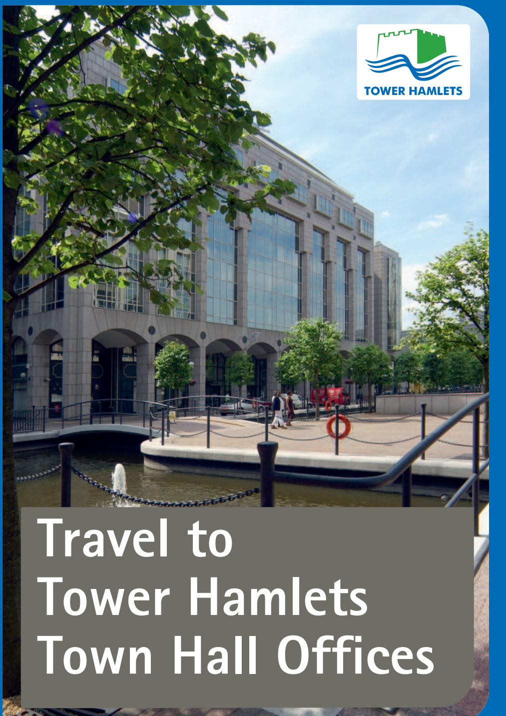


Travel to Tower Hamlets Town Hall Offices

By Bus

The site has excellent bus links which connect it to East and Central London and beyond.

The 277 bus route begins and ends at the site, and the 15 begins and ends a 3 minute walk away at Blackwall Station. There are a number of other bus stops close by.

Most local bus services are listed overleaf and shown on the map, with the closest bus stops clearly marked on the enlarged map below.

By DLR and Tube

East India and Blackwall DLR Stations are in the immediate vicinity of the Town Hall site, with many other DLR stations within a short walk.

The closest Tube stations are Canning Town or Canary Wharf (both Jubilee Line).

For further information visit www.tfl.gov.uk/journeyplanner

By Foot

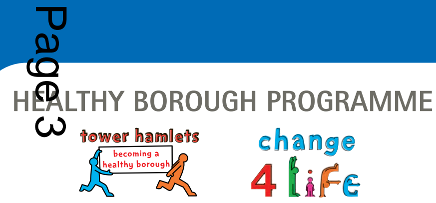
An approximate 20 minute walk from the site is shown by the blue circle (on the map overleaf). Many DLR and both Tube stations are within this zone.

There is pedestrian access to the site from all directions, allowing good access to the surrounding area.

For more information on walking in Tower Hamlets see www.towerhamlets.gov.uk/walking

For walking directions see www.walkit.com

HEALTHY BOROUGH PROGRAMME



This map has been funded as part of the Tower Hamlets Council Travel Plan which aims to boost the number of staff and visitors travelling to the site by sustainable modes of transport.

Tower Hamlets is one of 9 areas designated as a 'Healthy Town' and has been awarded Government funding to tackle the environmental causes of overweight and obesity. Active Travel (cycling and walking) plays a major role in the programme.

www.towerhamletshealthyborough.co.uk

Design, digital cartography and print by Pindar www.pindar.com 03.10

Tower Hamlets Town Hall Offices
Mulberry Place, Clove Crescent, London E14 2BG
t: 020 7364 5020
w: www.towerhamlets.gov.uk

By Bike

The site is well served by cycle routes, including Cycle Superhighway route 3 opening in 2010.

Cycle parking facilities for visitors are provided at ground level – see map (left).

Extensive cycling facilities are also available for staff who wish to cycle to work; email cycling@towerhamlets.gov.uk for details.

Further information on planning your journey by bike can be found at www.tflgov.uk/cyclejourneyplanner or visit www.towerhamlets.gov.uk/cycling for more information.

Map ▸▸▸

Bus Frequencies

15 Blackwall - Paddington Basin — Daily

Blackwall DLR - All Saints DLR - Limehouse DLR - Aldgate - Fleet Street - Charing Cross - Oxford Circus - Paddington - Paddington Basin

Monday - Friday daytime 6-10 minutes. Saturday daytime 6-10 minutes. Evenings and Sundays 6-10 minutes

Operated by East London

108 Lewisham - Stratford — 24 Hour

Lewisham DLR - North Greenwich - Blackwall Tunnel - Bromley-by-Bow - Stratford DLR

Monday - Friday daytime 8-10 minutes. Saturday daytime 10-14 minutes. Evenings and Sundays 20 minutes.

Operated by London General

115 East Ham - Aldgate — Daily

East Ham - Upton Park - Plaistow - Canning Town DLR - All Saints DLR - Limehouse DLR - Aldgate

Monday - Friday daytime 5-9 minutes. Saturday daytime 8-12 minutes. Evenings and Sundays 10-12 minutes.

Operated by East London

277 Leamouth - Highbury — 24 Hour

Leamouth - Canary Wharf DLR - Westferry DLR - Mile End - Hackney Central - Highbury & Islington

Monday - Friday daytime 5-8 minutes. Saturday daytime 6-10 minutes. Evenings and Sundays 9-12 minutes.

Operated by East London

D6 Hackney - Crossharbour — Daily

Hackney Central - Cambridge Heath - Bethnal Green - Mile End - All Saints DLR - Crossharbour DLR - Crossharbour ASDA

Monday - Friday daytime 6-10 minutes. Saturday daytime 7-11 minutes. Evenings and Sundays 15 minutes.

Operated by First

D7 All Saints - Mile End — Daily

All Saints DLR - Island Gardens DLR - Canary Wharf DLR - Westferry DLR - Mile End

Monday - Friday daytime 8-12 minutes. Saturday daytime 7-10 minutes. Evenings and Sundays 15 minutes.

Operated by First

D8 Crossharbour - Stratford — Daily

Crossharbour - Canary Wharf DLR - All Saints DLR - Bow Church DLR - Stratford DLR

Monday - Friday daytime 9-13 minutes. Saturday daytime 11-12 minutes. Evenings and Sundays 20 minutes.

Operated by First

For further information call 020 7222 1234 or visit www.tfl.gov.uk

Inner North East London Joint Health Overview and Scrutiny Committee 25 May 2012 Minutes of the last meeting	Item No 4

Outline

Attached are the draft minutes for the meeting on 15 July 2011.

Action

The Committee is asked to agree the minutes.

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

FRIDAY, 15TH JULY, 2011

Councillors Present:	**Councillor Luke Akehurst in the Chair**
	Councillor Denise Jones, Wendy Mead, Councillor Ann Munn, Councillor Benzion Papier, Councillor Lesley Pavitt, Councillor Rachael Saunders and Councillor Winston Vaughan
Apologies:	**Councillor Ted Sparrowhawk**
Officers in Attendance:	
Also in Attendance:	**Sarah Barr (Senior Strategy, Policy and Performance Officer), Jeremy Gardner (Head of Communications), Caroline Gilmartin (Deputy Director of Primary Care and Adult Community Nursing), Neal Hounsell (Strategy and Performance Director), Michael McGhee (Director of Older People Services), Dr Lucy Moore (Integration Director), Gerald O'Mahony (Clinical Director and Lead Consultant Older People Services), Don Neame (Communications Director), Thomas Pharaoh (Senior Project Officer), Dr Steve Ryan (Medical Director), John Wilkins (Deputy Chief Executive and Director of Performance and Business Development) and 3 members of the public**

1 APPOINTMENT OF CHAIR AND VICE CHAIR

1.1 The appointment of the Chair and Vice Chair will be postponed for two reasons:

a) Some Members present were interim appointments and permanent Members will not be confirmed until the following month
b) Some members were confirmed just before this meeting so the Committee was requested to allow Members more time to consider and prepare their nomination for positions of Chair and Vice Chair.

1.2 In the absence of an appointed Chair it was agreed the hosting Borough (London Borough of Hackney) Chair of Health Scrutiny (Cllr Luke Akehurst) would chair the meeting.

2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBER

2.1 Apologies for absence from Councillors: Ted Sparrowhawk from London Borough of Newham and Denise Jones from London Borough of Tower Hamlets

3 DECLARATIONS OF INTEREST

3.1 Cllr Luke Akehurst from London Borough of Hackney declared he was a member of the Homerton Hospital NHS Foundation Trust.

4 LONDON CANCER SERVICES - IMPLEMENTATION

4.1 Presentation by Thomas Pharaoh from London Health Programmes about the London Cancer Implementation Programme.

4.1.1 The proposals for changing services were proposed by commissioning support services for London. In 2010 a review of cancer services was conducted which engaged 45 clinicians.

4.1.2 The case for change was published in December 2009, the model of care proposals were developed in August 2010 followed by a 3-month engagement process. It was reported over 85 per cent of survey respondents were supportive.

4.1.3 The three work areas were early diagnosis; common cancers and general care; rarer cancers and specialist care.

4.1.4 The compelling case for change was influenced by factors such as:

- Late diagnosis resulting in poor survival rates
- Variations in quality of care. (It was reported there are areas of excellence in London but inequalities in access and outcomes exist).

4.1.5 The vision is for treatment and care to be standardised, whereby Specialist surgery is centralised and common treatments localised where possible.

4.1.6 Seeing comprehensive pathways commissioned and organisational boundaries not a barrier. It was explained a patient can get lost in the system through organisation transition during their care.

4.1.7 The national patient experience survey revealed the patient's perception of the quality of cancer service care was worse than actual performance.

4.1.8 The key themes for the model of care are:

- Improve early diagnosis
- Providers to work together in a small number of integrated systems delivering standardised pathways

- Extended local provision of common cancer services to improve cancer rates across London.

4.1.9 In relation to early diagnosis this is an area where the UK performs poorly in comparison to Europe and the USA. It is suggested if the number of people through the door was improved survival rates would increase.

4.1.10 Working groups consisted of GPs, Public Health Consultants, Diagnostic Experts and patient representatives to identify the most effective evidence based interventions to improve early diagnosis.

4.1.11 LHP view the new proposed Health and Wellbeing boards as a vehicle to support this process locally, recognising local population issues whilst engaging with key players and promoting positive messages.

4.1.12 LHP advised they were working closely with the cancer community to develop a specification against which proposed systems could develop their plans. Hospitals were being asked to demonstrate how they could work together to improve patient experience and provide seamless cancer care. Proposals were submitted on 30th June 2011 demonstrating how they would address clinical outcomes and improve patient experience.

4.1.13 Organisations have been requested to develop service plans with a view for implementation around April 2012.

4.1.14 The proposed systems for London were:

- London Cancer (NE and NC London)
- 'The Crescent' (SE, SW, NW London).

4.1.15 It is anticipated LHP will be in a position to announce local implications autumn 2011.

4.1.16 The Committee was informed providers and commissioners will be required to work differently together and commission services in a more effective way. There will be a closer alignment between pathway descriptions, quality standards, outcome measures and the way that services are paid for and monitored.

(If you would like a copy of the presentation please contact the overview and scrutiny officer)

4.2 **Questions and Answers**

(i) **Wendy Mead referred to the aim of reducing late diagnosis and enquired how the new system proposed to achieve this objective?**

The Senior Project Officer from LHP advised the work would be around increasing public awareness and improving GPs diagnosis of cancer. In London they wanted providers to work together to improve access to diagnosis and to do outreach work to GPs to improve their knowledge and review the trends.

(ii) **Wendy Mead enquired if LHP had been out to Europe to see how their system for cancer diagnosis operated?**

The Senior Project Officer from LHP informed this research would be conducted by the national programme because the problem of late diagnosis was not unique to London and there are pockets of good practice in London that they needed to learn from.

(iii) **Cllr Munn enquired if information was available to identify what groups were not being diagnosed early.**

The Senior Project Officer from LHP explained the case for change document highlighted the evidence on this. However this varied according to things like the type of Cancer tumour, social demographic and many more so plans needed to be developed for each specific area to take into account local challenges.

(iv) **Cllr Pavitt referred to the issue not presenting early and commented this was a big challenge advising often patient had to keep going back to their GPs several times before they could get the correct diagnosis.**

The Senior Project Officer from LHP agreed there was a real need to raise the awareness of GPs and the public before the rate of late diagnosis could improve.

(v) **Cllr Vaughan asked for more details about the integrated cancer system and if was known what locations the systems would be in London**

The Senior Project Officer from LHP advised the specification document provided details of the system. In relation to the locations it was explained they were currently in receipt of the bids and had an assurance panel assessing the bid over the summer period. This assurance panel would approve the integrated cancer system bids. It was noted the system would involve the hospitals that currently operate services now but they would be commissioned to operate in a different way specifically for cancer services.

(vi) **Cllr Vaughan enquired if there would be standard policy related to drugs operated across the board.**

The Senior Project Officer from LHP advised taking into account outcome measures to be achieved the policy for drugs would be down to the individual trusts. It was explained a drug unit in London was set up and made recommendations to the trusts and would continue to do this work under the new system.

(vii) **Cllr Akehurst referred to the proposal to make changes to the chemotherapy services but not radiotherapy and queried if this was the correct changes to make.**

The Senior Project Officer from LHP informed delivery of chemotherapy services was covered by policy and governance to ensure it was conducted safely. Radiotherapy services were different and required not only specialist equipment but a specially adapted building too. The changes being proposed

for chemotherapy services were not only about location and how the service would be delivered. The proposal was to change to larger doses to reduce the number of trips required for treatment.

(viii) **Mr Vidal referred to the use of a patient panels when developing the current proposals and enquired if the same action would be taken when developing patient pathways to obtain an understanding of how it worked.**

The Senior Project Officer from LHP advised the providers were asked to inform how service user input would be incorporated.

(ix) **Cllr Vaughan expressed the importance of consultation with the voluntary sector and enquired if this during the consultation process LHP had consulted organisations such as the Local Involvement Networks (LINks) across the capital.**

The Senior Project Officer from LHP confirmed LINk organisations across the capital were visited and Health Overview and Scrutiny Committees. Once they have more detailed information they would return and update.

(x) **Mrs Rocke-Caton expressed concern about clinicians sometimes leaving the patient in a state of fear whilst testing was being conducted leaving a person to think they had cancer. Remarking this caused undue stress and anxiety for the patient believing they have it and then later finding out they did not.**

The Senior Project Officer from LHP acknowledged there were some instances were information was not conveyed in the correct manner. However an organisation has an obligation to give potential life threatening news in a sensitive way. This it was hoped would be addressed through raising awareness.

5 BARTS AND EAST LONDON HEALTHCARE MERGER PROJECT

5.1 Presentation by Dr Lucy Moore, Integration Director of the Barts and East London Healthcare Merger Project and Dr Steve Ryan, Medical Director of the Barts and the London Trust about the proposed merger of three acute trust in North East London. The main points of the presentation were:

5.1.1 The hospitals being proposed in this merger are:

- Newham and Whipps Cross general hospital:
  local hospitals providing A&E, urgent and community care, outpatients, maternity, women's and children's services and planned surgery
- Barts and The London NHS Trust (BLT) which currently operates three hospitals:
  The Royal London: providing all the services available at Newham and Whipps Cross plus a major trauma centre, an acute stroke centre providing immediate care for people who have suffered a stroke, and more specialist care/complex surgery for adults and children
  Barts: near St Paul's provides specialist cancer, urology and cardiac (heart) care as well as sexual health services and a minor injuries unit

In 2016 the heart attack unit at **The London Chest** in Bethnal Green will move to Barts.

5.1.2 It was noted there was a huge amount of expertise and knowledge to be shared among the trusts and segments of exemplar services. For example

- Newham trust have a nationally adopted End of Life care model
- Whipps Cross trust have low rates for MRSA amongst the lowest in the country and;
- Barts and the London trust have the country's most advanced major trauma centre.

5.1.3 One of the major contributing factors to the decision for the merger is to improve the life expectancy and tackle the challenging health needs of the population. North East London has some of the most deprived, unhealthiest communities and big health inequalities (17 years difference in life expectancy).

5.1.4 Another key factor is the challenging financial climate currently facing the NHS. Members were informed health care was getting more expensive and it was important for the NHS to find ways to make services more sustainable in the long term, whilst creating the ability to invest in services such as maternity due to increasing birth rates in East London.

5.1.5 It was highlighted all three trusts individually cannot achieve foundation trust status as required in the pending Health and Social Care Bill. All three trusts face would have significant difficulty in being able to meet the financial requirements of foundation trust status. This would leave them subject to the following options:

- To merge with another trust,
- Be taken over,
- Have their future decided by the Secretary of State for Health.

5.1.6 It was recognised that there are areas that need to be improved such as:

- Patient experience could be much better
- Some services are excellent but far too many needed to improve.

5.1.7 The nature of healthcare is changing. New understanding of best practice means we need to take a fresh look at our services e.g. ensuring senior doctors are on site for more hours of the day.

5.1.8 A solution to the challenges outlined was being sought and it was proposed to develop an organisation that will be:

- Based on preventing ill-health
- Provide locally accessible, excellent quality, sustainable and comprehensive health services that are focused on each individual's need
- Ensures better access to high-quality care when it is needed
- Working with partners
- Grow its own talent and create jobs to bring greater prosperity to East London.

5.1.9 At the heart of this vision is a number of key benefits but it is expected to provide:

- Continued access to high quality and sustainable local hospital services

- Equitable access to high quality specialist services.

5.1.10 The benefits of the merger as expected to achieve and bring:

- Raise all standards of work to the best across the three trusts
- Work together to resolve areas where none of the trusts are doing well, e.g. involving patients in decisions about their care and improving the patient experience
- Take advantage of new developments in healthcare and technology to:
  - Provide locally led services supported by better use of IT and link to specialists
  - Consolidating specialist services
  - Separating urgent and planned care
  - Ensuring senior doctors are on site for longer.
    (In England an individual's rate of survival reduces if admitted to hospital at the weekend. By sharing rotas a 24/7 service could be developed.
  - Pooling resources to make more impact on public health campaigns like the small c campaign
- Remove organisational barriers:
- Reduce costs
- Be more competitive when bidding for research funding.

5.1.11 Merging the trusts would mean better prospects and being a world leader to attract quality staff giving access to better staff training and development for:

- Doctors and Nurses to gain experience in different hospitals along the whole patient pathway
- Opening up opportunities for career progression
- Becoming world class would enable the trust to recruit some of the best Doctors and researchers in the world.
- Joining forces with other partners in an Academic Health Science Centre would mean that senior Doctors should be more likely to secure funds and work with colleagues that could pool their talents to develop new technology, techniques and treatments.

5.1.12 The merged trust would be in a better position to develop partnerships that benefit patients:

- Local community and education providers to increase the community wealth as it has been evidenced that people in employment live healthier, longer, more productive lives
- Health partners such as GPs, community nurses, health visitors, other local hospitals and mental health trusts so as to gain a better understanding of local health needs to plan and deliver an integrated service. The transfer of Tower Hamlets Community Health Services to Barts and The London will bring significant benefits to the community, which could be developed in other areas
- Local Councils to provide tailored services that reduce inequalities and better integrate with social care and healthcare in the community.

5.1.13 The key milestones dates advised were:

- Outline Business Case signed off NHS London - August 2011
- Full Business Case approval - Sept/Oct 2011
- Submission to NHS transaction board/Secretary of State: Nov/Dec 2011
- Merger April 2012

- Foundation trust application 2013
- Foundation trust authorisation March 2014.

5.1.14 The Members were informed that to create a new and different organisation structure did not require a formal consultation with the public because it was not a service change. The trust was required to formally consult staff and was in the process of doing this.

5.1.15 Members were informed the project team proposed to distribute copies of the manifesto to the patients and public (around 15,000 copies) would be sent to libraries, membership lists and community groups. Engagement about these proposals would involve posters in hospitals. Attendance at meetings. Presentation to LINks and to LINk Forum to collate comments and views.

(If you would like a copy of the presentation please contact the overview and scrutiny officer)

5.2 **Questions and Answers**

(i) **Cllr Pavitt made the following comments and queries:**

a) **Referenced the use of IT systems and asked if assurance could be given that this new system the NHS was investing in would work**
b) **Referred to the trust's population of 1 million and queried why only 15,000 consultation booklets were being produced if the intent was to consult the full population**
c) **Enquired if the Gateway Surgical Centre was in house?**

The Medical Director from BLT informed as the lead for IT in BLT he acknowledged IT systems did not work well at present and they recognise systems need to be improved. It was noted there is an IT work stream and the proposal is to have the same IT system in all three trusts.

In relation the comments about the number of documents produced for the consultation the comments were noted and taken back for review by the project team.

It was confirmed the Gateway Surgical Centre referred to in the presentation was operated by Newham trust.

(ii) **Cllr Saunders made the following comments and queries:**

a) **Is the merger driven by money or could more information be provided about the clinical drivers behind the proposals?**
b) **Raising clinical standards what does it mean?**
c) **Will the new trust find it easier to attract staff having the reputation of being a world leader?**

The Medical Director from BLT acknowledged this was a big challenge but by having the ability to partner with big brand organisation like Alder Hey Trust could help to resolve the workforce issues like the difficulties in filling junior Doctor posts.

It was confirmed the proposal to merge was not just about finance but would assist with improving healthcare pathways for the local population; especially since BLT had recently acquired the community health services business. With

improved IT system it could work better and working more closely with pharmacists and dentists etc in the community setting could improve efficiency.

(iii) **Cllr Munn made the following comments and queries:**

a) **Asked for clarity if the proposed merger involved service reconfiguration or not?**
b) **If it was not possible for the individual trusts to obtain foundation trust status on their own?**
c) **had the trust taken into consideration the cost implications for implementing a new IT system as this usually involved a big initial expense before savings would materialise.**

The Integration Director from the Merger Project Team confirmed the project was aware there would be initial cost implications of changing an IT system and would be reviewing it in more detail.

In relation to the trusts achieving foundation trust status independently it was noted following a review all three trusts as individual organisations could not achieve foundation trusts status. This was due to a combination of factors such as accumulated debt, cost of improvements, cost of PFI schemes etc. The benefit from this proposal is by coming together as one they are more confident they can achieve foundation trust status.

In relation to service changes she advised for example maternity service would remain on three sites but specialist services may be consolidated.

(iv) **Cllr Cameron queried about moving specialist services and the impact this would have on the community.**

The Medical Director from BLT advised for example specialist services such as chemotherapy would in the vision be moved out to other sites and the project informed as one trust they could move this service out to the other acute trust locations quicker. It was envisaged by 2012/13 once established the trust could look into providing chemotherapy treatment at home for patients.

(v) **Cllr Cameron enquired if there would be plans to move radiotherapy treatment out to locations nearer to the community too because currently patients had a long travel route in addition to treatment.**

The Medical Director from BLT explained due to the expensive specialist equipment and building needed for this service there were no plans to move the location for this type of treatment. Although the trust had listened to the view of patients and were considering how best to support their needs and this involved looking at increasing the dosage to reduce the number of treatments.

(vi) **Cllr Vaughan commented on a big challenge facing the Newham acute trust was the increasing birth rate. Highlighting the problem was recruitment and retention of midwives and enquired if the proposed trust had considered how this problem would be addressed.**

The Medical Director from BLT informed there was a maternity working group reviewing projected birth rate and model of care to consider what the system would be able to cope with. It was reported the trust had plans and hoped to

work with City University to access the education programme for specialisms like midwifery to improve recruitment.

(vii) **Cllr Vaughan commented this had been an issue for Newham since the Darzi review and suggested if the trust talked to their healthcare workers they could give them the resolution. Highlighting even though staff were recruited the key issue was retention.**

The Medical Director from BLT explained staff would be a focal point in the new organisation and their vision was to achieve the aim outlined in the presentation related to staff to resolve the workforce issues.

(viii) **Wendy Mead made the following comments and queries:**

a) **Raise concern about the heart attack centre as the City of London was previously advised it would open 2014 but the presentation stated 2016**
b) **Raised concern about City residents having to travel to sites further away.**

The Medical Director from BLT confirmed the date for opening the Heart Attack Centre in 2014 was correct. He assured the Committee outpatients' appointments would remain local and gave an example of a planned hip operation being carried out on another site and this would mean it would not be subject to postponement as is currently the case if an emergency operation needed to be preformed. It may be decided to keep emergency operation at the Royal London and planned at another site. This was viewed as a really good proposal which should lead to shorter length of stays and planned cases not being cancelled, but confirmed any proposed changes would need to be consulted on.

(ix) **Cllr Munn referred to slide 12 and asked for confirmation the merger related to management or services.**

(x) **Mr Vidal requested for the final version of the business case once completed to be sent to Joint North London LINks group.**

The Integration Director from the Merger Project Team informed the final version of the outline business case should be ready shortly and she would make sure a copy was sent to LINks. The project was due to produce their manifesto at the end of July and this would be the start of their engagement. In response to concern raised about finances it was acknowledge this concern was shared by all. It was expressed the trust did recognise the size of the challenge and the need to give assurance. The project team advised it had heard a lot about what works and what does not work with mergers. A lot of work was being done through clinical groups to learn from past mergers and involve the staff.

The Medical Director from BLT advised slide 12, information about specialist services, would require the trust to carry out its statutory duty to consult.

The Communications Director from the Merger Project Team explained the merger being discussed related to bringing all the trusts together as one organisation. However whilst doing this process they were flagging up areas

where they may return to consult for service change. For the initial change they do not have a legal duty to consult but wish to engage in dialogue with the Health Overview and Scrutiny Committees but acknowledged for service changes they would need to consult.

6 INNER NORTH EAST LONDON MENTAL HEALTH INPATIENT SERVICES

6.1 Presentation by Gerald O'Mahony, Clinical Director and Lead Consultant Older Peoples Services, from East London NHS Foundation Trust, Caroline Gilmartin, Associate Director (Performance, contracting and Procurement) and Jeremy Gardner, Head of Communications from NHS East London and the City. The main points of the presentation were:

6.1.1 Dementia is deemed as a terminal illness that will end your life. 2/3rd of inpatient cases related to dementia. The Commission noted individuals were presenting late thus requiring hospital stay.

6.1.2 In keeping with national guidance and principles the vision is to develop a range of early identification, assessment and support services. At present 70% of people with dementia live at home and the trust wants to bring services to the community.

- Invest in a broader range of community services and offer intensive home-based support as an alternative to hospital/institutional care admission
- Offer choice in treatment and care options to users and carers
- Embed a re-enablement approach to treatment and care throughout the service.

6.1.3 A review of the bed base spend revealed a disproportionate amount of spend across the three locations.

6.1.4 This led to two options under consideration:

- The first was to stay as it is.
- The second was to re-configure dementia assessment wards to enable more investment and flexible services that would be person centred and in the community. Under the reconfiguration proposals the trust would change from operating three small units in three different boroughs to one large unit in a central location accessible by all the local authorities.

6.1.5 Out of scope of these proposals will be other adult in-patient and residential services, including continuing care wards and respite care these will continue to be borough based for each local authority.

6.1.6 It's proposed the reconfiguration of the centralised unit will enable pooling of skills which will develop the service.

6.1.7 Previously older people mental health services were not a priority and service performance became poor. A national strategy and refocus over the last two years resulted in investment in dementia services in East London.

6.1.8 It was explained how demand for the service had changed in Hackney from approximately 40 case referrals per year to 10 a week. The new Memory clinic in Newham alone was seeing approximately 500 referrals a year.

6.1.9 There has been investment over the past two years in dementia services for City and Hackney, Newham and Tower Hamlets.

6.1.10 Among the clinical benefits noted in the presentation from implementing the proposals the key highlights were:

- A sliming down of in-patient ward services
- Increased community services. There would be a nurse led service operating in the community. Greater emphasis would be placed on the building of partnership working following the centralisation of the unit.

6.1.11 It was highlighted the cost of running a ward was the same irrespective of the number of occupants i.e. the operating costs for a ward with 7 occupants was similar to one with 20 occupants. The financial savings would come from reducing the number of units from 3 to 1. This was expected to deliver approximately £2million in savings.

6.1.12 The reconfiguration will change staff teams to allow strong community services. Enabling a lot of close working with partners and good services.

6.1.13 The proposed location for the central unit was Mile End Hospital.

6.1.14 The consultation process was being led by NHS ELC and dialogue would be via the Joint Overview and Scrutiny Committee for Inner North East London.

6.1.15 Formal consultation was scheduled to commence 1st September 2011 and the PCT was in the process of preparing the consultation document.

6.1.16 A host of public engagement events were planned for each borough with the key aim being to engage with key stakeholder groups for older people and carers to acquire a range of views from the communities.

6.1.17 The main concerns raised so far related to access for patients and carers to Mile End Hospital.

6.1.18 A transport impact analysis was commissioned by East London NHS Foundation Trust and this identified an aggregate impact on journey time and journey complexity for service users and carers. Although there was likely to be some impact for some service users and carers in south Newham. Members were advised it was proposed to support service users and carers who faced travel problems to ensure access would be simple and equitable, by the use of minibus or taxi travel.

The proposed consultation timetable was listed in the presentation. *(If you would like a copy of the presentation please contact the overview and scrutiny officer)*

6.2 **Questions and Answers**

(i) Cllr Vaughan enquired about the travel analysis conducted and asked if it was conducted by Transport for London (TfL).

The Associate Director (Performance, contracting and Procurement) from NHS East London and the City (NHS ELC) advised the initial analysis was conducted by a private organisation and they worked with a range of sources to inform them. It was anticipated further analysis would be conducted to follow up on the gaps identified.

(ii) Cllr Munn raised concern about the current long average length of stay time and queried if it would be best to reduce the length of stay and establish a good discharge planning process first before implementing the changes.

The Clinical Director and Lead Consultant, Older Peoples Services from ELFT explained the assessment process was mapped out and identified to take 6 weeks. The trust has identified the delay related to finding long term placements i.e. residential care. As usually when an individual is admitted their illness is advanced. It was acknowledged it would be sensible to start with improving the discharge planning first. However this would require dedicated staff and as a small unit they do not have the staff available to carry out this work in tandem or prior to implementing the new model of care.

(iii) Cllr Munn enquired if the trust was sure that the new service model with fewer beds would work if currently they encountered challenges due to waiting for beds from partners.

The Clinical Director and Lead Consultant, Older Peoples Services from ELFT informed for Hackney the requirement is 7 beds and this same number will be allocated to Hackney in the new model of care.

It was noted the proposals were developed based on evidence of good practice. The comments from the consultation will form part of the decision making process. If there was clear evidence during the process that showed the proposals would not work they would need to be changed.

(iv) Cllr Vaughan enquired if the burden of care under the proposed model would fall to carers?

The Clinical Director and Lead Consultant, Older Peoples Services from ELFT informed the trust wanted to put a service together that gave meaningful support for a longer period of time. After diagnosis a service user would have follow up support, advice etc from services like Alzheimer's Society. It was noted on average a person could live with the illness for about 10 years and often came to inpatient services when the illness was at a critical stage i.e. 7-9 years into the illness. It was noted often families were happy to be left to their own devices and would seek help or support when the illness become too much to manage.

(v) Mr Vidal enquired if service users were involved and consulted when the travel analysis was being conducted.

The Older Adults Mental Health Commissioning lead from ELFT confirmed a selection of service users were consulted for a period of a week to review their old journey compared to the new journey. No one had a longer journey except those service users and carers in South Newham.

7 INNER NORTH EAST LONDON DRAFT TERMS OF REFERENCE AND PROCEDURE RULES

7.1 Cllr Vaughan from London Borough of Newham requested for Members agreement of the draft Terms of Reference (TOR) and Procedure Rules for the INEL JOSC could be postponed until the next meeting. He advised the Legal Officer in Newham Council had raised some concerns regarding the TOR and procedure rules and this was not present to their Full Council meeting for agreement. He suggested the Overview and Scrutiny Officer supporting the INEL JOSC liaised with the Overview and Scrutiny Team in Newham for the full details and amendments to present for sign off.

7.2 The Members agreed to postpone.

ACTION	Overview and Scrutiny Officer to contact Newham Overview and Scrutiny Team to get requested amendments for TOR and Procedure rules to present for the next meeting of the INEL JOSC.

8 URGENT ITEM / ORDER OF BUSINESS

8.1 Cllr Vaughan suggested the venues to host the INEL JOSC meetings were rotated and he offered Newham to start for the next meeting.
8.2 Member agreed.

ACTION	Overview and Scrutiny Officer to rotate INEL JOSC meeting around the Boroughs.

Duration of the meeting: 4.00 - 6.15 pm

Signed

…………………………………………………………………………………..

Chair of Committee

Contact:
Tracey Anderson
020 8356 3312
tracey.anderson@hackney.gov.uk

Item 6

Inner north east London Joint Overview and Scrutiny Committee

25 May 2012

Dr Steve Ryan, Medical Director
Shona Brown, Director of Organisational Development
Adrienne Noon, Director of Communications and Engagement (interim)

Purpose

To provide the committee with an update on our merger journey and benefits of becoming Barts Health

To provide an overview of our progress since merging, including transitional site arrangements, values of the new trust and senior leadership appointments

Our commitments as a new trust

Merger journey, benefits and future ways of working

Dr Steve Ryan, Medical Director

Barts Health is a platform for the future

The Vision

To offer acute, specialist and community services that are tailored to meet the needs of its local communities

To be recognised locally, nationally and internationally for outstanding clinical services, research and education

Identifying and sharing best practice across the trusts

- Standardise services to best practice – reducing length of stay

Realising any efficiencies and economies of scale

- Combining the clinical workforce to raise quality of care in paediatrics
- Change the way we deliver pathology services to capture economies of scale

Developing clear clinical pathways to enable rapid access to the right care

- Integrate acute patient pathways in cancer care
- Integrate specialist, secondary and community patient pathways for diabetic patients

Financially resilient trust with no organisational barriers,
a single clinical vision and accountability that is capable of becoming a foundation trust

Re-cap on merger journey milestones

- July 2011: Outline business case (OBC) approved by three legacy trust boards
- August 2011: OBC approved by NHS London
- August 2011: 16 week programme of local engagement undertaken
- December 2011: Full Business Case (FBC) approved by three legacy trust boards, two commissioning clusters and NHS London
- February 2012: NHS Cooperation and Competition Panel (CCP) recommend that merger takes place
- February 2012: FBC approved by the Department of Health Transaction Board
- March 2012: Final approval to merge received from the Secretary of State for Health
- March 2012: Consultation with trust staff and union reps on transfer of employment to the new merged organisation
- 1 April 2012: Barts Health NHS Trust established

What are the Clinical Academic Groups?

There are eight Clinical Academic Groups (CAGs):

- Ambulatory care
- Cancer services
- Cardiovascular services
- Children's Health
- Clinical support services
- Emergency care and acute medicine
- Surgery
- Women's Health

Each CAG in the new organisation will be led by a senior clinician, with a director of nursing and governance, an operations director, and an education and research lead

The CAGs will provide a range of services, to high standards of clinical quality, patient safety, and value for money. To achieve this, each CAG will prioritise:

•The experience of their patients and carers

•Health improvement and reducing health inequalities for our local communities

•Their role in promoting human rights and equalities, for staff and for patients

One of the early priorities will be to agree areas for early service improvement and/or for co-designing integrated clinical pathways. This work will be undertaken with the representatives of patients and carers, primary care and community health services, commissioners, public health teams and with partners in social care and other sectors.

Clinical academic group (CAG) appointments

Group directors

Cancer: Maurice Murphy

Cardiovascular: Charles Knight

Emergency Care and Acute Medicine: Alistair Chesser

Surgery: Andy Morris

Women's Health: Sandra Reading

Operations directors

Ambulatory: Janet Lewis

Cardiovascular: Sara Davenport

Clinical Support Services: Fiona Isacsson

Directors and nursing and governance

Ambulatory Care: Christine Pidgeon

Cancer: Catherine Walsh

Cardiovascular: Louise Crosby

Children's Health: Elaine Wall

Director of Therapy, Nursing and Governance – Clinical Support Services: Simon Ashton

Emergency Care and Acute Medicine: Scott Maclean

Surgery: Shirlene Jones

Director of Midwifery, Nursing and Governance – Women's Health: Dawn Johnston

Directors of education and research

Cancer: Nicholas Lemoine

Clinical Support Services: Muaaze Ahmad

There remain a number of posts with the CAGs to which no appointment has been made. The external recruitment process that has been put in place will be completed over the next month.

Transitional arrangements

A date for when we will change to this new CAG operational structure has not yet been determined, but will only happen when all the necessary appointments have been made to ensure that we maintain and improve performance at each of the hospital sites.

In the interim, Len Richards, Chief Operating Officer has strengthened the senior management team structures at each of our hospitals.

Since 1 April, three interim managing directors have been appointed to help lead the legacy organisations through the transition, whilst at the same time maintaining and improving performance. They are:

- Toby Lewis (St Bartholomew's, The Royal London, The London Chest hospitals)
- Mark Cubbon (Whipps Cross University hospital)
- Diana Lacey (Newham University hospital)

These colleagues are supported in the transition by the new and existing leadership teams (where possible), including the current medical directors, directors of nursing and most of the existing corporate leaders who work at each hospital.

Organisation values

Shona Brown, Director of Organisational Development

A sense that we have been listening to patients and what matters to them

- Staff attitude
- Communication to patients
- Communication between staff
- Appointment processes
- Maternity services
- Care of older people
- Patients as partners
- ‘Life style options’, e.g. noise, food, cleanliness, pain control, what happens in their bed area

The key ingredients for the Barts Health vision

- **Do the right thing, first time, every time.** Build a reputation for being dependable and reliable and focused on delivery. This means doing the right thing for our patients, our staff and our partners
- **Be honest** when we don't get it right
- Have a **focus on health** and addressing health inequalities
- **Listen and respond.** Build a reputation for being responsive and build local confidence in Barts Health
- Be recognised as being **consistently** concerned about **getting the fundamentals right**
- Provide easily **accessible, locally connected, great** healthcare
- Really **engage with our staff, patients, partners and local communities** to improve services and build a local, national and international reputation
- Have a workforce that is truly **reflective of our local population**
- Build on our **academic and research strengths** for the benefit of improving local care, treatment and promoting health
- Create an **organisation we are all proud of**, providing the best value sustainable services

Our indicative values

- **Caring and compassionate** with patients, with each other, and with our partners
- Actively **listening, understanding and responding** to patients, staff and our partners
- **Relentless improvement and innovation,** learning from our patients, and other experiences
- **working together** to deliver ambitious results
- **valuing** every member of **staff's contribution** to the **care our patients**

Trust Board

The Barts Health NHS Trust Board has now been formally established and is accountable for setting the strategic direction of the trust, monitoring performance against objectives, ensuring high standards of corporate governance and promoting links between the trust and local community

As part of the indicative values work the Board have committed to the following:

•**Amplifying the patient voice in the Board**: a patient story for each Board meeting was agreed at April meeting

•**Board visibility:** 'Friday Free' meeting days are a good illustration of how we want to dedicate quality time to hear from patients and staff (clinical and non-clinical)

•**Strong processes from front line to Board:** for raising concerns, with clear response and feedback mechanisms

Executive and senior leadership appointments

Shona Brown, Director of Organisational Development

Trust Board members

The Barts Health NHS Trust Board has 13 voting Board members comprising the Chair, seven non-executive directors and five executive directors:

•Mr Stephen O'Brien, Chair
•Mr Peter Morris, Chief Executive
•Dr Steve Ryan, Medical Director
•Professor Kay Riley, Chief Nurse
•Mr Len Richards, Chief Operating Officer
•Mr Mark Ogden, Chief Financial Officer
•Philip Wright, Non-Executive Director, Trust Board Vice Chairman and Senior Independent Director
•Millie Banerjee, Non-Executive Director
•Alastair Camp, Non-Executive Director
•Gautam Dalal, Non-Executive Director
•Sally James, Non-Executive Director
•Professor Richard Trembath, Non-Executive Director
•Anne Whitaker, Non-Executive Director

Other senior leadership appointments

The following senior leadership appointments have been made to support the new Trust Board and CAGs:

•Associate chief nurse: care standards: Hazel Tonge
•Associate chief nurse: nursing informatics and innovation: Lyn Hinton
•Associate director of finance: financial services: Martin Botterill
•Associate director of finance: income, contracting and costing: Tracey Braniff
•Deputy chief executive and development director: Toby Lewis
•Deputy chief nurse: patient experience and engagement: Hilary Shanahan
•Deputy chief nurse: quality and governance: Nancy Fontaine
•Deputy chief nurse: Tracey Carter
•Deputy medical director: workforce and deputy responsible officer: Celia Skinner
•Deputy trust secretary: Sean Collins
•Director of academic health science: Professor Jo Martin
•Director of communications and engagement (interim): Adrienne Noon
•Director of corporate affairs: Ian Walker
•Director of human resources (interim): Julia Whitehouse
•Director of organisational development: Shona Brown
•Director of planning: Graham Simpson
•Director of primary care: Dr Shera Chok
•Director of research development: Gerry Leonard
•Managing director of education academy: Dawne Bloodworth

Stakeholder engagement

Adrienne Noon, Director of Communications and Engagement (interim)

Stakeholder engagement

Following the publication of the OBC, over 10,000 people had an opportunity to help shape the new organisation through a variety of engagement activities including:

- **26,000 copies of prospectus** and **10,000 copies of clinical prospectus** inviting comments on the proposals were distributed throughout hospitals, to community and patient groups, libraries, trust membership lists and to local authority and commissioning colleagues – documents also available in a variety of languages and alternative formats including Easy Read and audio
- **25 roadshows for staff, patients and the public** to find out more, ask questions and give their views
- Attendance by clinicians and senior managers at **over 100 local meetings** including overview and scrutiny, local involvement networks and clinical commissioning groups
- Regular feature in **local community publications** and features on the **hospital trust and partner websites** and intranets for staff
- Transitional **website** to provide central information on the merger
- **Patient Advisors Group** established to help design the new organisation patient experience and involvement strategies, branding, signage and other key issues
- Frequent information and **briefings to staff** and their representatives

Further detail on the engagement period can be found here: http://www.bartsandthelondon.nhs.uk/assets/merger/Communications-and-Stakeholder-Engagement-Report-and-Letters.pdf

What we heard

The feedback received from our engagement with stakeholders and local partners was extremely valuable in developing our integration plans.

Six key themes arose from the engagement programme and discussions with a broad range of individuals, organisations and partners. These were:

- Financial sustainability for future generations
- Delivering care closer to home
- Partnership working
- Realising the benefits
- A need to improve communication
- Taking staff on the journey

Further engagement opportunities

Opportunities to be further involved and engaged with the new trust continue and include:

•partnership workshops to develop the new brand for Barts Health
•local events to share views and develop our values and behaviours
•engagement to develop a new trust website which meets local needs
•opportunities for patient pathway development
•existing meetings with stakeholders including overview and scrutiny committees, LINks, health and wellbeing boards, clinical commissioning groups and patient representative panels in addition to one-to-one meetings with MPs and GP commissioners
•becoming a member of the trust so that local people and their representatives can have a greater voice in the organisation

Further opportunities are planned for the months ahead and will continue to be shared with the committee.

Our commitments

Trust priorities

The new trust is absolutely committed to ensuring local people and their representatives can have a greater voice in the organisation.

At the heart of everything we do will be ten pledges below. These will permeate through every aspect of the trust's work. The pledges will help us to challenge the way we work and enable our stakeholders to hold us to account.

- Patients will be at the heart of all we do.
- We will provide consistently high quality health care.
- We will continuously improve patient safety standards.
- We will sustain and develop excellence in research, development and innovation.
- We will sustain and develop excellence in education and training.
- We will promote human rights and equalities.
- We will work with health partners to improve health and reduce health inequalities.
- We will work with social care partners to provide care for those who are most vulnerable.
- We will make the best use of public resources.
- We will provide and support the leadership to achieve these pledges

Trust priorities

Adherence to these pledges will also enable us to deliver on our strategic priorities which are essential for addressing our health challenges and achieving our vision:

•A significant contribution to programmes which improve health and reduce health inequalities achieved through joint working with local partners via the Health and Wellbeing Boards

•Secure local acute services, with improved access across north east London to the full range of specialist services supported by enhanced research and education capabilities

•Better quality as well as reduced variability of clinical outcomes, patient experience and operational performance

•Financial resilience and a sustainable platform for acute services in north east London

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ITEM 7

North Central and East London Commissioning Support Service

Context

North Central and East London Commissioning Support Service

- Health and Social Care Bill received Royal Assent – now an Act.
- We are moving to a new commissioning support system:
  - Clinical Commissioning Groups (CCGs)
  - NHS Commissioning Board
  - Commissioning Support Services (CSS)
  - Public Health for England
  - Public health transition to local authorities
  - Health and Wellbeing Boards.
- CCGs in north east London now have 100% delegation for budgets.
- April 2013, CCGs will have statutory responsibility for commissioning health services.
- CCGs will need support beyond in-house teams. CCGs will have choice about where they buy commissioning support.

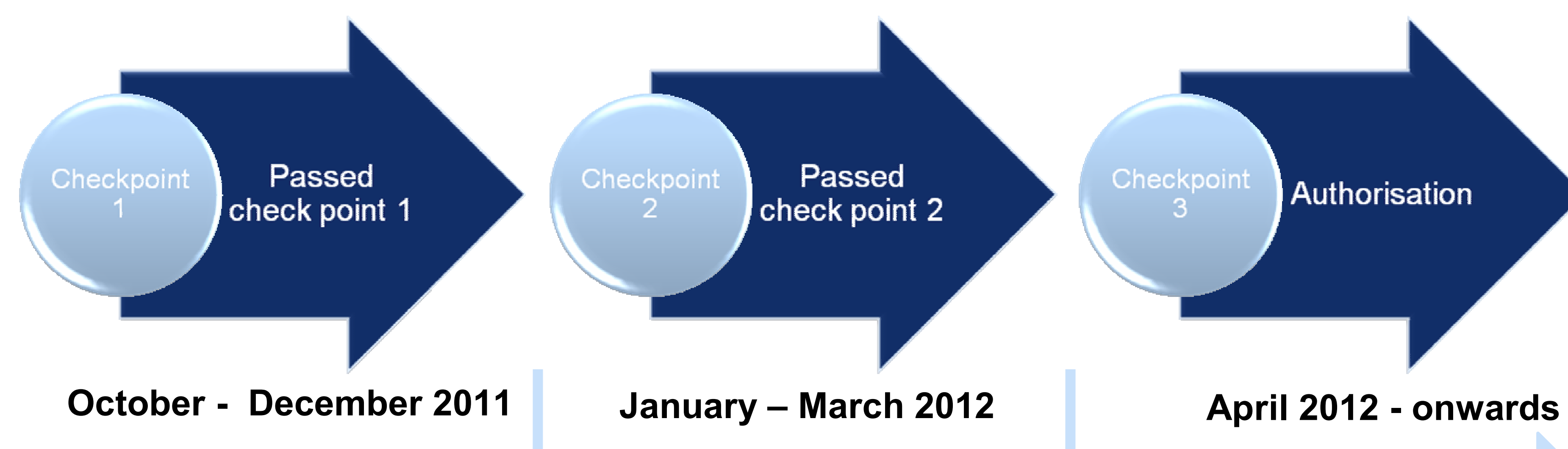
Commissioning support services

North Central and East London
Commissioning Support Service

- Commissioning support services are new organisations which are being set up to provide services to CCGs.
- Around 26 CSSs are being established in the UK. Three CSSs in London.
- One CSS for North East and North Central London. We will provide an 'end to end' service to 12 'foundation' CCGs .
- By working together, we aim to enhance our offer to customers and maximise impact of reduced running costs.
- The CSS will support CCGs to make decisions about health services to improve the health and health services for local communities.

CSS development – our journey

North Central and East London Commissioning Support Service



October - December 2011

- Discussions with customers, local authorities and staff
- Published commissioning support prospectus
- Identified services
- High-level operating model

January – March 2012

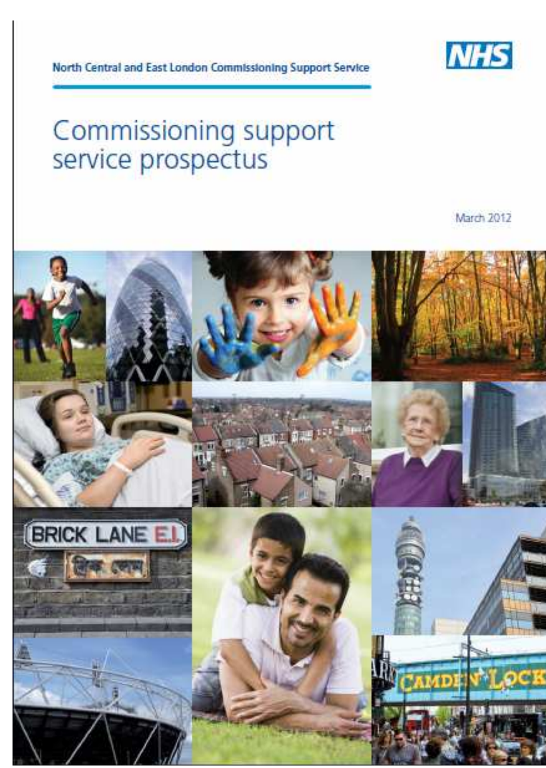
- Extensive customer engagement
- Discussions with local authorities and staff
- Detailed definitions of services and functions
- Submitted Outline Business Plan
- Passed checkpoint 2

April 2012 - onwards

- Demonstrate a viable operation
- Detailed transition planning
- Submit Full Business Plan to DH Business Development Unit by August 2012

CSS development

North Central and East London
Commissioning Support Service

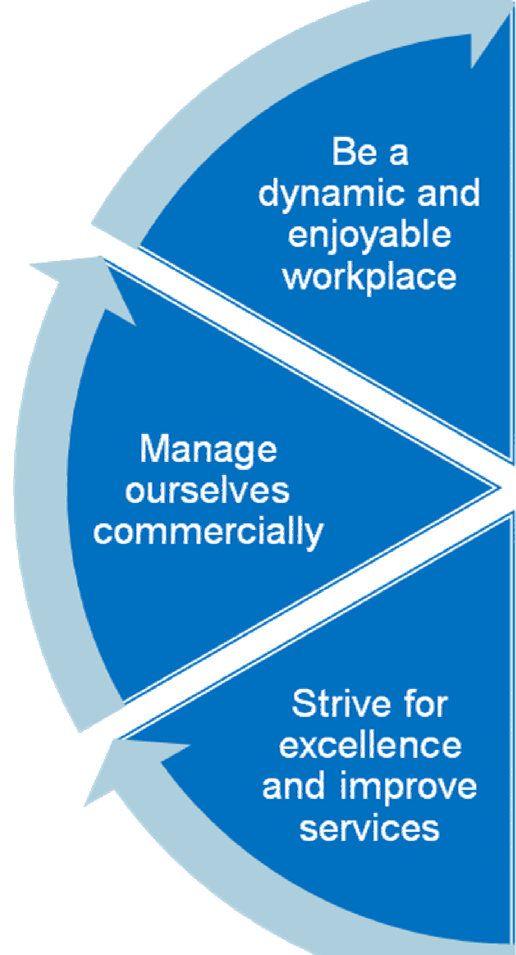


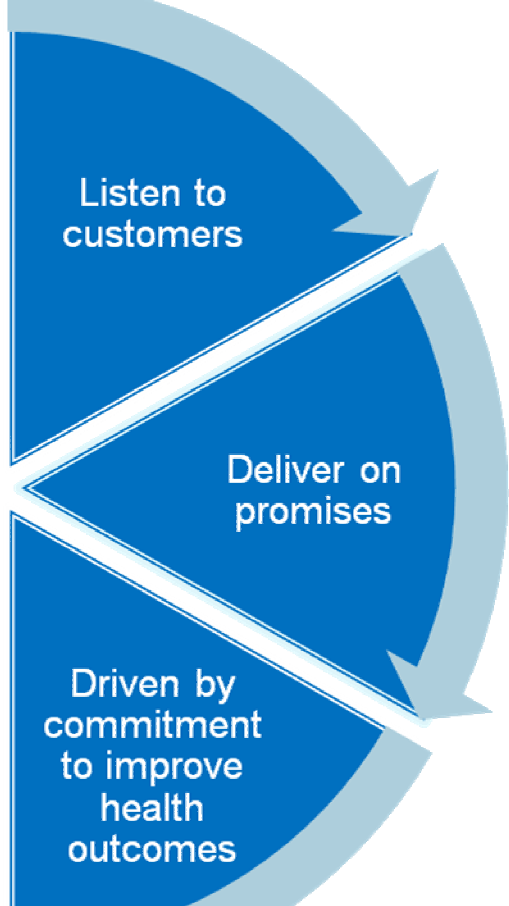
- Extensive engagement with CCGs to refine their needs for support – more than 60 meetings with CCGs in Feb / March 2012
- Concluded with affordable core offer for all customers with some customisation.
- Discussions with other potential customers and partners including local authorities and NHS CB.
- Service Level Agreements (SLAs) developed with each CCG. Ten customers have signed priced agreements covering three years, one for two years and one for five years.
- Staff workshops held in Dec 2011 and Feb 2012 – useful feedback on values and becoming a customer-focused organisation.

CSS development

North Central and East London
Commissioning Support Service

Supporting commissioners to make the best decisions for their communities





Our services

Key service lines:

1 Business intelligence, information technology and informatics
2 Communications, engagement and FOI requests
3 Support for commissioning/QIPP planning and service redesign
4 Procurement and market management
5 Quality and provider management
6 Corporate services including finance and financial management

At scale services:

Service	At scale
Business intelligence	Yes
IT	Yes
Clinical procurement	Yes

CSS next steps

North Central and East London
Commissioning Support Service

- Engagement underway with staff on CSS staff structures
- Selection and appointment of staff – aligned to national timeframes
- Development of Full Business Plan (FBP) by August 2012
- Engagement with stakeholders to continue – incl. local authorities and CCGs
- Prepare to form new organisation and transfer to NHS Commissioning Board (subject to successful FBP)

**JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
PROPOSED STANDING INNER NORTH EAST LONDON JOINT
OVERVIEW AND SCRUTINY COMMITTEE**

PROPOSED TERMS OF REFERENCE

1. Consider and respond to any health matter which:

   - *Impacts on two or more participating authorities or on the sub region as a whole, and for which a response has been requested by NHS organisations under Section 244 of the NHS Act 2006, and*
   - *All 4 participating authorities agree to consider as an INEL JOSC*

2. To constitute and meet as a Committee as and when participant boroughs agree to do so subject to the statutory public meeting notice period.

DRAFT

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

Proposed Committee Procedure Rules

DRAFT

1. Establishment

1.1. The establishment of the committee is for London boroughs: London Borough of Hackney, London Borough of Newham, London Borough of Tower Hamlets and the City of London Corporation. This is in accordance with s.245 of the NHS Act 2006 and the Local Authority (Overview and Scrutiny Committees Healthy Scrutiny Functions) Regulations 2002.

2. Chair

2.1. The INEL JOSC will elect the Chair and Vice Chair at the first formal meeting of the INEL JOSC. The preference is the Chair and the Vice Chair will be drawn from different participating authorities.

2.2. Members of the Committee interested in either post will provide a written submission to the Committee support officer a week before the first meeting.

2.3. The written submissions will be circulated to all the Members of the INEL JOSC and at the first meeting one Member will nominate for the position of Chair / Vice Chair and a second Member will second the nomination.

2.4. A vote (by show of hands) will follow and the results will be collated by the supporting Officer.

2.5. It is assumed that in addition to Chairing the meetings of the INEL JOSC the Chair and Vice Chair will act as the member steering group for the INEL JOSC.

2.6. The appointments of Chair and Vice Chair will be for a period of two municipal years, following which the JOSC will again elect a Chair and Vice-chair on the basis of the provisions contained in clauses 2.1 to 2.5 above. If the INEL JOSC wishes to or is required to change the appointed Chair or Vice Chair, an agenda item should be requested supported by three of the four constituent Authorities following which the appointments will be put to a vote.

3. Membership of Committee

3.1. London Borough of Hackney, London Borough of Newham and London Borough of Tower Hamlets will each nominate up to 3 members of the INEL JOSC. The City of London Corporation will nominate up to two members. Appointments will be until further notice. Individual boroughs may change appointees at any time

(providing they have acted in accordance with their own procedure rules) but should inform the supporting officers of any such changes.

3.2. Political proportionality rules apply to this Committee and each participating Borough's nomination should represent the political proportionality of their Borough.

4. Co-optees

4.1. If the Committee chooses it can co-opt non-voting persons as it deems appropriate to the Committee.

4.2. Confirmed appointments of co-optees will be for a duration as determined by the JOSC.

5. Substitutions

5.1. Named substitutes may attend Committee meetings in lieu of nominated members. Continuity of attendance is strongly encouraged.

5.2. It will be the responsibility of individual committee members and their local authorities to arrange substitutions and to ensure the supporting officer is informed of any changes prior to the meeting.

5.3. Where a named substitute is attending the meeting, it will be the responsibility of the nominated member to brief them in advance of the meeting.

6. Quorum

6.1. The quorum of a meeting of the INEL JOSC will be the presence of a member from each of three of the four participating authorities. In an instance where only three authorities choose to participate in responding to a consultation, quorum will be the presence of a member from two of the three participating authorities. Where only two authorities choose to participate in a consultation, quorum will be the presence of a member from both authorities.

7. Voting

7.1. Members of the INEL JOSC should endeavour to reach a consensus of views. In the event that a vote is required, each member present will have one vote. In the event of there being an equality of votes the Chair of the meeting will have the casting vote.

7.2. Where the Committee has reviewed a topic or proposed service change and it wishes to make recommendations to a statutory health body, the Committee shall produce a single final report, agreed by consensus and reflecting the views of all the scrutiny committees involved.

DRAFT

8. INEL JOSC Role, Powers and Function

8.1. The INEL JOSC can co-operate with any other Health Overview and Scrutiny Committee, joint health overview and scrutiny committee or committee established by two or more local authorities within the greater London area.

8.2. INEL JOSC will have the same statutory scrutiny powers as an individual health overview and scrutiny committee that is:

- § accessing information requested
- § requiring members, officers or partners to attend and answer questions
- § making reports or recommendations to any NHS body or unitary authority with social care responsibility.

8.3. Efforts will be made to avoid duplication. The individual health overview and scrutiny committees of individual authorities shall endeavour not to replicate any work undertaken by the INEL JOSC. All scrutiny statutory powers for that topic being reviewed will be transferred to the INEL JOSC.

9. Support

9.1. The lead administrative and research support will be provided by the Health Scrutiny officer from the London Borough of Hackney with assistance as required from the officers of the participating borough.

9.2. Meetings of the JOSC will be rotated between participating authorities as agreed by the JOSC. The host authority for each meeting of the INEL JOSC will be responsible for arranging appropriate meeting rooms; ensuring that refreshments are available providing spare copies of agenda papers on the day of the meeting; and producing minutes of the meeting within five working days.

9.3. Each authority will identify a key point of contact for all arrangements and Statutory Scrutiny Officers are at all times to be kept abreast of arrangements for the JOSC.

10. Meetings

10.1. Meetings of the INEL JOSC will be held in public unless the public is excluded by resolution under section 100a (4) Local Government Act 1972 / 2000 and will take place at venues in one of the four INEL authorities. Accessibility issues may mean that locations in the authorities main Council Office i.e. Council Chamber would be the preferred option.

10.2. However, there may be occasions on which the INEL JOSC may need to hold site visits outside of the formal Committee meeting setting. Arrangements for these site visits will be made by the officers

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nominated to support the INEL JOSC with assistance from the officers of the borough being visited.

10.3. A written record of information from any site visit undertaken will be made for noting purposes for the INEL JOSC.

11. Agenda

11.1. The agenda will be prepared by the officer supporting the INEL JOSC guided by the Chair. The officer will send, by email, the agenda to all members of the INEL JOSC, the Statutory Scrutiny Officers and their support officers.

11.2. It will then be the responsibility of each borough to:

- publish official notice of the meeting
- put the agenda on public deposit
- make the agenda available on their Council website; and
- make copies of the agenda papers available locally to other Members and officers of that Authority and stakeholder groups as they feel appropriate.

12. Local Overview and Scrutiny Committees

12.1. The INEL JOSC will invite participating authority's health overview and scrutiny committees and other partners to make known their views on the proposal(s) or review(s) being conducted.

12.2. The INEL JOSC will consider those views in making its conclusions and comments on the proposals outlined or reviews

13. Representations

13.1. The INEL JOSC will identify and invite witnesses to address the committee and may wish to undertake consultation with a range of stakeholders. However as a general principle the committee will consider any written or verbal submissions from individual members of the public and interest groups that represent geographical areas in Inner North East London that are contained within one of the participating local authority areas.

13.2. The INEL JOSC will specifically request that the NHS bodies conducting consultations consider reviews undertaken by participating Borough's Overview and Scrutiny Committees. Summaries of the key points from these submissions will be appended to the INEL JOSC's final report for submission to the consulting NHS body decision making board.

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14. Timescale

14.1. This Inner North East London Health Overview and Scrutiny Committee (INEL JOSC) is constituted until further notice and insofar as it continues to have the support of the constituent participating authorities. It may be dissolved upon agreement of the participating authorities.

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