

**INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND  
SCRUTINY COMMITTEE (INEL JHOSC)**

**Meeting held on 20th November 2013**

In Assembly Hall 3, Hackney Town Hall, Mare St, London E8 1EA

**Members Present:**

Councillor Winston Vaughan (Chairman), Councillor Luke Akehurst (Vice Chairman), Common Councilman Wendy Mead, Councillor Ann Munn, Councillor Terence Paul, Councillor Rachael Saunders and Councillor David Edgar

**Member Apologies:**

Councillor Dr Emma Jones, Councillor Benzion Papier and Councillor Ted Sparrowhawk

**Officers in Attendance:** Luke Byron-Davies (Scrutiny Manager, LB Newham), Jarlath O'Connell (Overview and Scrutiny Officer, LB Hackney), Hafsha Ali (Head of Scrutiny, LB Newham), Neal Hounsell (City of London Corporation), Tahir Alam (Strategy Policy and Performance Officer, LB Tower Hamlets), Sarah Barr (Senior Strategy, Policy and Performance Officer, LB Tower Hamlets) and Philippa Sewell (City of London Corporation)

**Also in Attendance:** Peter Morris (Chief Executive, Barts Heath), Mark Graver (Head of Stakeholder Relations and Engagement, Barts Health), Mark Cubbon (Executive Director of Delivery, Barts Health), Neil Kennett-Brown (NHS England), John Hines (London Cancer), David Fish (UCL Partners), Muntzer Mughal (UCL Hospitals/London Cancer), Ben O'Brien (Barts Health/UCL Partners), Hilary Ross (UCL Partners), Dr Ash Paul (Consultant, Public Health, LB Hackney), Aidan Keightley (Healthwatch Newham), Michael Vidal (Healthwatch Hackney), Beth Earmington (NHS North and East London Commissioning Support Unit), Ruth Hardy, Stuart Maxwell (Hackney resident), Christopher Sills (Hackney Resident)

**1. WELCOME AND INTRODUCTIONS**

The Chair welcomed everyone to the meeting and stated it had been convened to jointly consider the report on financial turnaround for Barts Health NHS Trust and the consultation on the proposals for specialist cancer and cardiovascular services in North and East London and West Essex.

**2. MEMBERSHIP OF THE COMMITTEE**

The Committee noted the updated Membership list for Inner North East London Joint Health Overview and Scrutiny Committee. It was noted that

Councillor David Edgar had replaced Councillor Lesley Pavitt from the London Borough of Tower Hamlets.

### **3. APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTES**

Apologies for absence were received from Councillor Dr Emma Jones from the London Borough of Tower Hamlets, Councillor Benzion Papier from the London Borough of Hackney, and Councillor Ted Sparrowhawk from the London Borough of Newham.

### **4. DECLARATIONS OF INTEREST**

There were none.

### **5. MINUTES OF THE PREVIOUS MEETING**

The Committee gave consideration to the minutes of the meeting held on 29 May 2013.

**RESOLVED** - That the minutes of the meeting of the Committee held on 29 May 2013 be agreed as a correct record.

### **6. ACTIONS AND MATTERS ARISING FROM THE PREVIOUS MEETING**

There was none.

### **7. BARTS HEALTH NHS TRUST - REPORT ON FINANCIAL TURNAROUND**

7.1 The Chairman welcomed the following senior officers from Barts Health NHS Trust to the meeting:

Mr Peter Morris, Chief Executive  
Mark Cubbon, Executive Director of Delivery  
Mark Graver, Head of Stakeholder Relations and Engagement

7.2 At their previous meeting on 29th May 2013, the INEL JHOSC considered the draft Quality Accounts for Barts Health NHS Trust. Mr Morris stated that since then the Trust had begun a financial turnaround programme to improve the quality of patient care, increase speed of delivery and improve efficiency whilst delivering cost savings and productivity improvements.

7.3 As the largest NHS Trust in the country the reduction of the National tariff by 4% would result in a £50m saving to be made per year for Barts. In addition, a further local target of £28m needed to be found as transitional funding had been received previously and would fall away over a 2 year period.

7.4 Mr Morris outlined a three year plan in place to achieve a sustainable long term financial position. In 2013/14 the focus was on stabilising finances

via cost reduction and increasing income through Payment by Results. In 2014/15 Mr Morris stated attention would shift to address the underlying financial deficit so that in 2015/16 a financial equilibrium could be achieved.

7.5 Mr Morris highlighted the need to change current operational practices, and advised that this would involve restructuring and unifying the workforce. A review of management, nursing and administrative posts within clinical services had followed a corporate review, and a consultation on staffing levels had been launched in August 2013 with unions, staff and stakeholders to ensure proposed structures and processes were fit for purpose.

7.6 The turnaround and change in practices would require continued support for clinical and corporate functions, along with support for smaller groups within the organisation in order to utilise opportunities for improvement and ensure best practice was shared.

7.7 With regard to income, Mr Morris advised that over the past 12 months they had moved away from block contract payments, and would operate via Payment by Results so that work undertaken would be paid for in full. He also stated that income was a significant consideration in the long term plan.

7.8 Mr Cubbon provided more detail on the process for challenging and scrutinising decisions and ensuring robust practices. Recommendations from the National Audit Office had been implemented to improve quality of care and health and safety: The organisation was split into a number of divisions and each would have assessment levels to scrutinise proposed decisions and plans.

7.9 Senior doctors would present to a panel of officers (i.e. from Finance and HR) on any new plans, giving assurance and taking questions. The scheme would then be accepted or challenged accordingly and go on to be presented to the Chief Nurse and Medical Doctor. The cost implications of each scheme would go to the Trust Board to undergo a further degree of scrutiny.

7.10 With regard to external involvement in the process, an overview of each scheme and the process followed would also be presented to NHS England. An on-going monitoring process would track further financial opportunities, assess how schemes were impacting patients and service users, and recognise any risks or emerging patterns.

7.11 Mr Cubbon acknowledged that this was an intensive workload, but stated that it was critical in such a large organisation to ensure opportunities were realised and decisions were robust. The Trust had received positive feedback concerning this arrangement.

## Questions and answers

7.12 Councillor Ann Munn opened the questioning by asking the officers to give more information concerning the financial predictions for 2014-2016.

7.13 Mr Morris replied that the end of 2015/16 should see the Trust break even. In 2014/15 the focus would be to reduce and eliminate the underlying financial deficit, which was in the region of £50m, in addition to accommodating the step in Private Finance Initiative (PFI) payments.

7.14 Wendy Mead queried the effect taking charge of the cardiovascular services at St. Bartholomew's Hospital would have on PFI payments.

7.15 Mr Morris responded that further to consultation, an application would be made to make changes to the building and the ground prepared for the other hospitals, extensively using the St Bartholomew's site. With regards to PFI, Mr Morris advised Members that the extra patient load would result in extra revenue and that there would be an exercise to determine the cost of changes

7.16 Councillor Ann Munn asked whether the process for scrutinising decisions would be on-going, and asked for more information regarding Clinical Academic Group (CAG) specific schemes.

7.17 Mr Cubbon confirmed that the efficiency process would be on-going, and that CAG specific schemes were small, local schemes which built up over time into significant costs.

7.18 Mr Morris added that the numbers concerned were constantly changing, with new schemes being delivered in addition to existing ones. As an example, he spoke about increasing the robustness of theatre scheduling, highlighting that although the target was set at 65%, the aim was to surpass this in 2014/15.

7.19 Mr Cubbon reported that significant resources were being put into the restructure of the work force to understand how it is constructed and that salaries were being paid on an equitable basis. The forthcoming changes to unify the workforce were expected to deliver significant savings as well as improving efficiency. Mr Cubbon stated that £48m of £62m savings for 2013/14 had been delivered so far, with the rest to be delivered in the next few months.

7.20 The Chairman queried whether Payment by Results would financially impact CCGs and whether it would be harder to achieve important outcomes.

7.21 Mr Morris assured Members that the Trust was working closely with CCGs, tracking economics across the system on a monthly basis to ensure a sustainable way could be secured to run care pathways. He added that they

were encouraging themselves to do more to reduce waiting times, treating patients close to home wherever possible through an integrated care agenda.

7.22 With reference to the feedback from staff consultation, Cllr Akehurst declared a non-pecuniary interest by virtue of being a member of Unite. He asked whether any lessons had been learned for future consultations and what steps were in place to increase morale.

7.23 Mr Morris acknowledged the difficulty in reaching thousands of people and reducing their stress and anxiety but confirmed that support arrangements were in place; downgraded staff were protected against loss of earnings and communication was on-going, particularly with staff reps.

7.24 With regards to lessons learned, Mr Morris stated that allowing sufficient time for comments to be submitted and for feedback to be considered was paramount. Both these timescales had been extended in the consultation, the latter from one to three weeks, and Mr Morris reported that a better set of outcomes had been reached as a result.

7.25 Cllr Edgar enquired whether benchmarking would be used more generally in the future, and whether the recruitment of staff whilst downsizing the workforce reflected a mismatch of skills?

7.26 Mr Cubbon responded that as a relatively newly merged organisation it was necessary to get outside expertise. Organisations and services of a similar size had been compared nationally, and showed that the Trust had more staff on higher pay than comparable peers. This comparison was supplemented with benchmarking which compared London against the National nursing skill base. Mr Cubbon reported that staffing levels were not universally reduced, as some areas were being recruited to.

7.27 Mr Morris advised Members that the benchmarking exercise had been tailored to suit the organisation's shape and size which allowed them to be more confident of the relevance and robustness of conclusions drawn. He stated that the Trust came close to benchmarks from Safe Staff Alliance, and had retained a 65:35 mix of trained-to-untrained staff. He added that the Chief Nurse had the power to change the staff mix in particular areas, and extra monitoring and flexibility would ensure shape and number of staff was fit for purpose.

7.28 Mr Cubbon stated that although recruiting whilst downsizing staff might seem counterintuitive, it was necessary to address the mismatch of vacant posts and current skill levels. The Trust wanted to reduce the reliance on temporary staff, with an internal target of achieving 95% of a workforce of 14,500.

7.29 In light of the CQC reports highlighting problems with staff morale, Cllr Saunders asked how they were being tackled.

7.30 Mr Morris replied that staffing was an issue in terms of the level of agency staff and morale. A low appraisal rate had been observed previously but now a consistent appraisal system was in place, including team meetings and appraisals which were up to approximately 90%.

7.31 Mr Morris spoke about an annual opinion staff review and a smaller monthly survey (of approximately 2000 staff) carried out to gauge the mood of the organisation. At a request from Councillor Saunders, Mr Morris confirmed he would be happy to share these with the JHOSC.

7.32 With reference to down-banding, the Chairman queried how staff members were being redeployed and whether patient experience had been affected?

7.33 Mr Morris explained that any redeployment depended upon which posts would be free and the extent to which individuals were willing to accept posts based elsewhere in the organisation, considering their personal circumstances.

7.34 In response to the Chairman's request for figures estimating redeployment, Mr Morris was not willing to judge what might happen over the next 18 months but undertook to come back with figures at a later date.

7.35 Mr Morris informed Members that, as yet, there was no evidence that redeployment of staff had affected patient experience either positively or negatively. Changes were still being executed and monitoring would continue in order to highlight and address any adverse effect observed.

7.36 Wendy Mead asked whether the planned movement of staff to St Bartholomew's was part of the redeployment plans.

7.37 Mr Morris confirmed that the London Trust team would move entirely to the St Bartholomew's site but this would not be part of the redeployment process. With regard to Heart Hospital, work was underway to establish the required workforce, and more detailed preparations would begin in summer 2014.

7.38 Cllr Paul queried the levels and locations of agency staff compared with benchmarking, and asked whether there was a risk map in place to assess issues of quality and safety concerning temporary staff.

7.39 Mr Morris assured Members that the reliance on temporary staff would be reduced to more sustainable levels over the next 12 months, but it would take time to iron out the differences in specific sites. 14 additional staff had been recruited in HR to manage this.

7.40 Mr Cubbon added that assessment of risk was part of everyday procedures, and a mitigation plan was in place from Ward level up to the Board.

7.41 With reference to the CQC report concerning Whipps Cross, Cllr Saunders asked how the issues identified were being addressed.

7.42 Mr Morris advised Members that numerous housekeeping issues at Whipps Cross had been identified during the inspection, and now the Trust were ensuring the correct mechanics were in place to recognise problems and address them internally. He confirmed that the maternity services at Whipps Cross were safe, secure and effective, but recognised that the maternity patient experience needed to be better. He reported that a culture change within the service was being embarked upon to improve the service of care.

7.43 In response to a follow up question from Councillor Saunders, Mr Morris gave more detail as to the changes made to pick up issues in the future. He stated that a six figure sum had been invested to fix the maintenance issues identified during the inspection, and this provided a visible change to drive further improvements. As other maintenance work was completed, staff were recognising that things were being fixed whenever they were discovered or reported, which encouraged better communication to highlight issues.

7.44 The Chair thanked Mr Morris and the officers for taking the time to attend and answer the Members' questions.

## **8. IMPROVING SPECIALIST CANCER AND CARDIOVASCULAR SERVICES IN NORTH AND EAST LONDON AND WEST ESSEX - CONSULTATION ON CASE FOR CHANGE**

8.1 The Chair welcomed the following senior officers to the meeting:

Neil Kennett-Brown, NHS England  
John Hines, London Cancer  
David Fish, UCL Partners  
Muntzer Mughal, UCL Hospitals/London Cancer  
Ben O'Brien, Barts Health/UCL Partners  
Hilary Ross, UCL Partners

8.2 Mr Kennett-Brown thanked the Chairman, and informed the JHOSC that early engagement to gather feedback on the proposals for improvements to specialist services showed strong support. A leaflet and public events campaign had begun on 28 October and would conclude on 4 December.

8.3 Mr Mughal, from UCL Hospitals and London Cancer, outlined the vision for a world class cancer service with an advanced computer system and the latest treatments. He informed Members that survival rates and patient experience was poor in this part of London, which was a major driver to change and strengthen services. Five centres were proposed for five rare types of cancer: brain, head and neck, urological (bladder, prostate and kidney), acute myeloid leukaemia and oesophago-gastric (upper GI). Focus

would be on giving patients access to the best specialist care and to the latest treatments and clinical trials, improving patient experience and holistic care, and utilising the research opportunities.

8.4 Mr O'Brien, from Barts Health and UCL Partners, spoke about the cardiovascular proposals. Although the new building was an enabling factor, the high a number of deaths from cardiovascular illnesses was the real driver for change. Recent innovations in treatment were now being offered, but there was still a high number of cancellations due to organisational issues.

8.5 The proposal would see specialist cardiovascular services currently offered by both University College London Hospital (UCLH) NHS Foundation Trust and Barts Health NHS Trust come together in a single centre for excellence at St Bartholomew's Hospital in late 2014. Services provided at the London Chest Hospital and The Heart Hospital would join the new site, but care would extend beyond the three centres to create an integrated system felt in the community. Academic forces would be linked to ultimately create one centre of excellence that could compete with the world's academic power houses.

8.6 In closing, Mr Kennett-Brown returned to the feedback from the on-going engagement exercise. Support had been received from Clinical Commissioning Groups (CCGs), although the Outer North East London Joint Health and Scrutiny Overview Committee had voiced concerns regarding prostate cancer and the future of oesophago-gastric cancer moving from two to one centre. Travel and access were also important issues, with patients prepared to travel further for better outcomes and the UCLH committing to specific access arrangements (i.e. requesting additional disabled parking bays).

8.7 Wendy Mead opened the questioning by asking officers why UCLH had been selected over Barts to provide specialist treatment for head and neck cancer, despite the latter treating more patients in 2012/13?

8.8 Mr Fish, from UCL Partners, responded that the lead for head and neck cancer was an employee from Barts who supported the selection of UCLH. The hospital could offer strong infrastructural support, including the UCLA Ear, Nose and Throat hospital and Postgrad Dental Institute. In addition this was a nationally funded site to develop proton beam therapy, and a support was available from neuro-surgery and neuro-oncology surgery.

8.9 Wendy Mead queried the robustness of communications planned between the various hospitals and sites?

8.10 Mr Fish agreed that communications throughout the NHS were inadequate, but advised that having fewer specialist sites would reduce communication difficulty as the complexity of interaction would also be reduced. He assured Members that investment in informatics could link



providers of care across the partnership; although the current baseline for communications was low, it was a priority for improvement.

8.11 Wendy Mead followed up her question, querying how reducing the number of sites would improve patient experience outside of their home territory, which was largely where problems arose?

8.12 Mr O'Brien replied that wider networking between colleagues would be facilitated to enable better working relationships and improve communication. Patient pathways would be integrated the entire way, to ensure patient experience was consistent and staff communication was continuous.

8.13 Mr Hines, from London Cancer, advised Members that Officers were familiar with the difficulties in moving patients around the system and that it would be easier with fewer places. Doctors and specialists would split their time between the centre and peripheral hospitals to improve communication and patient care, and investments into informatics would ensure GPs were updated at every step of a patient's treatment.

8.14 With particular reference to prostate cancer, the Chairman asked whether it was wise to proceed with the one centre approach when there were concerns over travelling for treatment.

8.15 Mr Kennet-Brown advised that all proposals were being evaluated, including single and multi-site options. There was no evidence to show that the current urology service at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRT) was poor, but the aspiration was to become world class, which was why a review was being carried out. Mr Kennet-Brown informed Members that he would be sharing the outcomes of this review with the ONEL JHOSC.

8.16 Mr Hines added to this, stating that statistics showed surgeons who performed complex surgeries on a regular basis achieved better survival outcomes and the complication rate for robotic surgery was halved. Cancer survival statistics for UCLH were comparable to large American centres (which were consistently successful), and it was therefore justifiable from a clinical standpoint that operations should be held centrally with high level surgeons and high level technology. Mr Hines pointed out that patients in North East London have been travelling to the centre for treatment since 2005, though patients coming from outer London would need more consideration.

8.17 Councillor Munn asked whether follow up care for cardiovascular treatments would be carried out locally.

8.18 Mr O'Brien responded that there was a wide spectrum of cardiovascular diseases; lesser illnesses would be followed up locally, whilst more complex ones would be treated at the centre. Ms Ross, from UCL Partners, added that staff would be rotated between the centre and peripheral

hospitals to ensure a cross site approach for the patient and to establish a robust relationship with outlying hospitals for discharges.

8.19 With regards to consultation on patient experience, Councillor Paul asked how softer issues would be addressed in the future.

8.20 Mr Kennet-Brown replied that listening to people was an evaluation criterion, and would be measured through the changes made as a result of feedback received. The 'hub and spokes' model for the centre allowed for an exchange of ideas and information to ensure all hospitals benefitted.

8.21 Councillor Saunders congratulated officers on their aspiration to create a world class centre for excellence, and queried whether this would mean an increase in private practise and smaller waiting lists?

8.22 In response Mr Kennet-Brown reported that an increase in private patients would not be detrimental as the income from their treatments would be used to improve the site. He advised Members that the aim was to attract more people in to using the centre through achieving an encouraging reputation.

8.23 Councillor Edgar asked what the long term implications were.

8.24 Mr Fish stated that the centre would be held to account permanently by the treatment outcome in the wider population rather than just the results from inside the hospital. Ms Ross advised Members that the current cardiovascular provision was rated excellent, and that twelve Transformation Leaders had been appointed to bring teams together in order to understand what is needed from the new service provision.

8.25 The Chairman allowed a question from the floor: Mr Michael Vidal (Board Member, HealthWatch Hackney) asked whether there had been discussions about the proposals with Monitor?

8.26 Mr Fish responded that there had been discussions with the relevant agencies and this included Monitor.

8.27 The Chairman thanked the officers for their report, and it was agreed that discussions would continue regarding Members' concerns over the proposals. Mr Kennet-Brown advised the JHOSC that he planned to meet with the Chairmen of the 3 JHOSCs to share and discuss outcomes after 29 November 2013.

## **9. ANY OTHER BUSINESS**

Councillor Akehurst proposed an amendment to the Committee Procedure Rules for INEL JOSC. This was seconded by Wendy Mead.

**RESOLVED** – That Rule 9.1 be amended to read:

“The lead administrative and research support will be provided by the Health Scrutiny Officer from the borough which holds the Chair with the assistance as required from the officers of the participating boroughs