INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

All Members of the Inner North East London Joint Helath Overview and Scrutiny Committee are requested to attend the meeting of the Committee to be held as follows:

Thursday, 20 November 2014 at 7.00 p.m.

London Borough of Tower Hamlets, First Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

This meeting is open to the public to attend.

Members		**Representing**
Chair: Councillor Ann Munn	–	**INEL JHOSC Representative for Hackney Council**
Councillor Asma Begum	–	INEL JHOSC Representative for Tower Hamlets Council
Councillor David Edgar	–	INEL JHOSC Representative for Tower Hamlets Council
Councillor Mahbub Alam	–	INEL JHOSC Representative for Tower Hamlets Council
Councillor Ben Hayhurst	–	INEL JHOSC Representative for Hackney Council
Councillor Rosemary Sales	–	INEL JHOSC Representative for Hackney Council
Councillor Dianne Walls OBE	–	INEL JHOSC Representative for Newham Council
Councillor Anthony McAlmont	–	INEL JHOSC Representative for Newham Council
Councillor Winston Vaughan	–	INEL JHOSC Representative for Newham Council
Councilman Wendy Mead	–	INEL JHOSC Representative for City of London

The quorum for this body is the presence of a member from each of three of the four participating authorities.

Contact for further enquiries:
Tahir Alam, Strategy, Policy & Performance Team,
Tel: 0207 364 5064
E-mail: tahir.alam@towerhamlets.gov.uk
Web:

Scan this code for electronic agenda:

1. **WELCOME AND INTRODUCTIONS (Pages 1 - 2)**

2. **APOLOGIES FOR ABSENCE (Pages 3 - 4)**

   To receive any apologies for absence.

3. **URGENT ITEMS / ORDER OF BUSINESS**

4. **DECLARATIONS OF INTEREST**

5. **MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING (Pages 5 - 14)**

6. **IMPROVING SPECIALIST CANCER AND CARDIOVASCULAR SERVICES - UPDATE ON IMPLEMENTATION (Pages 15 - 24)**

7. **IMPROVING QUALITY AT BARTS. HEALTH NHS TRUST (Pages 25 - 42)**

8. **ANY OTHER BUSINESS**

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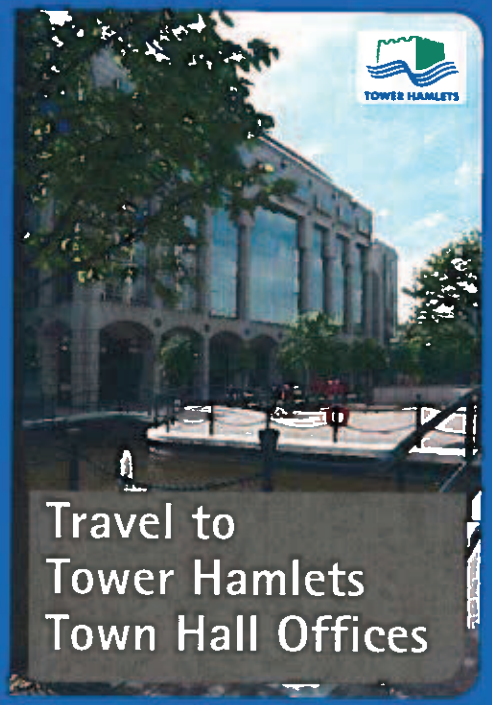


Travel to Tower Hamlets Town Hall Offices

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

tower hamlets becoming a healthy borough

change 4 life

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

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

By Bike

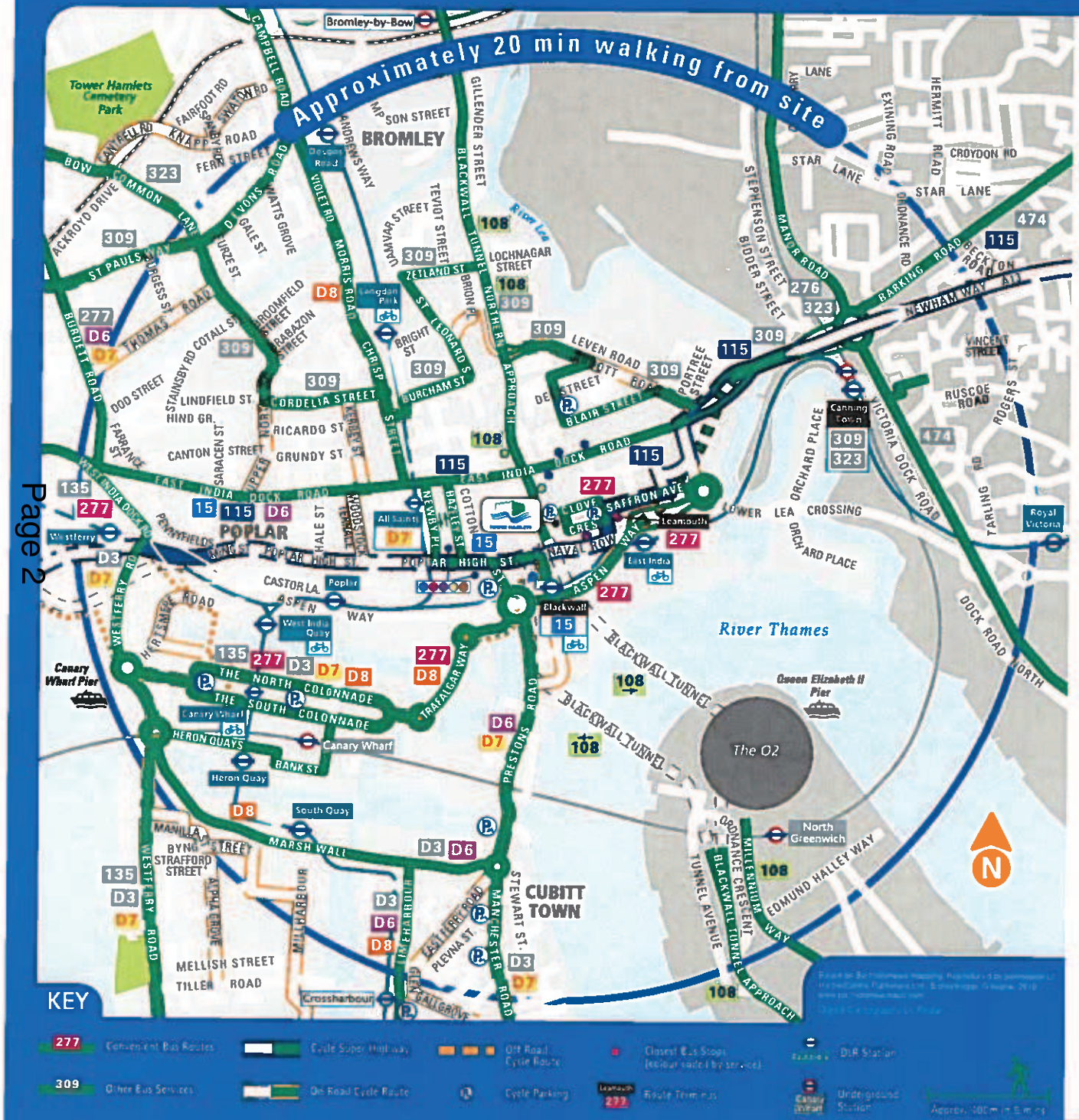
The site is well served by cycle routes, including Cycle Superhighway route 3 opening in 2010.

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 Overview and Scrutiny Committee (INEL JHOSC)

Membership 2014-16

Borough	Members
Hackney	Cllr Ann Munn (Chair)
	Cllr Ben Hayhurst
	Cllr Rosemary Sales
Newham	Cllr Dianne Walls OBE (Vice Chair)
	Cllr Winston Vaughan
	Cllr Anthony McAlmont
Tower Hamlets	Cllr Asma Begum
	Cllr David Edgar
	Cllr Mahbub Alam
City	Common Councilman Wendy Mead

The London Borough of Waltham Forest is also invited to attend when there are agenda items of interest, such as in regards to Barts Health NHS Trust.

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Inner North East London Joint Health Overview and Scrutiny Committee 20 November 2014 **Minutes and matters arising**	Item No **5**

Outline

Attached please find the draft minutes of the meeting held on 11 September 2014.

Matter Arising

There was one action from the previous meeting as follows:

Action on page 6 – item on withdrawal of MPIG
That the JHOSC write to Neil Roberts of NHS England, copying in MPs, summarising this discussion and outlining concerns.

Cllr Munn wrote to Neil Roberts on 16 September and this letter was circulated to members.

Attached please find a copy of his reply dated 28 October 2014.

Action

The Committee is requested to agree the minutes and note the matter arising.

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INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
Thursday, 11th September 2014

Meeting held on Thursday, 11 September 2014 at 7.00 pm
in East Ham Town Hall, London

Members Present:	**Councillor Ann Munn (Chair), Councillor Dianne Walls OBE (Vice Chair), Councillor Mahbub Alam, Councillor Asma Begum, Councillor David Edgar, Councillor Ben Hayhurst, Common Councilman Wendy Mead, Common Councilman Dhruv Patel, Councillor Rosemary Sales and Councillor Winston Vaughan.**
Member Apologies:	**Councillor Anthony McAlmont**.
Officers in Attendance:	**Luke Byron-Davies (Scrutiny Manager, LB Newham), Jarlath O'Connell (Overview and Scrutiny Officer, LB Hackney), Neal Hounsell (City of London Corporation), Tahir Alam (Strategy Policy and Performance Officer, LB Tower Hamlets), and Philippa Sewell (City of London Corporation).**
Also in Attendance:	**Councillor Richard Sweden (London Borough of Waltham Forest), Zoë Hooper (Transforming Services, Changing Lives, NEL Commissioning Support Unit), Jo Carter (Barts Health), Peter Morris (Barts Health), Neil Kennett-Brown (North East London Commissioning Support Unit), Dr Sam Everington (Chairman of Tower Hamlets Clinical Commissioning Group), Dr Fiona Sanders (Hackney Local Medical Committee Chair), Dr Jackie Applebee (Tower Hamlets Local Medical Committee), Maggie Falshaw (Practice Manager, GP Practice, Tower Hamlets and Save Our Surgeries Chair),**
Members of the Public:	**4**

The meeting commenced at 7pm and closed at 9pm

1. **WELCOME AND INTRODUCTIONS**
Past Chair Councillor Winston Vaughan welcomed everyone to the meeting and advised of a change in the order of agenda items.

2. **ELECTION OF THE CHAIR AND DEPUTY CHAIR**
RESOLVED – That Councillor Ann Munn be elected Chair and Councillor Dianne Walls Deputy Chair for the ensuing year.

3. **APOLOGIES FOR ABSENCE AND NOTICE OF ANY SUBSTITUTIONS**
Late apologies for absence were received from Councillor Anthony McAlmont. NHS England also sent apologies.

4. **DECLARATIONS OF INTEREST**
Councillor Ben Hayhurst declared an interest in item 6, the Removal of the Minimum Practice Income Guarantee (MPIG), by virtue of a conflict of interests arising from his career as a barrister, and undertook to leave the room during the discussion of this item.

5. **MINUTES OF THE PREVIOUS MEETING**
The Committee gave consideration to the minutes of the meeting held on 17 February 2014.

RESOLVED – That the minutes of the meeting of the Committee held on 17 February 2014 be agreed as a correct record.

6. **TRANSFORMING SERVICES, CHANGING LIVES**
The Chair welcomed Peter Morris from Barts Health, Neil Kennett-Brown from the NE London Commissioning Support Unit, and Dr Sam Everington, Chairman of Tower Hamlets CCG.

Mr Kennett-Brown reported that the programme had started in February 2014, with an interim case for change finalised in June. The engagement period had begun in July and would end on the 21st September, with a formal case for change and an outline of the work programme being in November 2014. Dr Everington advised Members that this programme needed to deal with health in general, not just health services, and find new, modern, and more productive ways of working to address the upcoming challenges to health care.

Councillor Winston Vaughan opened the questioning, asking whether the expected increased demand on hospitals from the predicted growth in population was to be addressed through current budgets?

Mr Kennett-Brown responded that an increase in patients would result in an increased budget, but that there would be a time lag on receiving it. He stated that policy and decision makers should be influenced to increase the speed. Dr Everington advised that the current funding formula was based on age, but deprivation levels in East London boroughs resulted in a 65 year old being equivalent to a 70 year old in health terms.

At a follow up request from Councillor David Edgar, Mr Kennett-Brown undertook to circulate a document summarising information on the funding formula.

Councillor David Edgar asked for more details concerning the level of engagement and the timing of the next stage of the process.

Mr Kennett-Brown replied that almost everyone recognised that this case for change as a fair and honest reflection, but wanted to know what changes would be made. Although the proposals were still being developed, Mr Kennett-Brown advised that CCGs would be presented with the formal case for change and proposals for work in November 2014, but that no details would be available until after the general election.

The Chair queried whether anything unexpected had arisen from the engagement process?

Mr Kennett-Brown confirmed that nothing had been a surprise other than that some basic services had been highlighted, such as late letters or general administration problems, as well as than clinical suggestions.

Councillor Ben Hayhurst queried why the details of the proposals were coming so late in the process, and whether there would be enough time for them to be considered and scrutinised properly.

Mr Kennett-Brown advised Members that they wanted to be as open as possible, and there was a requirement to consult fully on the proposals. Some changes would be a matter of communication (i.e. administration changes) and some would need formal consultation. In a follow-up question, Councillor Hayhurst queried whether any proposals would be made to close or merge A&E departments, and Mr Morris and Mr Kennett-Brown confirmed that there was no intention to shut any A&E or Maternity departments.

Councillor Dianne Walls enquired as to the movement to community based services, in particular the practical implications of such a move.

Mr Morris replied that a shift to integrated care to address the change in demographics and economics inevitably meant more resources would be needed in the community. He added that in primary care the biggest change would be cultural, not structural. Dr Everington advised that a joined-up approach was being sought to improve the patient's whole journey; this would involve new technology and new roles, such as care co-ordinators.

In a follow up question, the Chair asked whether an argument was being made in favour of primary care funding during discussions with ministers. Mr Morris responded that that was the answer he would give if asked, and advised that better interconnectedness was needed in the NHS to ensure effective knowledge transfer. He added that if acute providers didn't act now they wouldn't be any space in hospitals in 10 years time as they would be full of patients waiting for elective procedures because of a failure to deal with the primary care aspects..

Councillor Rosemary Sales queried whether the proposals were based more heavily on monetary savings or on achieving efficiency?

Mr Morris replied that there were three drivers for the change: an economic one, the achievement of better interconnectivity, and to address the shift in demographics.

Common Councilman Dhruv Patel asked how improvements to the healthcare system requiring significant investment would be made during a period of budget cuts.

Mr Kennett-Brown responded that the NHS budget included schemes to provide invest-to-save schemes, and Mr Everington added that proposals would be about clinical changes that should be implemented for practical reasons as well as cost efficiency.

Councillor Ben Hayhurst asked about the £400million of quality and productivity savings to be made over the next five years.

Mr Kennett-Brown advised that pages 53 and 54 of the full case for change outlined the details.

Councillor Mahbub Alam queried whether technological improvements would replace jobs.

Dr Everington responded that there was no suggestion for a loss of jobs, that the technology would just enable a different, more efficient way for staff to work. It was hoped that improvements would provide an ease of service for most patients, and free-up staff time for more face-to-face interaction with patients needing direct communication.

In response to a question from a member of the public, Mr Morris advised that the cost of capital would be higher when derived from the private sector and that there was a need overall to smooth out the cost of capital, public vs private, in the NHS. He added that Barts had reduced the size of soft services in their PFI contracts which had reduced them by £8m per year. Dr Everington added that there needed to be a national solution to the PFI issue. Mr Kennett-Brown added that the overall focus of the proposals addressed the whole of the healthcare journey, offering a holistic service for patients. Services would have to join together within the NHS wherever possible to provide a seamless service while addressing the challenges ahead.

The Chair thanked the officers for attending and answering questions.

7. **REMOVAL OF THE MINIMUM PRACTICE INCOME GUARANTEE (MPIG)**

The Chair welcomed Dr Fiona Sanders, Hackney LMC Chairman, Dr Jackie Applebee, from Tower Hamlets LMC, and Maggie Falshaw, the Chair for Save Our Surgeries. NHS England had sent their apologies for the meeting.

Dr Jackie Applebee advised Members that funding for GP surgeries had been reduced to an all-time low of 8.7%. The MPIG had previously protected practices from loss of services as a result of cuts and was originally set in place

in perpetuity, but now plans had been made to phase it out over the next 7 years. Instead, money would be put into a national pot with distributions weighted by patient age. This had a disproportionately negative effect on East London owing to deprivation levels causing residents to become ill at a younger age.

Lots of practices were threatened by this change, but a higher proportion of these were in East London, and campaigns were underway to halt the removal of the MPIG. Ms Saunders reported that an offer had been received from NHS England with criteria offering help for practices losing over £3 per head. She added that very few practices fell into this category, and those that were able to absorb the first few years of cuts would struggle to manage services 3 or 4 years later as cuts continued.

Councillor Rosemary Sales opened the questioning, querying the progress of the Judicial Review (JR) and the role of the Local Authorities.

Dr Applebee replied that the JR was going ahead but the timescale was still unknown. Dr Sanders reported that Local Authorities could help by ensuring their portion of public health contracts (split between LAs and CCGs) was reinvested with local practices. Dr Applebee also asked the JHOSC to help keep pressure on NHS England and politicians to change the proposal.

The Chair highlighted the need for data to be presented for Local Authorities to become involved fully in the issues.

Ms Falshaw replied that the Clinical Effectiveness Group could provide some data, and that the British Medical Association had a calculator to work out loss per patient for practices on the GMS contract. She advised that data collected for Tower Hamlets could be anonymised and shared with the Committee. Dr Sanders added that staffing data was more anecdotal.

Councillor Winston Vaughan asked whether NHS England had been approached for meetings.

Dr Sanders advised that contact had been made but owing to cuts in NHS England there had been difficult in getting a response; she added that meetings were now being confirmed.

Waltham Forest Councillor Richard Sweden queried whether an alternative funding allocation had been suggested, taking account of deprivation levels (e.g. healthy-life expectancy) as well as age.

Dr Applebee responded that an alternative which looked at ‘years to death’ (rather than from birth) had been drawn up, which she agreed to share with the JHOSC. This demonstrated a life expectancy for richer areas up to 15 years longer than those with high levels of deprivation.

Members discussed the points raised by members of the public, and it was:

RESOLVED – that the JHOSC write to Neil Roberts of NHS England, copying in MPs, summarising this discussion and outlining concerns.

The Chair thanked Dr Sanders, Dr. Applebee and Ms Falshaw for attending and answering questions.

8. **AOB**
The Chair advised that the next meeting would provisionally take place on 20th November 2014 at 7.00pm in Tower Hamlets.

The meeting ended at 9.00 pm

Chair

Officer contact for INEL:

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28 October 2014

London Region
Southside
105 Victoria Street
SW1E 6QT

0207 932 3700

Our Ref:
Your Ref:

BY EMAIL ONLY

jarlath.oconnell@hackney.gov.uk

Cllr Ann Munn
Chair
Inner North East London Joint Health
Overview and Scrutiny Committee

Dear Ann

Threats to viability of GP Practices in East London due of the withdrawal of the 'Minimum Practice Income Guarantee' (MPIG)

Thank you for your letter of 26 September 2014.

I note the key points made by the senior GPs present and that the Committee had asked the BMA and LMC representatives to prepare a joint business case to put to NHSE to challenge our proposals. I also note the Committee's suggestion about the type of aggregated evidence from the practices affected that might be useful in such a case. I shall await this document with interest. On the assumption that such a case is made we are likely to discuss this with national colleagues.

Your letter went on to say that if NHS England is aware of the extent of the *(MPIG/Global Sum)* problem, as a Committee that you would argue that NHS England has a duty to ensure that these Practices are properly funded. Whilst NHS England is the main commissioner of GP services, part of their income is also derived from services commissioned by the CCGs and the Local Authorities' public health functions. Co-commissioning between area teams and CCGs is likely to increase the proportion of GP practice funding that is being managed through CCGs. The duty on commissioners is to secure services that enable patients to receive

- Health- and Wellbeing-promoting care
- Fast, responsive access to care
- Proactive and coordinated care
- Holistic and person-centred care
- Consistently high-quality care

To deliver this, those GPs that are on the GMS contract type are funded for their core service provision (and a range of Directed Enhanced Services) on nationally determined contracts (specifications for DES) for which a "price" is negotiated nationally with NHS Employers (for NHS England) and the General Practice Committee of the BMA for the GPs. Government sets out the level of any national pay award/uplift by responding to evidence submitted by the Doctors' and Dentists' review Body (DDRB). The duty of NHS England is to establish those contracts and ensure that they are paid in accordance with the contract terms and the various Statutory Instruments that sit behind them. Income is only one side of the equation. NHS England has no control or sway over practice costs

(which includes staffing costs) or the amount doctors choose to take “as profit” from their businesses. The NHS England position is that through contract negotiations with the GPC we are discharging our responsibility to ensure that practices are fairly funded for the work they do.

You asked NHS England to explain how the revision of the Carr-Hill Formula is going to reconcile the ongoing tensions between ‘age’ vis-à-vis ‘deprivation’ in how the formula is devised. Your view is that unless the funding formula takes proper account of what is known as “healthy-life expectancy” the formula will continue to be weighted against GP Practices in areas where there are both significant health inequalities and where Practices are under increasing pressure because of the population pressures.

There is an expert group established nationally to look at revisions to the Carr Hill funding formula. It is worth noting that Carr-Hill was reviewed in 2007 by a group which included GPC / BMA representatives, but then in the negotiations on the GMS contract subsequently, the GPC refused to see the implemention of the recommendations, their concern being that any changes, would inevitably result in there being winners and losers.

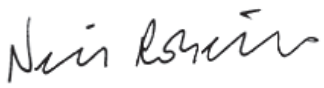
I have already referred upwards to the national team some interesting proposals about life expectancy being used within a funding model. That will be ultimately for the national review group, working with the GPC / BMA to consider.

Finally, I have discussed the issue of production of redacted data with the national Head of Primary Care. Our position remains that it would be inappropriate for NHS England to release any information regarding funding to practices in advance of what the HSCIC will publish in relation to 2013/14 practice income from our audited accounts in December.

We do not believe redaction can effectively anonymise financial data, and whilst we intend to move towards a position of greater transparency of GP income, this is necessarily sensitive and is being currently negotiated with the GPC. Our stance does not however preclude individual practices disclosing their own data to the LMC and the overview and scrutiny committee of its funding streams.

I hope this clarifies the position of NHS England (London) and is of help.

Yours sincerely,



Neil Roberts
Head of Primary Care
NHS England (London Region, North, Central & East)

Inner North East London Joint Health Overview and Scrutiny Committee 20 November 2014 **Improving specialist cancer and cardiovascular services – update on implementation**	Item No **6**

Outline

At its meeting on 20 November 2013 INEL JHOSC gave consideration to a formal case for change proposal from the NHS on '***Improving specialist cancer and cardiovascular services in north and east London and west Essex'***.

Prior to this on 30 May 2013 the Committee had given consideration to the first tranche of these proposals which related to changes to urological cancer services.

On 25 July 2014 NHSE London wrote to Cllr Vaughan (then chair of INEL) to confirm that the proposals had received approval and a copy of this letter is attached. They subsequently wrote to stakeholders again on 15 October 2014 confirming that it was taking its final decision on the preferred service option at a meeting on 21 October. The changes are now being implemented.

Cllr Munn has asked the NHS North East London Commissioning Support Unit to return to the Committee to present a short briefing on the implementation of these plans and a copy is attached.

Attending the meeting to present the briefing will be:

Neil Kennett-Brown, Programme Director – Transformational Change, NHS NEL CSU
Sarah Mcilwaine, Senior Consultant, NHS NEL CSU

Action

The Committee is requested to give consideration to the briefing.

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Cancer and cardiovascular services

INEL JHOSC – 20 November 2014

THE NHS CONSTITUTION
the NHS belongs to us all

The case for change

- Currently our specialists, technology and research are spread across too many hospitals
- Evidence suggests that focused specialist centres lead to better outcomes
- Clinicians and commissioners have now agreed to create integrated cancer and cardiovascular systems providing care locally where possible, specialist care where necessary

- Specialist centres will work with local hospitals and GPs to improve the whole patient journey

Specialist cardiovascular services

What is the decision?

Transfer The Heart Hospital (Marylebone) and London Chest services to St Bartholomew's Hospital (West Smithfield), to create a single integrated cardiovascular centre.

The Royal Free Hospital (Hampstead) and the integrated cardiovascular centre at St Bartholomew's Hospital would act as heart attack centres for the area.

Decisions for specialist cancer services

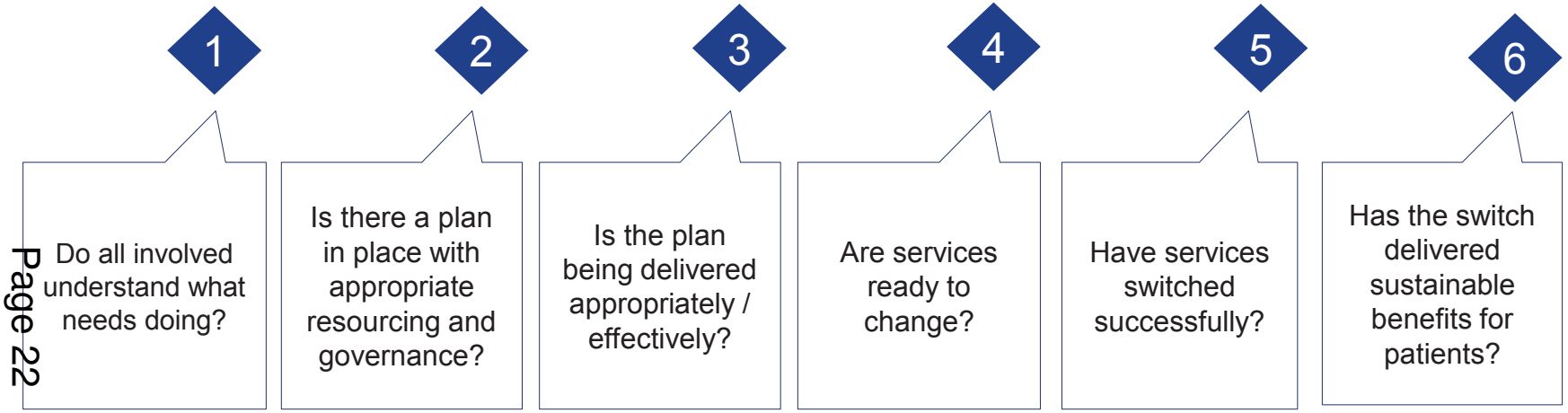
Pathway	Configuration	Royal Free	Barts Health	UCLH	Barking Havering Redbridge	Barnet, Chase Farm	Homerton	North Mid	Princess Alexandra
Brain	Current		S	S	S				
	Recommended			S	S				
Head & neck	Current		S	S		S			
	Recommended			S					
Bladder& Prostate	Current		S	S	S	S			
	Recommended			S					
Renal (kidney)	Current	S	S	S	S	S	S		S
	Recommended	S							
HSCT (blood)	Current	S	S	S					
	Recommended		S	S					
AML (blood)	Current	S	S	S	S	S		S	
	Recommended		S	S	S				
OG (stomach)	Current		S	S	S				
	Recommended			S	S				

How did we get here?

1 2010	London-wide review concluded fewer specialist high-volume units would improve clinical outcomes for patients
2 Early to mid 2013	Local clinicians developed the Case for Change
3 Late 2013	We engaged with local people on these proposals from Oct-Dec 2013
4 March-May 2014	NHS England published its engagement report, then business case and recommendations for change.
5 May-June 2014	Further phase of engagement; communicated with c600 stakeholders
6 July 2014	Final decision made by CCG commissioners, incorporating stakeholder feedback
7 Oct 2014	Final decision made by NHS England to approve proposals

Services would only transfer if safe to do so

Commissioner will conduct regular checks….



If approved, these changes would take place over 1-3 years

Cardiovascular services	→ from March 2015
Specialist cancer services	→ from August 2015

Services will communicate in advance of any service change…

London Region
Southside
105 Victoria Street
London
SW1E 6QT
Tel: 020 7932 3700

Inner North East London Health Overview and Scrutiny Committee

25 July 2014

Dear Cllr Vaughan

Specialist cancer and cardiovascular services in north and east London and west Essex:
With cancer and cardiovascular disease accounting for approximately two thirds of early deaths in England and Wales[1], a pioneering approach will link local hospitals and GPs with specialist 'centres of excellence'

We recently conducted a second phase of engagement on plans to improve specialist cancer and cardiovascular services in north and east London and west Essex. The aim was to seek views on preferred options and to provide people with the opportunity to contribute to the implementation work, particularly around some of the themes raised in the first phase of engagement, such as travel and transport.

Following the engagement period, a commissioner 'meeting in common' was held in public between NHS England and Camden, City and Hackney, Enfield, Haringey and Islington CCGs on 25 July 2014. The purpose of this meeting was for commissioners to receive the feedback from this phase of engagement[2] and formally determine their chosen options for implementation. The meeting was held with those organisations who are the direct commissioners of the services under this review, and as such were required to make a decision on the proposals. These are the same as those who took part in the last commissioner decision meeting in May 2014.

We are writing to inform you that following the meeting, the proposals to improve specialist cancer and cardiovascular services in north and east London and west Essex have now been approved. This is a momentous change for patients across the capital as studies have shown that high volume hospitals have better outcomes for major cancer surgery and other high-risk procedures.[3] It is hoped that the decision made today to reconfigure services will improve patient care and boost

[1] Office for National Statistics, 2012, data on avoidable mortality in England and Wales.
http://www.ons.gov.uk/ons/dcp171778_362295.pdf

[2] NHS England has published the report on the second phase of engagement on its website http://www.england.nhs.uk/london/london-2/engmt-consult/. The report outlines our response to all the comments received during the engagement period, which ran from 23 May to 27 June 2014 and an overview of the engagement process that was undertaken. You will also find supporting appendices such as the detailed feedback report and the communications activity log.
[3] Citation needed

survival, in the same way that the creation of specialist stroke centres in London has saved more than 400 lives and driven improvements and value since being introduced in 2010. Commissioners also approved the assurance and proposed governance framework, which includes recommendations for implementation. We would like to take this opportunity to offer our sincere thanks for your helpful feedback on the proposals and involvement in the programme. Where we received specific feedback, commissioners will build this into the planning for the next stage, to ensure any issues are resolved ahead of implementation.

Under the new system, St Bartholomew's Hospital will become the centre for specialist treatment of heart disease including the largest cardiac surgery centre in England. Bringing together cardiac services onto one site would make it the world's biggest unit for adults with congenital heart disease[4] and it would perform more heart MRI and CT scans than any other centre in the world.

University College Hospital, working within a system of hospitals including The Royal London, St Bartholomew's, The Royal Free and Queen's in Romford, will become a centre for the specialist treatment of five types of rare cancer – brain, prostate and bladder, head and neck, haematology and oesophago-gastric. The Royal Free will become a centre for the specialist treatment of kidney cancer.

The next steps in the programme will now involve providers implementing the plans as per the proposed assurance and governance framework. It is expected that this will take place over a number of years, starting with the opening of Barts Health new cardiovascular unit in mid-2015, in order to ensure that services can be transferred safely.

As we have stated from the onset of the proposals, our focus is on improving outcomes and services for patients, saving an estimated 1,200 lives each year through earlier diagnosis and prevention of disease, improved treatment in hospital and in the community and better access to clinical trials[5]. This is truly a major step in that direction, enabling us to create world class care for cancer and heart patients. If you would like to discuss the next steps of implementation, or if you require further information at any point, please do get in touch.

Yours sincerely,

Dr Anne Rainsberry, Regional Director, NHS England (London)
Professor Sir David Fish, Managing Director, UCLPartners

[4] UCLPartners' clinical case for change for cardiovascular http://www.england.nhs.uk/wp-content/uploads/2014/03/ucl-parts-clin-props.pdf

[5] If the NHS in London were to reduce early deaths from cardiovascular disease in people aged 75 and under in north central and north east London to the rate for England, we would save an estimated 1,117 lives per year (statistics from Public Health England). Similarly, if the NHS in London we were to improve five year survival rates for all cancers in people aged 75 and under in line with at least the rate for England, we would save an estimated 190 lives per year (statistics from Public Health England/NCIN/UKACR).

Inner North East London Joint Health Overview and Scrutiny Committee 20 November 2014 **Improving quality at Barts Health NHS Trust**	Item No **7**

Outline

The 6 hospitals which comprise Barts Health and the services they offer cover the 4 INEL boroughs and Waltham Forest. Waltham Forest however is a member of ONEL JHOSC (Outer NE London) but its Scrutiny Chair(s) are invited to this meeting when there are Barts Trust items.

In addition to the scrutiny undertaken by the individual Health Scrutiny Committees in the individual boroughs INEL taken an ongoing interest in the steps being taken to improve quality at the Trust, particularly in the context of their ongoing financial challenges.

Senior Barts Trust executives continue to engage with INEL and in the recent past they have attended to discuss the following Barts related items:

11 September 2014 – Transforming Services Changing Lives programme
17 February 2014 – CQC Chief Inspector of Hospitals report
20 November 2013 – the Trust being put in financial turnaround.
29 May 2013 – 2012/12 Quality Account

Attached please find a briefing from the Trust which addresses quality issues and in particular the disappointing performance of the Trust on the 2014 National Cancer Patient Survey.

Attending the meeting to present the briefing will be:

Dr Steve Ryan, Medical Director
Karen Breen – Director of Delivery and Improvement
Mark Graver, Head of Stakeholder Relations and Engagement

Action

The Committee is requested to give consideration to the briefing.

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Barts Health NHS
NHS Trust

INEL Joint Health Overview and Scrutiny Committee

Update from Barts Health

20 November 2014

Agenda

- Our finances
- Operational performance
    - 18 weeks performance
    - Friends and Family Test results
    - Cancer performance and patient survey results
- Managing serious incidents and Never Events
- Our patient transport service
- Cerner Millennium at Whipps Cross
- Improving our administrative support
    - Letters to GPs and patients
    - Reducing appointment errors
- CQC follow up inspections

Our finances

- At the end of Month 6:
    - Year to date deficit was £53.1 million, £13.3 million worse than plan
    - In month deficit was £11.8m - £7.0m worse than plan
- This reflects underachievement of CIPs and partly deductions in income for fines and challenges, and expenditure on agency staff
- As a result, we have revised the year end forecast outturn from a deficit of £44.8 million to a deficit of £64.1 million
- To achieve, or better, our year end deficit plan, we are focusing on:
    - Strengthening controls, particularly on agency spend and consultancy
    - Bridging forecast deficits through further cost improvement schemes properly assured for quality and safety, and avoiding attrition through slippage of approved schemes
    - Eliminating agency spend via our Drive 95 recruitment program
    - Addressing our emergency pressures overspend with

Operational performance

A&E four hour access standard

•Overall Trust performance in September was 94.29%

•Year to date performance is 94.22%

•Increased length of stay is biggest factor affecting performance

•Mitigating measures include:

- £10.2m support for winter, including increased staffing, better patient flow and increased admission avoidance/community support
- Developing neuro-rehabilitation service with the Homerton

Infection control

•Clostridium Difficile – six (post 72-hour) cases reported in September; year to date total 40 against a target of 71

•MRSA bacteraemias – two reported in September; year to date total is seven against a target of zero

18 weeks referral to treatment

The target is for 90% of admitted patients and 95% of non-admitted patients to be treated within 18 weeks.

Actions we are taking to achieve the standard:

- Clinical harm process is in place
- Established a programme management office (PMO) structure to lead the work
- Focus on data quality
- Training programme and standard operating policies
- Development of a single, reliable patient tracking list (PTL)
- Clinical engagement
- Capacity/demand and recovery plans
- Working with NHS IMAS Intensive Support Team

Friends and Family Test

- The national Friends and Family Test (FFT) is now being used across the NHS to gauge how likely patients are to recommend local hospital services
- The survey is currently in use for inpatients, A&E and maternity
- Barts Health data for September (latest available) shows:
    - Return rate for inpatients and A&Es is 31.65%
    - 83.75% of these respondents were “extremely likely” or “likely” to recommend our services, slightly lower than August
- We are now rolling the FFT out in outpatient departments, day case treatment centres and community services

Cancer services – our performance

Target	Latest position - for September, some figures provisional
14 days from urgent GP referral to date first seen	91.6% against 93% target
14 days from urgent GP referral to date first seen – Breast symptomatic	93.4% against 93% target
31 days from decision to treat to first treatment	91.2% against 96% target
31 days from decision to treat to subsequent treatment (drugs)	100%
31 days from decision to treat to subsequent treatment (surgery)	92.6% against 94% target.
31 days from decision to treat to subsequent treatment (radiotherapy and other treatments)	95.5% against 94% target
62 days from urgent GP referral to first treatment	68.0% against 85% target
62 days from consultant upgrade to first treatment	77.8% against 85% target.
62 days from screening programme to first treatment	84.2% against 90% target.

Cancer services – patient survey results

2014 national cancer patient survey results

•We were disappointed by the recent results for Barts Health.

•Over past year, begun range of improvements in partnership with Macmillan:

- Holistic needs assessment
- Clinical nurse specialist forums
- Schwartz Rounds
- Bowel cancer pilot at Whipps Cross
- Improved patient information

•Will continue to build on national best practice, focusing on patient experience, early diagnosis and improving the quality of life

•Also welcome recent approval of the application by the Maggie's charity to build a facility at St Bartholomew's

London Cancer 2013 radiotherapy patient satisfaction survey

•100% of patients would recommend our service

•Over 95% rated their care as very good or excellent

•Also showed reduction in waiting times for treatment

Managing and reporting incidents

- Our staff reported 21,662 patient safety incidents in 2013/14, compared to 19,493 in 2012/13
- We reported 407 serious incidents to our commissioners and NHS England in 2013/14
- We actively encourage all staff to report incidents – higher numbers reported does not mean an unsafe environment
- It is important for staff to report incidents so that everyone can learn from them. Remedial action can be put in place at a local level and across the wider organisation before any serious harm occurs
- We have now eliminated overdue serious incidents as a result of collaboration with all our local CCGs

Managing and reporting never events

- All NHS trusts report against a nationally mandated list of never events – events that should not occur in a modern healthcare setting
- It is good practice to report all potential never events and to review each one again after thorough investigation
- We reported **eight** events in our 2013/14 Quality Account, but this reduced to **six** after full investigation with commissioners
- We have reported **four** so far in 2014/15, but expect **two** of these to be downgraded
- We launched a campaign on learning from all never events in April 2014, based on eight key messages
- We have significantly improved patient safety during surgical procedures in the last year, including implementing recommendations from an external review of theatre systems
- All our hospitals now use the SurgiNet electronic tracking system to help staff monitor use of WHO safer surgery checklist

Our patient transport service

- We introduced a new, single transport provider on 1 June, replacing 14 individual previous contracts
- Moving to a single supplier was an important step in improving quality of service
- Initial changeover caused delays and cancellations
- Any patient who missed an appointment had both their appointment and transport rebooked
- Real-time performance monitoring of service by hospital directors and senior managers
- Dedicated 24/7 helpline established for GPs
- Working group identified long term solutions. Over the past four months the performance has significantly improved to levels that were seen at pre-mobilisation.
- Call waiting times and numbers of complaints have fallen consistently month on month
- A few areas where issues are still being resolved

Cerner Millennium at Whipps Cross

- Implemented the Cerner Millennium electronic patient record at Whipps Cross in May 2014 - provides a single patient record across Barts Health
- Problems experienced with entering information from clinics and tracking patient records
- Immediate response put in place, including:
    - Additional staff and training to support Whipps Cross teams
    - Prioritising patients needing urgent treatment
    - Daily assurance meetings with key staff and leaders
    - Dedicated team in place to manage paper records
    - Improvements made to outpatients telephone service
- Full investigation carried out, including an independent external review
- Situation now resolving and moving to “business as usual” activity levels and standards
- Urgent two week wait referrals are now registered or booked within three days of receipt, and all routine referrals are registered and digitally scanned within a five day turnaround

Letters to GPs and patients

Postal service

•Review of service and function across all sites undertaken – plan to move to new provider in February 2015

•New escalation processes and procedures now in place to ensure issues are identified and rectified swiftly

•Admin and clinical teams reminded of the need to ensure adequate notice and time allowed for letters to be delivered. Monitored regularly. Additional work at Whipps Cross to avoid short notice cancellations

Letter typing

•Function is managed within each clinical service

•Standards currently monitored via the outpatient transformation board

•Will be monitored through a new outpatient performance dashboard – to be in place by January 2015

Reducing appointment errors

Actions already taken and complete

- Review of staffing structure to align best practice and resources
- New process in place for reinforcement of the minimum rule for clinic cancellations
- Standard operating processes now in place in all outpatient areas

Actions still in train and ongoing

- Development of Dashboard with revised set of KPIs to monitor performance – to be completed by December 2014
- Many staff already trained to reduce error rate. Training is ongoing according to need
- Outpatient turnaround work will centralise all booking functions to ensure standardised and consistent approach to booking and performance . Focus upon three main areas – access to services, environment and experience, and patient outcomes (to be completed by March 2015)

CQC follow up inspections

- As part of the new inspection model, and following the intensive review in November 2013, CQC are now undertaking a series of follow-up inspections across all our sites.
- These are an opportunity for us to confirm and celebrate improvements and excellence in care, and to highlight where we need to further improve.
- CQC carried out first follow up inspection at Whipps Cross during w/c 10 November – 40 to 45 inspectors on site, split into nine groups focusing on our core services.
- A full report of the inspectors' findings will be published by the CQC later in the year
- Dates of other site inspections yet to be confirmed but will be shared once available.
- Inspections will form part of the rating we are given in 2015.

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