LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY PANEL

HELD AT 6.30 P.M. ON TUESDAY, 3 SEPTEMBER 2013

ROOM C1, 1ST FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Rachael Saunders (Chair)

Councillor David Edgar (Vice-Chair)
Councillor Dr. Emma Jones
Councillor M. A. Mukit MBE
David Burbridge

Other Councillors Present:
Nil

Co-opted Members Present:

David Burbridge	–	(Healthwatch Tower Hamlets Representative)

Guests Present:

John Wardell	–	(Deputy Chief Officer, Tower Hamlets Clinical Commissioning Group)
Michael Pantlin	–	(Director of HR, Barts Health NHS Trust)
Dr Steve Ryan	–	(Medical Director, Barts Health NHS Trust)
Paul Larrisey	–	(Associate Director, Community Health Services, Barts Health NHS Trust)
Janet Perry	–	(Barts Health NHS Trust)
Dhruv Patel	–	(City of London Corporation Health Scrutiny Committee)
Neal Hounsell	–	
Wendy Mead	–	(City of London Corporation)
Farrah Hart	–	(City of London Corporation)
Luke Akehurst	–	(London Borough of Hackney)
Ann Munn	–	(London Borough of Hackney)
Mark Mann	–	(Head of External Communications, Barts Health NHS Trust)

Officers Present:

Deborah Cohen	–	(Service Head, Commissioning and Health, Education, Social Care and Wellbeing)
Sarah Barr	–	(Senior Strategy Policy and Performance Officer, Corporate Strategy and Equality Service, Chief Executive's)

Tahir Alam	–	(Strategy Policy & Performance Officer, Chief Executive's)
Robert Driver	–	(Strategy, Policy and Performance Officer, One Tower Hamlets, Chief Executives)
Frances Jones	–	(Service Manager One Tower Hamlets, Corporate Strategy and Equality Service, Chief Executive's)
Alan Ingram	–	(Democratic Services)

COUNCILLOR RACHAEL SAUNDERS (CHAIR), IN THE CHAIR

1. APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of Dr Amjad Rahi, Co-opted Member.

2. DECLARATIONS OF INTEREST

There were no declarations of Disclosable Pecuniary Interest.

3. UNRESTRICTED MINUTES

RESOLVED

That the unrestricted minutes of the meeting of the Panel held on 11 June 2013 be agreed as a correct record of the proceedings.

4. REPORTS FOR CONSIDERATION

Following introductions of those present, the Chair indicated that agenda item 4.3 would be considered as next business after item 4.1. However, these minutes reflect the original agenda order, for ease of reference.

4.1 Barts Health NHS Trust - Update on Financial Turnaround

Michael Pantlin introduced the presentation, as included in the previously circulated agenda, and commented that Barts Health NHS Trust faced financial challenges in order to achieve £78m savings by 31 March 2014. This had been further compounded by the merger of trusts over the past year. The Board of Barts recognised that there had been a slow start to the year, meaning that there was a current £24m year to date deficit but it was expected that the balance would be delivered by the due date.

He stressed that there had been no change in the Trust's health care mission to change and improve lives in East London and Barts Turnaround was being developed as a whole organisation effort to accelerate the development and delivery of safe cost improvements, never losing focus on quality. The Turnaround encompassed 10 main principles, with patient safety being

paramount, and care improvement plans to achieve £55.7m savings, designed from the bottom up, with rigorous quality assessment and peer review mechanisms.

Proper bill coding was very important, as the Trust was now paid on the basis of services delivered, rather than a block payment.

The CQC report on Whipps Cross hospital had been disappointing, with three warning notices having been issued, and action plans were in place to address the areas of concern, which related to infection control in the maternity unit; safety and suitability of equipment in the maternity unit; staff appraisals and supervision in the elderly care service. The Chief Hospital Inspector would review the action plans in November 2013.

The Turnaround also aimed at reducing the length of patients' stay in hospital, which reduced costs and improved the patient experience. A further initiative, #becausewecare, was a call for all staff to commit to improving compassionate care and be welcoming to patients.

The Chair then invited questions from those present and the Barts representatives made responses that:

- Care improvement plans were supported by clinical leads, who worked with CIP teams on a sometimes cross-services and cross-sites basis.
- They were confident of achieving the required savings by March 2014 and each proposal was rated on how competent the organisation was in safety and deliverability. All proposals were subject to very rigorous assessment and there were some 1700 such schemes in progress.
- It was anticipated that the Chief Hospital Inspector's report on Whipps Cross would be received by Christmas 2013, following which an action plan would be developed.
- Over the past year, clinically-led schemes relating to procurement had achieved substantial recurrent savings. Savings would also be achieved by getting people home from hospital as soon as possible, as long as this was a safe and effective course of action.
- It was not considered that there was any way to negotiate a reduction in the national tariff efficiency requirement of £50m, as this was set on a national basis.
- With regard to possible departmental/site closures, there would be a transformation in how health care was delivered. For instance, stroke care and cardiac care services were now pooled and were thereby achieving better results. A standard hospital model was not appropriate for all districts and discussions were also in progress with Newham about how health care would be structured in 10 years' time and what would be the actual population needs. Diabetes care had been revolutionised with skype appointments systems, etc.
- The unacceptable results at Whipps Cross were not the result of leadership failures or changes, however, the aim now was to establish cross-organisational, topic-specific clinical groups. It was accepted that work was also needed on how to deploy management and leadership to improve standards.

- Some wards at Whipps Cross had been found to be under-staffed and this would be addressed by efficiencies elsewhere. The Trust's 1600 vacant posts were almost all filled by temporary staff and provided opportunities to give up vacancies, rather than staff members.
- Work was ongoing to improve patient engagement with the Trust.
- There had been success in good clinician to clinician liaison and patients were only referred back to their GP if an additional condition was discovered during treatment.

NOTE: Dr Steven Ryan asked Mr Burbridge to provide him with details of the arrangement he had mentioned whereby liaison between a housing provider, the local authority and hospital staff could free up to six hospital dialysis beds.

The Chair thanked the Barts representatives for their contribution and commented that the Panel would use this to gain a better understanding of what the savings proposals meant for local services.

4.2 Mental Health Needs Assessment and Strategy Update (TO FOLLOW)

Deborah Cohen introduced the presentation and Draft mental Health Strategy that had been previously circulated with the supplemental agenda, adding that an updated Strategy document had been **tabled** at the meeting. The Strategy was being supported by the Health and Wellbeing Board.

Ms Cohen added that it was intended that service users could take control of their own lives and recovery, with a service approach that looked at the whole person. The document also summarised development work that had been undertaken and summarised how the strategy had been organised.

Due to the fact that the Borough had many young people, whose numbers would increase over the next 10 years, it was important to target the mental health of children and young people as a huge number of adults suffering from mental illness had manifested symptoms before the age of 18.

Despite having achieved a national award for dementia services, other older people's ailments such as depression would not be neglected.

In response to questions from the Panel, Ms Cohen indicated that:

- There were very low referral levels from the Bengali community to dementia services. However, this had been addressed through the Alzheimer's Society and a Sylheti-sepaking dementia café in the East London Mosque.
- Elderly people were also affected by overcrowding. Many people did not seek help due to a perceived stigma and discrimination regarding mental health problems, which caused embarrassment.
- The next step in the strategy was to produce an action plan and it was hoped to work with other partners using the Council's influence.
- It was important to include schools in the process, as their effect on the mental health of young people was significant and this might be

addressed by bringing them into the work of the Health and Wellbeing Board.

- The new community teams could be monitored by patient satisfaction surveys and interviews as part of the assessment process. Most dementia care would continue in specialised services and the teams would be looking mainly to address and support depression services.
- Small voluntary organisations that wished to be included in the commissioning process but did not have the resources to do so could be helped by using consortium arrangements – as long as a lead organisation had appropriate rigour, this would not need to pass down to all groups included.

The Chair stated that the Draft Strategy seemed to cover all of the main issues and was well though-out and comprehensive. The Panel would continue to do what they could to scrutinise this work.

Ms Cohen asked that Members email her with any other comments they may wish to make.

4.3 Community Health Services and Integrated Care - Update from Barts Health NHS Trust and Tower Hamlets CCG

John Wardell introduced the presentation as contained in the previously circulated agenda, which comprised an overview of work currently being undertaken to achieve integrated care. He added that the over-arching aim was to allow individual service users to live independently and take more control of their own health care. An added advantage would be the reduction in duplication of systems. He made further comments that:

- Meetings had been held for over a year involving Third and voluntary sectors to empower patients, users and their carers and to ensure that service users had to provide information only once.
- Health and social care navigation would provide support to proactively deal with people' needs across these areas of care.
- Nine areas of interventions would be rolled out over the next 3 – 5 years and patients would be risk-stratified to ensure appropriate concentration of care.
- Key enablers had been identified, one of the largest of which was development of IT systems.
- Tower Hamlets had developed a localised vision for an integrated care system wrapped around patients, GP services and social care. The main principle of this was to put the patient at the centre of the system.

Paul Larrissey put forward his section of the presentation, stating that weekly meetings were held involving the Council, Barts Health NHS Trust and mental health services, to develop a strategy over the next 3 – 5 years and there was much to achieve. He also indicated that:

- The Community Health Service had core services working with similar or same patient groups, including Adult Community Nursing; Community Virtual Ward; CReST short term intervention; Specialist

Nurses; Palliative Care Centre; Referral Hub (a single point of access for services).

- Phase 1 of the process was moving towards the provision of eight integrated care teams across Tower Hamlets, based on the eight GP networks. It was intended that they would manage all aspects of health for the local population and would include a rapid response element. People would be supported at home to reduce hospital admissions.
- A new governance framework was being developed around the teams and the aim was for them to be up and running by the end of 2013.
- The current Phase 1 proposal was more like a co-ordinated care approach, with more integration occurring over years two and three. The CHS out-of-hours service was also being co-located with that of the Council.

Mr Wardell added that application was being made to the Department of Health to participate in a pilot programme which might bring in extra IT and contractual support. Interviews in this connection were to be held on 6 September.

In response to questions from the Panel, Mr Larrissey and Mr Wardell stated that:

- Some IT solutions were hoped to go live this Autumn and it was intended to move towards more mobile working, whereby real time access to patients' records could be achieved during home visits. Work was needed to ensure systems compatibility and how to record data. At present there was no common denominator for this.
- Work was underway on the governance element and patient assent for use and disclosure of personal information.
- In order to monitor the success of the programme, there was a results sub-committee that would assess whether services had been delivered as promised and information on service quality would be obtained from patient feedback. An overview would have to be taken to determine whether financial savings were being delivered by the proposals.
- Each of the eight local partnership groups would have a Board jointly chaired by a GP and a Senior Nurse. Consideration was being given to the inclusion of other partners and to determine the level of patient involvement. The GP chairs would then report to a Joint Board, e.g. Barts Health NHS Trust Board.
- Data would be refreshed regularly to ensure all individuals on the system were identified and to prevent any from falling out of view.

The Chair thanked Mr Wardell and Mr Larrissey for their contribution and wished them well with their pilot application.

5. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

5.1 Tower Hamlets Health and Wellbeing Board

The Chair expressed concern that there was not yet a properly constituted Health and Wellbeing Board for the Borough, despite the requirement for a statutory board to have been established as from 1 April 2013. This put Government funding in jeopardy and must be addressed. She intended to write to Deborah Cohen to get full details of the situation.

The Chair added that she had previously raised the matter with Mayor Rahman, who had not responded, as he would have to initiate the process of establishing a formal board. She had spoken on the matter with Chief Officers and had also brought up the issue at Cabinet and was now asking Officers to seek advice on how arrangements for the board might be implemented if the Mayor would not proceed.

The Chair felt that the Panel should be provided with Health and Wellbeing Board agendas and asked that the Mayor and Cabinet Lead Member be invited to attend the next meeting of the Panel to discuss the matter, if it remains unresolved by that time

Action by:
Deborah Cohen, Service Head Commissioning & Strategy

The meeting ended at 8.35 p.m.

Chair, Councillor Rachael Saunders
Health Scrutiny Panel