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

MONDAY 26 OCTOBER 2015

Meeting held at 7.00 pm at City of London Corporation, Guildhall, London EC2P 2EJ

Committee Members present:

City of London
Common Councilman Wendy Mead OBE

Hackney Council
Cllr Ann Munn (Chair)
Cllr Ben Hayhurst
Cllr Rosemary Sales

Newham Council
Cllr Susan Masters (substituting for Cllr Walls)
Cllr Winston Vaughan

Member apologies:

Tower Hamlets Council
Cllr Amina Ali
Cllr Shahed Ali
Cllr Dave Chesterton

Newham Council
Cllr Anthony McAlmont
Cllr Dianne Walls OBE (Vice Chair)

Officers in attendance:

***City of London Corporation*:**
Farrah Hart (Health & Wellbeing Policy Manager)
Philippa Sewell (Committee & Members' Services Officer)

Hackney Council
Jarlath O'Connell (Overview & Scrutiny Officer)

Also in attendance:

Barts Health NHS Trust
Alwen Williams (Chief Executive)
Professor Jo Martin (Interim Chief Medical Officer)
Jan Stevens (Chief Nurse)
Claire Hogg (TST Out-of-Hospital Programme Manager)
Jo Carter (Stakeholder Relations Manager)
Jamie Whitburn

NHS North & East London Commissioning Support Unit
Dr Kate Adams (GP and TST Clinical Lead for Out-of-Hospital Programme)
Don Neame (Director of Communications)
Alex Smith (Assistant Director of Transformational Change)
Jessica Brittin (Programme Director, WELC Integrated Care)

Newham CCG
Dr Prakash Chandra (Chair)
Steve Gilvin (Chief Officer)
Satbinder Sanghera (Director of Partnerships and Governance)

Waltham Forest Council

Cllr Richard Sweden (Chair, Social Care Scrutiny Committee)

2 members of the public

1. APOLOGIES FOR ABSENCE

1.1 Attendees were welcomed to the meeting and introductions were made.

1.2 It was noted that Cllr Susan Masters from Newham was substituting for Cllr Dianne Walls.

1.3 The Chair stated that he had received apologies from the three Members from Tower Hamlets. Apologies were also received from Neil Kennett-Brown from the CSU.

1.4 It was noted that the Health and Social Care Scrutiny Chairs from London Borough of Waltham Forest had been invited to this meeting as observers and that this was customary when there were items relating to Barts Health NHS Trust. The Chair welcomed Cllr Richard Sweden (Chair, Social Care Scrutiny Committee) to the meeting.

2. MEMBERSHIP OF THE COMMITTEE

2.1 Members were invited to note the revised membership of the Committee. It was noted that three new members had been appointed from Tower Hamlets.

RESOLVED:	**That the membership of the committee for 2015/16 be noted.**

3. DECLARATIONS OF INTEREST

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

4. MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING

4.1 The minutes of the meeting held on 27 May 2015 were agreed as a correct record and the matters arising were noted.

5. BARTS HEALTH NHS TRUST IMPROVEMENT PLAN

5.1 The Chair welcomed for this item the following from Barts Health NHS Trust: Alwen Williams (**AW**) (Chief Executive), Professor Jo Martin (**JM**) (Interim Chief Medical Officer) and Jan Stevens (**JS**) (Chief Nurse).

5.2 Members' gave consideration to the following reports/presentations:
(a) *Safe and Compassionate* – presentation
(b) *Safe and Compassionate – Our Improvement Plan* – full report

And two tabled items:

(c) *Safe and compassionate Progress Report: Oct 2015* - newsletter
(d) *Safe and compassionate – our plan for improving services* - leaflet

5.3 In introducing the reports AW stated that Barts Health was fully committed to delivering high quality care and in mid-September they had published their major improvement plan 'Safe and Compassionate' which had set out the various priorities. Tangible improvement on these would only be delivered within the individual hospital sites she added. The October newsletter, as tabled, was an attempt to produce frequent updates for all stakeholders on progress. The Improvement Plan was underpinned by strengthened governance arrangements and a strong governance framework which had been agreed with the Regulators. This was mirrored at each site and there was also a Quality Improvement Committee. The Trust Oversight and Assurance Group would in addition include representation from the CCGs the CQC and Health Education England and this would be mirrored at site level.

5.4 JM added that the key priority was to change the culture of the organisation so that the problems in the past would not recur. A practical example included the introduction of the 'Safety Huddles', where ward staff met daily to review the past 24 hrs and plan for the next 24 hours by for example establishing what patients had specific problems (e.g. a mental health issue or an end of life care plan) and which would require special attention. In addition, JM stated that they had implemented further training on the Mental Capacity Act and on Deprivation of Liberty Safeguards (DoLS) assessments. The Trust had also benchmarked their processes and procedures and had looked, for example, at how UCLH used safety dashboards. The Trust had also developed a new App for antibiotic prescribing and had also done much work on early warnings of cardiac arrest.

5.5 JS added that one heartening thing arising from the CQC reviews was the acknowledgement that staff had been caring. Nevertheless, there was also a requirement for a full staffing review to set the ward establishment levels appropriately. They were investing a further £20m into increasing the funded nursing establishment by 500 and this would be very challenging. There was also focused investment in the Band 7 super-numerary grade as part of an increased focus on training and development. Another issue which had been addressed was streamlining the documentation which nurses have to deal with and this had been benchmarked against other similar Trusts. There were also now in place a different set of processes for responding to complaints focused on looking at the root causes. The Trust received 350 formal complaints per month but much progress was being made in getting these numbers down. In relation to workforce they were still heavily reliant on bank and agency staff and this was not good for either staff or patients. There were c.900 nursing vacancies. While this seemed high it had to be considered in the context of the size of the Trust, which was the largest in the country and that similar situations prevailed nationally. Nursing establishment numbers had been increased everywhere post the Francis Report. In addition to these pressures many nurses were now also working outside the NHS, thus creating a 'perfect storm' in terms of recruitment. She added however that despite these pressures and the Trust having been placed in special

measures many people still wanted to come and work at Barts Health and they were taking on 100 newly qualified nurses the following week, for example. Another aspect requiring attention was staff turnover and the shortage of Emergency Department doctors in the middle grades. As for End of Life Care they had replaced the Liverpool Care Pathway with a new process and new documentation had been introduced relating to 'Do Not Resuscitate'. 70% of actions required in the CQC report on the Margaret Centre had also now been completed. Finally, another challenge was training and the need to quickly implement training for several thousand staff at once.

Questions and answers

5.6 With reference to p.45 Cllr Hayhurst asked about the 9 'never events' between Nov 2013 and Jan 2015, asking if there had been any since Jan 2015 and what type these were.

5.7 JM replied that there had been 5 additional 'never events' since January 2015. 4 had involved naso-gastric tube misplacements and one an incorrectly sized hip-socket. The Root Cause Analysis of these established that failure to follow protocols was the reason. In only one of the cases was it one of the contributing factors to a death. She added that unfortunately initial safeguards which had been put in place had not been sufficient to prevent the latest incident and the situation was of course being reviewed again.

5.8 Cllr Vaughan asked what departments would receive the increased funded nursing establishment of 532. He further asked for clarification on the vacancy rate, the fill rate and the aspiration to get to 90% of established capacity.

5.9 JS replied that they were spread across the Trust with roughly 148 at Whipps Cross, 200 at Royal London and the remainder at Barts and Newham. The allocations were based on a review of the staffing establishment. The fill rate was 85% and the aspiration was to get to 90%.

5.10 Mrs Mead asked about the challenges in recruiting specialist cancer nurses and Cllr Vaughan also asked whether there were enough bank staff in place.

5.11 JS replied that with the newly set establishment there was an acknowledgement of the need also for longer training and the need to increase the capacity for training within these posts. On bank staff it was noted that good bank staff would be preferable to agency as they were the Trust's own staff and could be trained more easily. The NHSE cap on agency spend was proving a further challenge as was the limits on foreign recruitment with the need to put nurses into the 'protected occupations' category. They recently had recruited, for example, 45 critical care nurses from the Philippines.

5.12 Cllr Sweden (Waltham Forest) stated that a major impediment to finding nursing staff was the need to find suitable affordable accommodation for them and he was concerned that in the emerging proposals for developing Whipps

Cross there were plans to sell off the old nurses home. He asked therefore whether the redevelopment plans included any accommodation for nurses. He noted that while he was aware that the plans for disposal of assets had been put on hold the plans for re-development had not.

5.13 AW replied that they were working closely with Waltham Forest Council and other partners on developing options for the Whipps Cross site. In any property disposal plans that would be put in place there would have a strong interest in looking at housing options for staff and they needed to find innovative ways forward with the local authority to resolve this.

5.14 Cllr Sweden stated that the Margaret Centre was held in much esteem locally and he was concerned that the CQC had noted that safeguards on the improper use of the site had not been adhered to.

5.15 JS replied that in addressing the points raised by the CQC it was being made clear what the proper use of the site would entail.

5.16 Mrs Mead commented that the proposed new ward structures appeared to indicate a return of 'Ward Sisters'.

5.17 JS replied that it did and that the loss of a single sister-in-charge had been a mistake. The problem had been that those in that role had also been expected to also carry their own caseload of patients and this was not viable. There was a need to establish the Ward Sister role as many in the meantime had lost some of the necessary skills.

5.18 Cllr Sales stated that she had read with some concern reports in the press about the number of Employment Appeal Tribunal cases against the Trust which had been won by staff and this had raised concerns about staff morale and a culture of bullying.

5.19 AW replied that they had made significant changes in recent months on improving staff structures which should address this problem. Each hospital site would have a Managing Director, a Director of Nursing and a Director of Operations. There were still a number of HR related issues which needed to be focused on. Under investment in IT systems had put constraints in the workplace which engendered much frustration, for example. Also the Trust had instigated staff engagement programmes which had been tried and tested elsewhere in the NHS. There were now for example 40 clinical projects which were being led by staff and the aim of this was to engender a shared leadership culture across the organisation. In November and December 25 different 'Big Conversations' session were taking place. JS added that when she joined in March she had been impressed with the very good guardianship programmes which were in place and on the good staff dynamic overall. The 'Speak in Confidence' programme involved putting in place 12 senior managers who could be contacted in confidence by any staff who were experiencing problems. JM added that Health Education England had commended the Trust for this programme and at the undergraduate level it

was heartening to see that the training sessions were uncovering fewer incidents of staff having these concerns.

5.20 Mrs Mead raised a concern about the level of debt overall of the Trust whilst it had to invest so much more currently in nursing staff for example.

5.21 AW replied that it was an ongoing major concern and the Trust was spending over and above its deficit. The investment in new nursing posts however was an 'invest to save' initiative as it would reduce dependence on bank and agency staff. It was important now she added that the new structures remained in place for at least a 2 or 3 year period while the organisation stabilised and hopefully after that time they would be able to go back to a less intensive level of senior executive support. They would be in a negative financial positon for a number of years and sustainability was the key because also so much was changing in the overarching health economy.

5.22 Cllr Hayhurst asked if the Trust was on course for its budgeted deficit. He also asked if the documents such as those tabled could in future distinguish between aspirations and achievements so it would be clearer to the reader where the Trust stood.

5.23 AW replied that the budgeted deficit was £135m and they were not on plan. A key factor was medical staffing issues and agency spend and they were catching up on the efficiency programme. A rigorous recovery plan was in place and she explained that while the aspiration was to reach 100% of the planned deficit target, 90% would be a more likely figure.

5.24 Cllr Hayhurst asked what would happen to the Trust if it couldn't catch up.

5.25 AW replied that she could not quote a figure but could come back later in the year on it. It was not their intention to exceed the financial deficit but there were significant financial challenges facing all the NHS. They had moved to a site based management in the hospitals to bring more rigour to the finances.

5.26 Cllr Masters raised the issue of down banding of staff grades which had been referred to in the CQC report. She expressed concern that on the bullying issue there had been no mention in the improvement plan of working with trade unions and commented that unions appeared quite weak in the Newham site.

5.27 JS stated that she couldn't comment on the previous staffing plan. 500 extra nurses were being brought in based on a rigorous benchmarked assessment. AW added that the Trust had strong partnerships with the unions. There was a staff partnership trust and site based staff partnership forums.

5.28 Cllr Sales asked whether the various monitoring committees would be permanent and for an assessment of when senior management was expecting to reach these targets.

5.29 AW replied that this was about organisational turnaround and it would be carefully monitored. There was a real commitment to site based running. They now had produced the first monthly update on the Improvement Plan. At the end of each chapter of the Plan the expected outcomes were detailed and the monthly reports would feed in to this process. JS commented that in a previous role she had been the Healthcare Assessment Programme Manager for the national programme to tackle rates of MRSA and it had taken at least 12 months to get the numbers decreasing, so there was a need to persevere with these plans.

5.30 The Chair made reference to the Committee's disquiet at the two CCGs responses to the CQC inspection reports and asked the CCG reps present what outcomes they were expecting from the Trust in one year's time.

5.31 SG replied that the challenge for the two local CCGs was to strike the correct balance between holding the Trust to account and at the same time supporting the clinicians who were shown to be caring and providing good levels of care. Often it was the case that staff were trying hard within systems which were failing and it was important to bear in mind that these were three very different hospitals with three very different sets of issues. The difficulties in Newham were medical care related and because that was rated inadequate it had affected the overall rating. Improvements in quality must take place because this wasn't good enough but again those trying to improve things needed to be supported. He added that some areas of outstanding practice such as the 'Gateway' service at Newham had been acknowledged. They had also of course instigated monthly meetings with GPs to monitor progress on the improvement plan. He added that from Newham CCGs point of view he was very pleased with the new operating model and this was allowing GPs to gain some traction in helping to improve matters. Overall the role of the CCGs was to provide challenge on the pace and ambition of the Plan but to acknowledge that it was happening in the context of serious financial challenges.

5.32 Cllr Hayhurst asked whether, in the context of the new discussions on Devolution, whether Barts Health was too big?

5.33 AW replied that many NHS organisations were actually looking to the system in Barts as a way forward. The last thing Barts Health needed now was more change and stability was what was required. The Transforming Services Together programme had aspirations to deliver care close to home and the Trust needed to be part of the leadership on this programme.

5.44 The Chair thanked the senior officers from Barts for their reports and for their attendance.

RESOLVED:	**That the reports and discussion be noted.**

6. 'TRANSFORMING SERVICES TOGETHER' – UPDATE

6.1 The Chair stated that the Committee had last discussed the proposals at its meeting on 12 February and she welcomed to the meeting groups of officers from the CSU, from Barts Health and from Newham CCG.

6.2 Members gave consideration to the report "Transforming Services Together – update".

6.3 In introducing the report Steve Gilvin (SG) stated that east London had been identified as one of the most challenged health economies. The plan envisaged savings of 50% on productivity and 50% on estates and workforce. The plan did not involve any major closing of departments. The programme was being delivered in the context of the major challenges now facing the NHS. He highlighted that Newham now had the fastest growing young population in the Europe and it was anticipated that there would be an additional 5000 births per year across the three CCGs. In relation to the timetable, a draft strategy had been released in July and there was a need to complete the full detail in this document. More had to be done on the finance and estates elements for example. Obviously, he added, the financial challenge facing Barts Health NHS Trust had also to be factored in. They were hoping to publish the Strategy at the end of November.

6.4 Claire Hogg (CH) stated that in relation to the TST Programme's Out-of-Hospital workstream, there was a need to strengthen the leadership model around the overall strategy. One focus was to ensure that enough people were able to focus on the strategic delivery and able to leave aside the operational delivery for this period. TST was part of Barts Health's own sustainability plan and it had strong leadership. A key element of the programme was the creation of specialist hubs for elective surgery and the success of the Gateway centre in Newham was a good beginning. It focused on orthopaedic surgery. She was currently working on developing the obstetric hub for example.

6.5 Dr Kate Adams (KA) stated that the key to Out-of-Hospital transformation was on care being delivered closer to home. The aim was to treat people out of hospital whenever possible and to leave hospitals for the acute work which they were better at delivering. This change was dependent on expanding integrated care and reform of urgent care was a current challenge. It would involve improving the tools for self-care and the capacity for digital response for example. The challenges here included changing the culture whereby most people will default to A&E. As regards End of Life Care too many people were dying in hospitals when their choice would have been to die at home. Transforming Primary Care was the key and yet east London was short 175 GPs. Furthermore, 28% of GPs in Newham were over 65 years old. Another challenge was to make better use of pharmacists. In terms of the "Enabler" workstreams here, they would look closely at both IT and workforce issues and address barriers such as the poor record of sharing data, use of over testing and use of over ordering in the system. Supporting greater access to Primary Care was the key part of the TST Programme.

Questions and answers

6.6 Mrs Mead asked if Barts Health was struggling to recruit nurses, as it was, how could more community nurses be recruited in this climate?

6.7 KA replied that there was a need to be more proactive in nursing recruitment, in particular going outside London and of course the two groups needed to work together as both were facing shortages. Steve Gilvin (SG) added that a key barrier was that affordable housing wasn't affordable and conversations were taking place with the Mayor of London on designating housing for nurses as well as health and social care professionals. Mrs Mead commented that the NHS had however taken a decision that it no longer wanted to house nurses. SG acknowledged that the NHS had not been very good at being a housing provider in this context but there was now a responsibility on the NHS to work with others to achieve solutions to this problem.

6.8 Cllr Vaughan asked why there appeared to be no clear plan on estates.

6.9 SG replied that there were two different aspects here: hospital estates and primary care estates. As part of this programme they were looking at the plans to develop the old London Chest Hospital site as well as looking to regenerate the Whipps Cross site. In terms of primary care they would reduce the number of sites. Each CCG was required to develop an Estates Plan by the end of December and the plan was to produce a strategic document for TST by March. There was also a need for the NHS to have a voice in the London Land Commission, which was led by the Mayor of London.

6.10 Cllr Vaughan asked about the succession plans for the many older GPs.

6.11 SG replied that no steps were being taken to reduce the number of GPs overall despite the ageing profile and the many who were now reaching retirement age. To partly ease the problem each CCG was putting in place a pilot study on getting Pharmacists to work more closely with GP Practice and they were also looking at additional roles which Health Care Assistants might be able to play.

6.12 Cllr Masters asked how the huge savings which needed to be made in Public Health budgets over the next four years were being factored in to the TST programme.

6.13 SG replied that all local authorities were having major funding difficulties and there were obvious pressures therefore in both adult social care and in public health. He was also worried about the £22bn in net savings also required of the NHS. They all recognised that there was a need to work more closely with public sector partners to be more innovative. As an example of this joint working there were projects in Newham to address the fact that Year 6 children had levels of obesity which if not tackled would lead to diabetes. KA added here that if a child was overweight at 11 years old they had in fact

missed the boat with them. This was proving a huge challenge but they acknowledged too the huge funding problems facing all public sector partners. Don Neame (DN) added that there were representatives from the councils feeding in to all the workstreams of TST, this included councillors, senior public health staff and directors of adult social care.

6.14 Cllr Hayhurst asked about the progress being made on Devolution and how this would impact on TST. Could the integrated vision be achieved by pooling Public Health, Adult Social Care and CCG budgets? He also asked for further clarity on the amount of cost savings being envisaged in the Programme and if the Programme was working towards an ideal number of GP Practices in each borough, what was this number?

6.15 SG replied that integration in out-of-hospital care was primarily for the boroughs and the Better Care Fund programme had made a good start on this. In terms of larger devolution programmes nationally, everyone was looking closely at Manchester to see what might be learned from their pilot. There would be a need to look at pooling of budgets and Health and Wellbeing Boards would need to give impetus to this work. He concluded that the TST vision couldn't be delivered without integration. On the issue of costs, they were not ready as yet to come back with a costed plan. On the configuration of services, they needed to look at how much they might pay on a Payment by Results tariff as opposed to other options. A key driver of this work was to ensure that decisions on the future of Barts Health were kept in local hands and that another Lewisham situation did not develop.

6.16 CH added on TST costs, that it was important to avoid an alternative to TST which would be the need, down the line, to spend the money on building another hospital or another midwifery unit. There was a need to re-design the whole system and to better develop the workforce and care pathways. In obstetrics for example having more high risk patients' leads to more complex care pathways and higher costs so there was a need for more prevention and early intervention. There was a need to ensure for example more capacity at Birthing Centres. In terms of the reforms in Tower Hamlets, known as the Integrated Provider Partnership, it was in the vanguard having a single block contract budget. A move to capitated budgets i.e. assessing how much you need to deliver for a set population, needed further exploring. The problem up to now with Payment By Results tariffs had been that they didn't incentivise the right kinds of things within the system. The aim was fewer hospital admissions and more care closer to home.

6.17 KA added that solo GP Practices were no longer really fit for purpose. Primary Care needed to be delivered by teams in larger settings but this did not necessarily mean losing the link to a familiar family doctor. Newham in particular has many smaller or solo Practices.

6.18 Dr Prakash Chandra (PC), Chair of Newham CCG, added that it was important not to look at these issues in isolation. There was a need for the enabler sites to get off the ground as the quality of premises in Newham for

example were very poor. Because of the large number of small or solo Practices, capacity was limited and training was limited.

6.19 Cllr Hayhurst asked what would be a target number of GP centres for a borough? Would it be 10?

6.20 KA replied that many Practices currently had 10-15K patients each and some merged Practices could go up to 30k for example. This could be achieved in a confederation model but this was a long journey and they were just beginning. SG added that the model of Primary Care going forward needed to be layered and rather than focusing on an optimal size they needed to be ensuring that there was a more consistent quality of care across the system. There was no doubt however that in 18 months' time the configuration of Primary Care would likely be very different.

6.21 The Chair thanked all the officers for their briefings and for attending to answer the Members' questions. She suggested to SG and KA that it would be appropriate to bring the TST plan back to the Committee only when they had worked up a full Case for Change. SG replied that they would return in due course with a costed strategy.

RESOLVED:	**That the briefings and discussion be noted.**

7. ANY OTHER BUSINESS

7.1 The Chair stated that a date for the next meeting would be set to fit in with the requirements of the next stage of the TST 'case for change'.

7.2 The Chair stated that Hackney had the Chair of the JHOSC for two years now and she would be stepping down in May and there was a need for the other boroughs to consider how they would be supporting this Committee from now on. Support to the JHOSC was a cost in terms of officer time and while all boroughs were undergoing major cost savings programmes, this burden needed to be equally shared. Finding the resource to support a JHOSC, on occasions when it is required, should be reflected upon on further in each of the boroughs she added.