NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

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Thursday 6 June 2013 10:00 a.m.
Islington Town Hall, 222 Upper St, London N1 1XR

Councillors: Alison Cornelius and Graham Old (L.B.Barnet), Peter Brayshaw and John Bryant (L.B.Camden), Alev Cazimoglu and Anne Marie Pearce (L.B.Enfield), Reg Rice and Dave Winskill (Vice Chair) (L.B.Haringey), Martin Klute (Chair) and Alice Perry (L.B.Islington),

Support Officers: Andrew Charlwood, Linda Leith, Robert Mack, Pete Moore and Shama Sutar-Smith

AGENDA

1. ELECTION OF CHAIR AND VICE CHAIR

To elect a Chair and Vice Chair for the Committee.

2. WELCOME AND APOLOGIES FOR ABSENCE

3. DECLARATIONS OF INTEREST (PAGES 1 - 2)

Members of the Committee are invited to identify any personal or prejudicial interests relevant to items on the agenda. A definition of personal and prejudicial interests is attached.

4. URGENT BUSINESS

5. MINUTES (PAGES 3 - 14)

To approve the minutes of the meeting of 14 March 2013 (attached).

6. BARNET AND CHASE FARM HOSPITALS; ACQUISITION BY ROYAL FREE HOSPITAL (PAGES 15 - 16)

To report on the proposed acquisition of Barnet and Chase Farm Hospitals by the Royal Free.

7. FRANCIS REPORT (PAGES 17 - 62)

To consider the implications of the Francis report for health scrutiny and, in particular, the role of the JHOSC.

8. 111 SERVICE (PAGES 63 - 78)

To report on the setting up and commissioning of the new 111 non-emergency telephone service.

9. MATERNITY SERVICES (PAGES 79 - 82)

To report back to the JHOSC on the outcome of a meeting of Barnet, Enfield and Haringey Members that was set up following the discussion at the last meeting on maternity. The notes of the meeting are attached.

10. UROLOGICAL CANCER SURGERY

To consider further the status of proposals relating to changes to urological cancer surgery services in the light of previously circulated legal advice provided to the Chair. These concern whether the proposed changes could be considered to constitute a significant change and therefore requiring formal public consultation.

11. WORK PLAN AND DATES FOR FUTURE MEETINGS (PAGES 83 - 84)

23 May 2013

Agenda Item 3

DECLARING INTERESTS FLOWCHART - QUESTIONS TO ASK YOURSELF

What matters are being discussed at the meeting?

Do any relate to my interests whether already registered or not?

NO → You can participate in the meeting and vote

YES

Personal interest

Is a particular matter close to me?

Does it affect:

- me or my partner;
- my relatives or their partners;
- my friends or close associates;
- either me, my family or close associates:
  - job and business;
  - employers, firms you or they are a partner of and companies you or they are a Director of
  - or them to any position;
  - corporate bodies in which you or they have a shareholding of more than £25,000 (nominal value);
- my entries in the register of interests

more than it would affect the majority of people in the ward affected by the decision, or in the authority's area or constituency?

NO

NO

YES

You may have a **personal interest**

Declare your personal interest in the matter. You can remain in meeting, speak and vote unless the interest is also prejudicial; or
If your interest arises solely from your membership of, or position of control or management on any other public body or body to which you were nominated by the authority e.g. Governing Body, ALMO, you only need declare your personal interest if and when you speak on the matter, again providing it is not prejudicial.

Prejudicial interest

Does the matter affect your financial interests or relate to a licensing, planning or other regulatory matter; and
Would a member of the public (knowing the relevant facts) reasonably think that your personal interest was so significant that it would prejudice your judgement of public interest?

YES

You may have a **prejudicial interest**

YES

Do the public have speaking rights at the meeting?

YES

You should declare the interest but can remain in the meeting to speak. Once you have finished speaking (or the meeting decides you have finished - if earlier) you must withdraw from the meeting by leaving the room.

NO

You should declare the interest and withdraw from the meeting by leaving the room. You cannot speak or vote on the matter and must not seek to improperly influence the decision.

Note: If in any doubt about a potential interest, members are asked to seek advice from Democratic Services in advance of the meeting.

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North Central London Sector Joint Health Overview and Scrutiny Committee
14 March 2013

Minutes of the meeting of the NCLS Joint Health Overview and Scrutiny Committee held in the Conference Room, Enfield Civic Centre on 14 March 2013

Present

Councillors	**Borough**
Martin Klute (Chairman)	LB Islington
Dave Winskill (Vice Chairman)	LB Haringey
Reg Rice	LB Haringey
Alison Cornelius	LB Barnet
Barry Rawlings	LB Barnet
Alev Cazimoglu	LB Enfield
Anne Marie Pearce	LB Enfield

Support Officers

Rob Mack	LB Haringey
Peter Edwards	LB Islington
Andrew Charlwood	LB Barnet
Linda Leith	LB Enfield

1. **WELCOME AND APOLOGIES FOR ABSENCE**
Apologies for absence were received from Councillors John Bryant (LB Camden), Graham Old (LB Barnet) and Alice Perry (LB Islington)

2. **DECLARATIONS OF INTEREST**
Councillor Cornelius declared that she was an assistant chaplain at Barnet Hospital but did not consider it to be prejudicial in respect of items on the agenda.

3 **URGENT BUSINESS**
There was none.

4. **MINUTES OF THE 17 JANUARY 2013**
The minutes of the meeting on the 17 January 2013 were agreed with the following amendments

Item 6 Barnet and Chase Farm Hospitals NHS Trust Update –
Para 1 – '…developments at the Trust in relation to its potential transaction with the Royal Free London NHS Foundation Trust' - the words 'transaction with' to be replaced by 'acquisition by'

Para 2 – '…the Trust made contact with possible partner organisations operating within a 25 mile radius of the Trust's Enfield location' - the word "mile" to be replaced by kilometre

Matters Arising
The Chair reported that a reply had been received from the Secretary of State to the letter sent on behalf of the JHOSC regarding the transfer of NHS properties to NHS

Property Services Ltd. This had been circulated to JHOSC Members. The Minister appeared to be sympathetic to the issues raised although he had been non committal about the retention of capital receipts for local use when properties were disposed of.

The Chair also reported that he had received correspondence from the Chief Executive of NHS North Central London regarding the developments at Barnet and Chase Farm Hospitals. This had stated that the plans by the Trust to seek an external partner had been discussed at the Enfield Health and Wellbeing Scrutiny Panel in October 2012. Reference had been made to the potential transaction between the Royal Free Hospital and Chase Farm Hospital and it had been confirmed that this was not a private takeover of services.

A site visit had been requested to Whittington hospital, anyone wishing to take part should contact the Chair.

5. **UROLOGICAL CANCER**

Neil Kennett-Brown (Programme Director, Change Programmes) together with Mr John Hines (Consultant on Urology & Cancer, Whipps Cross and Barts) provided the JHOSC with an update on proposed changes to urological cancer surgical services and the review currently being led by London Cancer, which represented all hospitals providing urological cancer services in north central London, north east London and west Essex.

They highlighted the following points:

- The area covered by this review covered a population of 3½ million people
- London Cancer's report – published January 2013 referred to the need to change the way services were currently arranged in order to maximise the delivery of the highest quality of care, research and training. The report had been widely circulated to patient groups, community organisations, LINks, councils, MPs, CCGs and clinicians.
- There were no proposals to close any of the units that currently provided services but London Cancer was recommending that all complex surgery be consolidated in one specialist centre for bladder and prostate cancer and one specialist centre for kidney cancer.
- Less complex surgery would continue to be provided at local units. 95% of care would still be carried out locally and overall standards of care would also be improved.
- Evidence demonstrated a clear link between higher surgical volumes and better patient outcomes. On clinical grounds, it was thought better to have two separate specialist surgical centres. Each surgical centre should serve a population of at least two million.
- Recommendations following the submission of formal expressions of interest were for University College London Hospital (UCLH) to host the specialist centre for bladder and prostate cancer surgery and for the Royal Free hospital to host the specialist centre for renal (kidney) cancer surgery
- The engagement process included meetings with patient groups and CCGs. They had also offered to attend all LINk meetings. Comments and feedback were welcomed at cancer@elc.nhs.uk

The following issues were raised by JHOSC and answers provided

Travel impact - Royal Free hospital

From data, it would appear that approximately 170 patients per year would have to make a longer journey to use the Royal Free hospital. The proposed changes would mean people would have access to a fuller range of services, for example there were 9 different treatment options available for prostate cancer. An advantage of having specialist surgical centres was that they would attract the most talented staff and increase the skill of the team. Clinicians would work in both specialist and local urological units. Local units would provide a comprehensive diagnostic service led by a consultant urological surgeon and linked to the specialist centre.

Broxbourne - Consultation Area

It was confirmed that the Broxbourne area had been included in the consultation. However it was explained that this was not a full formal consultation exercise. An engagement process was being undertaken at this stage as proposals were not considered to constitute a substantial change. While the proposals would affect a wide geographical area, the number of patients which would need to travel to a different hospital for complex surgery was small. It was considered that the service provided was not being reduced. The only change was in the location from where some of the services would be provided.

Waiting time

The national standard was for 62 days for referral to see a specialist from when a patient had been diagnosed by a GP. The waiting time for treatment at one of the local centres should remain unchanged but it was anticipated this could be reduced for treatment at the specialist surgery centres.

The number of specialist centres

Concerns were expressed that proposals for only one specialist centre for bladder and prostate cancer surgery and one for renal cancer surgery were being put forward and that these were both in central London. The Committee noted that there were nevertheless some other surgical centres elsewhere and patients could choose to use these if they so wished.

Future provision of the service at Chase Farm hospital

It was asked if the urological service would continue at Chase Farm hospital if and when it merged with the Royal Free hospital and what would happen to the robotic equipment currently used at Chase Farm for urological procedures. It was thought the less complex surgery procedures would remain at Chase Farm. However the robotic equipment currently used was not the latest model and patients would be able to access the newest robotic equipment available following implementation of the changes.

Expression of interest for specialist service for prostate cancer at UCLH

It was questioned why only one expression of interest had been received for this specialist service. Confirmation was given that every Trust Board had been contacted but only UCLH felt they were able to fulfil all requirements specified for provision of the service.

Parking and Transport links – Royal Free Hospital
Confirmation was given that additional designated parking spaces would be available and this was being monitored.

Engagement process
The Committee noted that if major concerns were voiced about the proposals, consideration could be given by the NHS Commissioning Board to undertaking a formal consultation.

A member of Proactive (a prostate cancer support group) thought there were flaws in the engagement process – he stated that he was of the opinion that patient choice was being restricted and there had been insufficient consultation. The response was that a number of groups were being consulted in April and commissioners would consider other forms of engagement such as focus groups. He also questioned whether there might be a need for two surgical centres based on the population that the services would cover. The response was that if additional centres were commissioned, they might not be able to achieve the "critical mass" necessary to ensure the high level of service quality aspired to.

Resolved that –
Legal advice be sought from LB Islington legal officers on the legal requirements for a public consultation exercise to be taken on this issue.

6. **UPDATE ON THE NHS COMMISSIONING BOARD**
Peter Coles, Interim Delivery Director, gave an update on the NHS Commissioning Board (NCB) and referred to the new commissioning arrangements that would be operational from 1 April 2013. He reported that Paul Bennett was the new Delivery Director who would attend future meetings of the JHOSC.

The following issues were highlighted:

- NHS Commissioning Board (NCB) was responsible for commissioning £25 billion worth of services, including primary care, some public health services and specialised health services.
- The NCB had responsibilities for establishing and authorising Clinical Commissioning Groups (CCGs) and helped to support them by advising on effective commissioning arrangements.
- NCB had responsibility for consultations and also developing relationships and agreements with delivery partners at national level and locally through the health and wellbeing boards. It led on the development of strategy and vision for the NHS and set policies and standards for the NHS.
- A document was circulated which included a table listing the 'National Outcomes Framework Indicators for CCG' for the London boroughs. Rankings showed the areas which were of particular concern for local areas. Indicators within the red dotted lines showed the most significant challenges faced.

The following issues were raised by JHOSC and answers provided-

Role of NCB
In answer to the question whether the service was commissioning or overseeing

CCGs, it was confirmed that they would be carrying out both functions. CCGs would not be 'performance managed' by NCB but must show that they are 'fit for purpose'. Regular meetings would be held with them to support them in this task.

Underspends
It was thought likely that it would be possible to retain some 'underspends' for the year resulting from the Barnet, Enfield and Haringey Clinical Strategy. Members of the Committee felt that it was critical for Enfield that this should happen. It was noted that meetings were taking place to discuss 'carry forwards'.

Conflicts of Interest.
Reference was made to recent media coverage about links that GPs have with private health companies. It had been stated that more than a third of GPs involved in CCGs had links to private firms which stood to make money treating NHS patients. Mr Coles reported that this was a concern and had resulted in additional 'lay' members being enlisted to help with the decision making process. It was noted that GPs were required to ensure that they declared any interests they had. If any further advice was given about this issue, it would be reported back to the Committee.

Health Visitors and School Visitors
Mr Coles reported that these would be commissioned by the NCB but transferred to local authorities in the next financial year.

Key strategic issues for North Central London
Pressures for London were well known but it remained important that work was undertaken with HOSCs and health and wellbeing boards. It was noted that it was not the intention of the NCB to exert control over local issues. Local strategies required local ownership but they also needed to be aligned over several boroughs.

The focus for change
NHS London had been looking at findings related to strokes, which had shown a significant improvement. However, it was currently unclear how this issue and similar strategic issues would be addressed in future. Greater clarity was necessary to show where the focus will be for change under the new arrangements. Mr Coles stated that it would be the responsibility of the NCB to take forward strategic change.

Holding Clinical Commissioning Groups and providers to account
One of the 10 design principles of the NCB was to enable assumed autonomy. The NCB was also required to hold Clinical Commissioning Groups and providers to account and ensure performance remained high. It was asked how the NCB intended to do this.

Mr Coles stated that CCG clinicians would start from a position of independence, but should there be any reason to change this view, the NCB could trigger a 'directions to CCG' instruction which would require that they would then need to seek approvals from the NCB.

Service demand

It was asked if money would be returned to Enfield if a service demand was not being met. Mr Coles responded that if a demand was not being covered, a new course of action could be developed.

Complaints handling

The Francis report referred to the need for a clear complaints process. It was thought essential for the NCB to ensure a transparent complaints process existed and was well advertised.

Mr Coles was thanked for his presentation and for the diagrams circulated with the presentation notes which

a) listed the 'National Outcomes Framework Indicators for CCG' - rankings for the London Boroughs and
b) showed the 'NHS landscape from April 2013' which showed the funding and accountability lines under the new NHS arrangements

Resolved that-

1. The NCB be recommended to ensure the structures for overseeing CCGs are reliable to monitor any 'conflict of interest' contentions that may arise.

2. As service develops, further monitoring would be beneficial of complaints publicity.

7. **MATERNITY SERVICES**

Fiona Laird Head of Midwifery NMUH and Suzanne Sweeney Acting Maternity Network Manager gave an update on the provision of maternity services in north central London.

It was noted that the Maternity Network would cease to exist from 1st April. Key issues that had previously been raised by the JHOSC were:

- work force planning in response to the ageing midwife population
- maternity unit suspensions (diverts) where women in labour have needed to be transferred to an alternative hospital and
- standardisation of the midwife to birth ratios

The following issues were highlighted

- It was anticipated that maternity services would be moved from Chase Farm to Barnet Hospital in November 2013
- All trusts in the NCL had undertaken workforce planning. There was a disparity in the age of the workforce in each unit so a programme for training and mentoring to enable junior midwives to become clinically competent earlier had been introduced.
- There had previously been a difference in the way the midwife to birth ratios had been calculated between the trusts. All units had now standardised the way in which this data was collected and figures would be regularized by end of the year. NHS London recommended a ratio of 1:30 for London units.
- There were 158 intra-trust diverts at Barnet and Chase Farm Hospital Trust (transfer of women in labour between Barnet and Chase Farm hospitals) for 2012.

The following issues were raised by JHOSC and answers provided-

Capacity of birth centres and number of nurses

Concerns were expressed that there was insufficient capacity for the number of births expected following the transfer of this service from Chase Farm hospital, especially considering the high birth rate in the area. There was particular concern for those women who had needed to be transferred between Chase Farm and Barnet hospitals, often when they were in the first stages of labour. It was also mentioned that midwives also had to be diverted between the two hospitals. It was asked if adequate measures were in place at both hospitals, such as the request for a greater number of ambulances to assist with this problem. It was noted that when transfers took place, the patient should be accompanied by a midwife in an ambulance. Concern was expressed that this might not always be happening

It was noted that the country was losing 213 nurses a month and it was asked if this was impacting on the midwifery. Although NHS London recommended a ratio of 1:30 midwife to birth ratios it was understood that current ratios were 1:33. It was asked if there would be sufficient beds at North Middlesex and Barnet hospitals to cover for those people who would have used Chase Farm hospital. Because of these concerns, it was asked that figures be provided on births at Chase Farm and Barnet and the capacity available following proposed changes at Chase Farm hospital.

Ms Price responded that while it was understood that there might be some shortage of midwives in other areas of London, there was sufficient capacity for maternity units in the local area. Services were aware of the population increase, especially relating to the 'eastern corridor', which was an area that led up to the M25. It was understood that recent census figures showed birth rates rising in some areas by 9%. The projected number of births for the next 10 years had been looked at and this had confirmed that it will be a big challenge for both trusts. Weekly meetings were being held to discuss proposals and there should be sufficient capacity for 6,500 births a year.

It was suggested that further information be given to the next meeting and local members would be invited to visit the sites. The midwifery unit at the North Middlesex University Hospital (NMUH) was congratulated for winning the Bio Oil Team of the Year Award at the Royal College of Midwives annual award ceremony.

Plans at Whittington Hospital

It was asked if the Maternity Network had been consulted on any of the proposed plans that were being proposed at Whittington hospital. They confirmed that they had not been consulted.

Resolved that:

A briefing would be given at a meeting (prior to the 6 June scheduled JHOSC meeting) of JHOSC Members from Barnet, Enfield and Haringey on the number of births at Chase Farm and Barnet, 'diverts' and the future capacity for women giving birth following the proposed BEH changes. Siobhan Harrington, BEH Programme Director, agreed to provide modelling information on births and on the number of

ambulances.

8. **CONCLUSION TO PLANNED CHANGE TO THE PROVISION OF NEUROSURGICAL SERVICES IN NORTH CENTRAL LONDON**

Linda McGurrin, Divisional Director of Operations, Surgery and Associated Services, Royal Free Hospital, Robert Bradford, Clinical Director & Consultant Neurosurgeon, Royal Free Hospital/ UCLH, Jackie Sullivan, Divisional Manager UCLH and Jamie McFetters, Business Manager for Neurosurgery at Queen Square UCLH gave an update on this issue.

The following points were highlighted:

- The transfer of non-elective, neurosurgical patients, intracranial neurosurgery elective inpatient work and complex spinal work was transferred in June 2012 (phase 1). This has been a success with excellent patient outcomes, the service was received on one site and the majority of staff had transferred from the Royal Free to University College London Hospital (UCLH).
- The next phase of the transfer was due to take place from 1 April 2013 when the remaining staff would transfer. The two stage process was necessary because additional beds were needed at Queen Square (UCLH). This additional capacity was now in place with 7 extra beds and improvements to the availability of day care facilities.
- It was beneficial for this transfer to take place to centralise equipment and specialist care in one place, which enabled the service to increase its skills base and offer a world wide service

The following issue was raised by JHOSC:

<u>Major trauma care</u>
In response to a question it was confirmed that, should an accident occur, it was unlikely that a patient would be taken to this centre as initially treatment would be dealt with at a major trauma unit. Transfer of a patient from a major trauma unit to the neurosurgical service might take place at a later stage.

Resolved:
That the proposals for the final stage of the transfer of the neurosurgical service be supported and that the team be thanked for their report and work undertaken.

9. **TRANSITION PROGRAMME PROGRESS UPDATE**
Sile Ryan, Transition Programme Manager, NHS North Central London, gave an update on the Transition Programme. She highlighted the following:

- The report gave an update on the handover from NHS North Central London to the new NHS organisations from 1 April 2013. She said that 95% of staff had so far found new roles.
- The legacy management organisation would co-ordinate and resolve issues following on from the transfer of services. Issues to be dealt with were currently being identified by the Department of Health, NHS London and NHS North Central London. The Legacy Management Organisation would be a national organisation with a dedicated Legacy Management Programme for

London.

The following issues were raised by JHOSC and answers provided

Costs
The Legacy Management Organisation would be able to provide information on the overall costs involved for the transition at a future meeting of JHOSC.

Maternity Services
Sile Ryan would let the Committee know what panel/team would be taking over maternity service duties after the NCL grouping had been discontinued. The Committee expressed concern that responsibility for this service was not clear.

High risk areas
It was asked if there were any causes for concern/high risk areas that the Committee should be made aware of relating to the transition. It was not thought there were any particular service areas for concern although the handling of complaints needed to be scrutinised to ensure that it was 'fit for purpose'

Legacy Management –finance and outstanding claims
It was asked when it would be known if there were any remaining funds left following the transfer of services and who would meet outstanding insurance claims. It was also asked if there were any financial issues that the Committee might not be currently aware of but which could be a cause for concern. It was answered that some of the 'live' insurance claims would move over to new service arrangements and additional financial details can be brought back to a future meeting of JHOSC.

Timeframe
From April and until the end of June most transfers should have taken place. Transport issues and concerns relating to the number of ambulances and also transport for patients/visitors were all issues that would be discussed further at the Barnet, Enfield and Haringey Strategy meeting to be arranged and would be reported back to the JHOSC.

10 **WHITTINGTON HEALTH – TRUST ESTATES STRATEGY AND 5 YEAR CAPITAL INVESTMENT STRATEGY**

Dr Yi Mien Koh, (Chief Executive) and Philip Lent (Director of Facilities) at Whittington hospital gave an update on the Trust Estates strategy. This was a 'direction of travel' and was based on different ways and ideas for the development of health care. If clinical strategies changed, the Trust would need to be able to adapt and remodel its estate. Key investments were to be made in the estate. It was confirmed that negative press coverage had been reported on this matter. Open days and Councillor visits were being planned to allay any fears.

The following issues were raised:

Strategy
Confirmation was given that the strategy, agreed by the Board on 23 January, was a 'Direction of Travel' document

Reduction of staff and hospital beds

It was questioned why, at the Islington HOSC meeting in October, there had been no reference made to the proposed reduction of staff and reduced number of hospital beds. This information did not emerge until January 2013. It was asked if anything had happened to bring about the proposals in January. The Committee noted that there had been discussions about the possibility of medical students moving from the Whittington site to an alternative hospital site in the summer of 2013. The Trust had a strong wish to retain its teaching hospital status and this desire had meant that it was necessary for it to respond quickly to the changing circumstances.

Social care costs for Local Authority

Dr Koh explained that new proposals in the development of health care would result in quicker recovery times as mobilisation of patients would be improved. Older people would be treated immediately and as a result they would be able to go home earlier. Their recovery rates were expected to be greatly improved and fewer people would need longer hospital care.

Hospital size

The Committee noted that only 4% of the area for Whittington hospital included in the proposals was currently used for clinical services. All other areas included in the proposals were vacant or used for administration purposes. It is essential that the Trust make more use of the hospital site.

Foundation status. Is the 'Direction of Travel' Strategy necessary for the foundation bid

A suggestion was made that the hospital had acted like a private business and it was asked if proposals were put forward in an attempt to finance a foundation bid. It was answered that the strategy is related to the bid but not essential to it. The Trust was firstly aiming to invest in the site. The proposals aimed to bring about clinical changes/improvements. The Trust was aiming to improve maternity services, as it wished to improve the buildings and encourage more people to use its maternity services. Reference was also made to clinicians desire for an ambulatory care centre at the Whittington.

Integrated care service

It was asked if as the 'Direction of travel' strategy document was causing anguish should this now be withdrawn and should further work be done with the community on integrated care It was answered that it was necessary for the Trust to align the work with the new plans/arrangements of the CCG .

Engagement with community

A Member of the Committee stated that there appeared to be some similarities with the changes that had occurred at Chase Farm hospital and stressed the importance of the hospital engaging with the community at an early stage to answer any concerns or fears they may have.

It was noted that local residents had many concerns about possible changes at the hospital and a demonstration was being held soon about these issues. Many people

who might have difficulties obtaining GP appointments had faith in the A&E service and the Trust needed to address this issue together with primary care colleagues.

Timetable
Engagement with HOSCs and visits would take place between now and summer.

Ringfenced capital money
It was confirmed that capital receipts must be used for capital projects only

Maternity care
In answer to a question whether limits were being put on the number of people who were able to use the maternity services, it was stated that the Trust was trying to encourage more people to use its services, expecting approximately 4,000 births a year.

The midwifery unit at the North Middlesex University Hospital (NMUH) had won a prestigious award and it was suggested that changes for improvements to the maternity service at Whittington hospital be discussed with them.

Resolved:

1. That the application for foundation trust be supported and the Committee be kept informed of developments; and
2. That the Trust be recommended to consider further improvements to its engagement with the local community.

11. **WORK PLAN AND DATES FOR FUTURE MEETINGS**

It was asked whether the area covered by this JHOSC should be expanded so that it was coterminous with the area covered by the Commissioning Support Unit for the area. However, it was agreed that the current JHOSC was of a manageable size at present and should remain as it currently exists.

Resolved that:

The following items to be added to the Forward Work Programme:

- Transition programme progress/costs
- BEH Midwifery statistics and ambulance capacity (additional interim meeting to be arranged)
- Meeting 6.6.13 - Barnet and Chase Farm acquisition by Royal Free, Out of hours service – Harmoni, Barndoc and 111.
- 6 weekly JHOSC meeting frequency agreed.
- The Scrutiny Process and how this is to be co-ordinated following the Francis report on Staffordshire hospital. Clinical Care to be a standard item on future agendas.
- Ownership of strategic direction
- CCGs commissioning – quality/cost criteria.

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North Central London Joint Health Overview and Scrutiny Committee 6 June 2013

BARNET AND CHASE FARM HOSPITALS NHS TRUST

Created in 1999 following a merger of the former Chase Farm Hospitals and Wellhouse NHS Trusts, the Barnet and Chase Farm Hospitals NHS Trust (BCF) provides services at its two general hospitals in Barnet and Enfield and at four community hospitals in Barnet and Hertfordshire managed by other NHS bodies.

In July 2012 the BCF board concluded that it was not likely to become a foundation trust alone. It therefore invited competitive proposals from others to be its partner with a view to becoming part of a larger foundation trust. A number of organisations initially responded to the invitation, but by September the Royal Free was the single remaining candidate. The BCF board examined the Royal Free's case against its criteria, and then formally accepted the Royal Free as its preferred partner.

At the end of November 2012 NHS London approved the recommendation of the strategic outline case submitted by BCF that the Royal Free should be asked to 'proceed to develop an outline business case' for the acquisition. The term 'acquisition' is used because this would be a foundation trust acquiring the assets and liabilities of an NHS trust.

Since that decision the Royal Free has undertaken a first stage due diligence process. Over that same period the clinical leaders of the two trusts and the GP chair of one of the clinical commissioning groups have formed a group to identify the clinical benefits that could be derived were the two trusts' services to be brought together.

The two trusts, BCF's main commissioners and the NHS Trust Development Authority (TDA) – which, since 1 April 2013, has been the new body whose main purpose is to support all remaining NHS trusts to become foundation trusts - have formed a joint programme board to oversee the process.

At the end of February 2013 the Royal Free's board reviewed the information about BCF that it had gathered to date, and decided that it would proceed to the next stage, which is for an outline business case to be developed. If such a case proved viable, then it would be submitted to the TDA for consideration. The target date for this is August 2013, subject to the Royal Free's board authorising its submission at its July meeting.

Two groups, comprising clinicians from both trusts, continue to develop proposals for the larger organisation:

- a high level joint clinical working group chaired jointly by the two medical directors, with the chair of Barnet CCG and consultants and nurse directors from each trust; and
- a clinical project team, comprising consultants and others from each trust, whose role includes meeting with all clinical specialties to identify how to maximise the clinical benefits of the two organisations coming together.

Groups of the trusts' consultants and local GPs recently spent two days working on revised pathways for a range of specialties.

As with all proposed transactions involving NHS trusts, the TDA is the vendor on behalf of the Secretary of State for Health. The next formal decision points from the TDA's point of view are:

- outline business case – asking what in detail is the proposition, and whether it is the best available
- final business case – addressing the details left outstanding in the outline business case.

If the outline and final business cases are agreed by the Royal Free's board and approved by the TDA, Monitor (the regulator of foundation trusts) will examine the proposed transaction from the point of view of finance and governance risks.

The final decision on the transaction will be taken by the Secretary of State for Health, taking account of the TDA's and Monitor's recommendations. The aim is for the acquisition to come into effect in spring 2014.

Royal Free London NHS Foundation Trust
22 May 2013

North Central London Joint Health Overview and Scrutiny Committee (JHOSC)

6 June 2013

Implications for Health Scrutiny of the Francis Report

1. Introduction

1.1. In June 2010, the Secretary of State for Health, Andrew Lansley, appointed Robert Francis QC to undertake a public inquiry into the failures of Mid Staffordshire NHS Foundation Trust. Its terms of reference were:

- T• examine the operation of commissioning, supervisory, regulatory and other agencies in their monitoring role of Mid Staffordshire NHS Foundation Trust (Stafford Hospital) between January 2005 and March 2009;
- To identify why problems were not identified and addressed sooner;
- To identify relevant lessons for how any future failing regimes can be identified as soon as practicable within the context of NHS reforms.

1.2. The final report was published on 6 February this year and made 290 recommendations. It describes the failings as a 'disaster' and 'one of the worst examples of bad quality service delivery imaginable'. The Inquiry looked at the hospital itself and the roles of the main organisations with a role in overseeing it, including the Department of Health, the strategic health authority, the PCT, national regulators, other national organisations, local patient and public involvement and health scrutiny.

1.3. Sections of chapter 6 of the report set out the role and responsibilities of overview and scrutiny and describes the activity of Stafford Borough Council Health Overview and Scrutiny Committee (HOSC) and Staffordshire County Council HOSC and are attached.

1.4. Particular conclusions about the role of scrutiny included:

- Lack of detail in notes of some meetings about Stafford Hospital;
- The need to for HOSCs to be more proactive in seeking information;
- An over-dependency on information from the provider rather than other sources, particularly patients and the public;
- Lack of resources, particularly in small borough committees; and
- The need for scrutiny to be conducted at arms-length rather than as a 'critical friend'.

1.5. The conclusions and recommendations within chapter 6 of the report that relate directly to health scrutiny are as follows:

- 6.276 – 6.295
- 6.344 – 6.353
- 6.459
- Summary of recommendations

put in place was working. A mere glance at almost any of the minutes which it has been the misfortune of this Inquiry to have to read would have given serious cause for concern whether the structure and membership of LINks as they were being set up were capable of delivering the statutory objectives. Sadly, the impression gained from the evidence is that it took the crisis at the Trust, and the direct intervention of the DH and Ministers, to galvanise the council into taking corrective action.

Local authority overview and scrutiny committees

Legislative framework

6.169 County Councils, Borough Councils, and District Councils for areas in which there is no County Council, and London Borough Councils, are required by statute to have an overview and scrutiny committee (OSC) with the power to:

> *... review and scrutinise, in accordance with regulations ... matters relating to the health service (within the meaning of that section) in the authority's area, and to make reports and recommendations on such matters in accordance with the regulations.*[166]

6.170 Such a committee has the power to:

> *Review and scrutinise any matter relating to the planning, provision and operation of health services in the area of its local authority;*[167]

- Make reports and recommendations to local NHS bodies, its local authority and Monitor on any matter reviewed or scrutinised;[168]
- Require a local NHS body to respond to its report or recommendation;[169]
- Require such a body to comply with reasonable requests for information about:

  the planning, provision and operation of health services ... in order to discharge its functions;[170]

- Require an officer of a local NHS body to attend before it:

  ... to answer such questions as appear to the committee to be necessary for discharging its functions.[171]

166 Local government Act 2000, section 21(2)(f) as inserted by the Health and Social Care Act 2001, section 7
167 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 2(1)
168 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 3(1); Health and Social Care (Community Health and Standards) Act 2003, Schedule 4, para 116 – "Local NHS bodies" are defined to include, SHAs, PCTs, NHS trusts and NHS foundation trusts.
169 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 3(3)
170 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 5
171 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 6(1)

6.171 Consequential duties of OSCs include:[172]

- Inviting interested persons to comment on the matters under consideration by it;
- Taking account of:

  ... relevant information available to it and in particular, relevant information provided by a patients' forum pursuant to a referral ...

6.172 With certain immaterial exceptions, local NHS bodies have a duty to consult the OSC if it:

> *... has under consideration any proposal for a substantial development of the health service in the area of a local authority, or for a substantial variation in the provision of such service.*[173]

6.173 Where the OSC is not satisfied that an adequate consultation in terms of content or time to comment has been provided, it may report this to the Secretary of State for Health who may require the NHS body to carry out such a consultation or further consultation as considered appropriate.[174]

6.174 Where the OSC considers that such a proposal:

> *... would not be in the interests of the health service in the area of the committee's local authority, it may report to the Secretary of State in writing who may make a final decision on the proposal and require the local NHS body to take such action or desist from taking such action, as he may direct.*[175]

6.175 The OSCs of one authority have the power to delegate functions to that of another where it considers the latter to be better placed to undertake it.[176]

172 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 2(2)(b)(c)
173 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 4(1)
174 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 4(5)
175 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 4(7)
176 Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048], Reg 8, www.legislation.gov.uk/uksi/2002/3048/made

Statutory Guidance

6.176 Statutory guidance, to which OSCs are obliged to have regard,[177] was published in 2003.[178]

General points

6.177 A number of points emerge from this:

- The primary aim of scrutiny was said to be:

  to act as a lever to improve the health of the local people, ensuring that the needs of local people are considered as an integral part of the delivery and development of health services.[179]

- OSC members were advised of the:

  need to take a constructive but challenging approach to the role, bringing together evidence and people's experience, to identify priority issues and drive forward improvement ... It is important for elected councillors who are involved in overview and scrutiny of health to gain an understanding of the NHS and the provision of health services, as well as to understand local needs.[180]

- The powers of the OSC:

  enable committees to review any matter relating to the planning, provision and operation of health services in the area of its local authority. It is recommended that best use of these powers will depend on committees scrutinising a health issue, system or economy, not just the services provided.[181]

- Its work was to focus on an objective review of issues of local concern but:

  it is not the role of the committee to performance manage the NHS. Other organisations exist to perform this role. Committees are best places to concentrate on ensuring that health services address the needs of local communities.

177 Local government Act 2000, section 38; Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 [SI 2002/3048, Reg 2(2)(a)] www.legislation.gov.uk/uksi/2002/3048/made
178 SBC00010000257, *Overview and Scrutiny of Health - Guidance* (July 2003)
179 SBC00010000257, *Overview and Scrutiny of Health - Guidance* (July 2003), para 1.1
180 SBC00010000257, *Overview and Scrutiny of Health - Guidance* (July 2003), para 1.2
181 SBC00010000257, *Overview and Scrutiny of Health - Guidance* (July 2003), para 1.4

Approach to scrutiny

6.178 With regard to the manner of scrutiny involved, the guidance advised that:

> *A constructive approach based on mutual understanding between the committee, the local authority executive function and local NHS bodies will be a prerequisite for success ... Scrutiny is sometimes challenging and will sometimes be uncomfortable for the organisation being scrutinised but if the process is aggressive, or relies on opinion rather than evidence, it is unlikely to lead to positive or sustainable improvement. Likewise health bodies will need to respond honestly to questioning and provide explanations if they are unable to implement overview and scrutiny committee recommendations ...*[182]
>
> *The power to scrutinise the NHS needs to be applied both robustly and responsibly. Scrutiny should be probing and incisive, focusing on its primary aim of improving services for members of local communities. Asking the obvious question can be very revealing, but committees must also recognise that some of the problems facing the NHS have no simple or universally popular solution ...*[183]

6.179 The OSCs were advised that they needed to:

> *develop a close working relationship with* [patients'] *forums relating to the health service within their area. This might include discussing the outline and process of a scrutiny review with members of forums prior to beginning the review, and also co-opting forum representatives onto the committee or inviting them to become expert witnesses or advisers. It will also be important for committees and forums to discuss appropriate responses to matters of concern to patient safety and welfare should such circumstances arise.*[184]

6.180 The guidance advised that OSCs had a choice of approach: of being reactive, for example by responding to referrals, or proactive in determining their own subject matter and terms of reference.[185]

6.181 To be effective, the guidance suggests:

> *committees must balance 'expert' opinion and public concerns where these conflict ... To ensure credibility, committees should consider all views and evidence before finalising recommendations ... To achieve this effectively ... committees will need adequate support and advice from the local authority's officers.*[186]

182 SBC00010000257, *Overview and Scrutiny of Health - Guidance* (July 2003), para 1.7
183 SBC00010000257, *Overview and Scrutiny of Health - Guidance* (July 2003), para 1.10
184 SBC00010000257, *Overview and Scrutiny of Health - Guidance* (July 2003), para 4.5.3
185 SBC00010000257, *Overview and Scrutiny of Health - Guidance* (July 2003), para 5.1
186 SBC00010000257, *Overview and Scrutiny of Health - Guidance* (July 2003), para 5.4

Information and communication

6.182 The guidance emphasised that collated data from PALS and the Independent Complaints Advocacy Service (ICAS):

> *... will be a crucial input to the scrutiny process ...*[187]

6.183 The need for *"clear lines of communication and information exchange"* with patient's forums was emphasised. It was noted that:

> *... patients' forums will monitor trusts and PCTs at an operational level.*[188]

Discretion to delegate

6.184 Referring to the statutory power for scrutiny functions to be delegated from County Council to District Council level, it was suggested that for this to be effective:

> *... there must be clear terms of reference agreed between the local authorities and clarity about the scope and methods of scrutiny which might be used.*[189]

Terms of reference and understanding of responsibilities of Staffordshire County Council Overview and Scrutiny Committee

6.185 In 2002, Staffordshire County Council (SCC) set up a Health Policy Commission consisting of seven councillors to review NHS provision in Staffordshire in order to provide the Council with a:

> *... clear picture of the issues facing health providers in Staffordshire, the availability and type of information which is available to scrutinise and to make recommendations on how scrutiny may be carried out.*[190]

6.186 The commission devised a scheme whereby both the County Council and the eight Borough and District Councils in Staffordshire would have OSCs.[191] The proposal was that:

> *The County Council will concentrate on more general issues and the District Committees on more local issues particularly relating to individual PCTs.*[192]

187 SBC00010000257, *Overview and Scrutiny of Health - Guidance* (July 2003), para 4.1
188 SBC00010000257, *Overview and Scrutiny of Health - Guidance* (July 2003), para 1.6
189 SBC00010000257, *Overview and Scrutiny of Health - Guidance* (July 2003), para 7.3
190 AE/01 WS0000003060
191 Stoke-on-Trent, as a primary authority, was outside these arrangements and has its own committee.
192 AE/01 WS0000003063

6.187 Each of the borough and district committees was to have a representative on the county committee which is otherwise populated with county councillors appointed by their parties in proportion to the political make-up of the council. In the other direction, a county councillor was to sit on each of the local committees.

Terms of reference and allocation of responsibilities by County Council

6.188 Pursuant to what the Inquiry was told were the original terms of reference for County Council OSCs,[193] the County Council's Health Scrutiny Committee (HSC) was empowered to:

- Within the scope of its allocated roles and responsibilities, respond independently to health related consultations from Government and external agencies;[194]
- Assume responsibility for overview and scrutiny or matters relating to the planning provision and operation of health services, and make reports on such matters in accordance with the legislation.[195]

6.189 Borough and District Councils without a social care function are not obliged by statute to have a health scrutiny committee, but the Inquiry was told that most do so, and all in Staffordshire have such a committee. As mentioned above, the County Council had power to delegate functions to district committees. The extent to which it did so in the case of the Trust has been a matter of debate before the Inquiry.

6.190 In 2003, the County Council and the District and Borough councils agreed a scheme of joint working under which certain functions would be performed by the local bodies. The intention of this was that the county HSC would deal with matters having a countywide theme whereas the local committees would deal with local issues.[196] The county HSC could also appoint one local council to lead on a particular scrutiny activity. In such a case there would be terms of reference determined by the county HSC.[197] The matters which local OSCs could deal with included "local national health service bodies". Among the general working principles adopted was one on accessibility:

> *Scrutiny activity will, for each piece of work, actively seek to identify interested parties and to involve them where appropriate in the overview and scrutiny process.*[198]

6.191 The same principle was repeated in the county's Joint Code of Working of June 2008 and, substantively, in an amendment in June 2010.[199] However, the latter document expressly

193 SCC00030000079 Article 8 – Scrutiny Committees
194 SCC00030000080 Article 8 – Scrutiny Committees, para 8.3.xiii
195 SCC00030000081 Article 8 – Scrutiny Committees, para 8.5.a
196 SBC00010000087–SBC00010000094, *Report to the Health Scrutiny Committee* (24 June 2008)
197 SBC00010000095, *Report to the Health Scrutiny Committee* (24 June 2008)
198 SBC00010000098, *Report to the Health Scrutiny Committee* (24 June 2008)
199 SBC00010000093; SBC00030000091–94; SBC00010000234–237

provided that the scrutiny of the acute hospital trusts, including the Trust, would be retained by the county HSC. Therefore, objectively, on the evidence seen, there was a lack of clarity about what precise function in relation to the Trust the County Council HSC delegated to the Borough Council.

Terms of reference and understanding of responsibilities of the Borough Council

6.192 At its first meeting, the Stafford Borough Council's OSC noted its terms of reference and its function as being:

> *To review and scrutinise* [in accordance with legislation] *matters relating to the health service in the Council's area and to make reports and recommendations on such matters in accordance with the regulations.*[200]

6.193 The Chief Executive was empowered to call a meeting of the Borough Council's OSC if he or other officers thought there was an item requiring consideration and the Chairman failed to call such a meeting. Similarly, the officers, or any member on seven days' notice, could require a matter to be placed on the agenda.[201] It adopted as a method of working:

> *Selecting a single topic in the current year which it could examine in detail and come forward with meaningful conclusions.*[202]

6.194 Ian Thompson, Chief Executive of Stafford Borough Council, had been the lead officer responsible for the OSCs between October 2005 and May 2008. He told the Inquiry that the terms of reference had been unclear as to which of the County and the Borough Council's committees were responsible for the scrutiny of the three Staffordshire hospitals and pointed out that there was no joint code of working until June 2008.[203]

6.195 Councillor Philip Jones has been a long-standing member and was, between 2008 and 2009, Chair of the Borough's OSC, as well as a member of the County HSC (from 2009). He considered that the arrangements for delegation from county to district level had always been unclear. He pointed out that there had never been terms of reference as required by the DH guidance. Before the joint code of 2010, there had been no formal devolution of authority. Therefore, he contended that primary responsibility remained throughout with the County Council.[204]

200 SBC0001000024, Minutes from the Health Scrutiny Committee meeting (10 July 2003)
201 SBC0001000000012, Minutes from the Health Scrutiny Committee meeting (10 July 2003), para 2.1.d
202 SBC0001000026, Minutes from the Health Scrutiny Committee meeting (10 July 2003)
203 Thompson WS0000002308, paras 8–10
204 Philip Jones WS0000001784, paras 6–7

6.196 County Councillor Jim Muir had not been involved when the County HSC was set up, but disagreed that there had ever been a lack of clarity, asserting that it was "abundantly clear throughout, until 2010, that it was for the Borough Council to scrutinise the Trust".[205] He said that the minutes made it clear that in practice the Borough Council OSC dealt with the issues relating to the Trust.

6.197 An examination of the subsequent conduct of business by the County and Stafford Borough Council committees suggested that it was implicitly accepted that scrutiny of the Trust was a matter which could be, and was, addressed by the Borough Council OSC. For example, at the Borough Council OSC's first meeting, it accepted an invitation from the Trust for members to attend a Board meeting and to inspect facilities at the two hospitals. The Borough Council OSC's minutes repeatedly refer to its use of delegated powers.

6.198 However, this does not mean that the County Council Committee had divested itself of its statutory responsibility; it retained a duty to oversee the scrutiny, to receive reports from the Borough OSC and to take any action it saw fit in relation to this trust.

6.199 It is right to conclude that there had been a lack of clarity in relation to the formal allocation of responsibility, which was clearly undesirable. However, there is no evidence that this uncertainty played any part in hindering scrutiny by either committee.

Resources of overview and scrutiny committees

6.200 There was, and remains, a significant disparity between the resources of the County and Borough Committees. The County HSC has the benefit of being supported by a large infrastructure. Staffordshire County Council has a budget of £1.5 billion, a staff of 30,000, and a cabinet member leading in health and social care who commands a budget of £270 million. The County HSC is supported by officers experienced in scrutiny. All members receive training.[206]

6.201 Stafford Borough Council, on the other hand, although one of the larger councils in the county, now has a staff of 400 whole time equivalent post, and has a budget of around £54 million. It also has one scrutiny officer, who serviced all its scrutiny committees.[207]

205 Muir WS0000034482, paras 33–34
206 Matthew Ellis T34.8–9
207 Thompson T35.3–7; T35.74

Activity of Stafford Borough Council Overview and Scrutiny Committee

Committee records

6.202 In order to see what scrutiny activity was carried out, it has been necessary to consider what the minutes and other evidence showed the committee knew about and what, if any, activity was carried out. It has been far from easy to determine this as the minutes, particularly those of the Borough Council, are brief to the point of being uninformative: they register that a topic was discussed and summarise presentations made by external bodies, or formal questions put, but there is no summary of the debate, merely a series of very short reports of any decision taken. In many cases, the decision was often merely to "note" a presentation. It was widely accepted by witnesses that this style of minute taking was inadequate as it gives little idea what members of the committee actually contributed. That it was possible for them to ask many detailed questions was shown by a clerk's note preserved from one meeting, but such notes have not been routinely kept. It was suggested that this form of minute was common local government practice.[208] If this is so, the practice needs reviewing. While a Hansard style transcript is not required, it is unfair to the councillors and obstructive to public involvement and engagement for there to be no record of the contributions made by committee members whether by way of observations or questions, and of responses given. The essence of public engagement is that their views are captured to inform the decision-making processes within the service. This requires the recording not only of an outcome but also of the range of views expressed.

6.203 Stafford Borough Council intends to review this practice, but if it is prevalent, a more widespread review is required. The proceedings of bodies performing a statutory scrutiny function should be more fully recorded than appears in many of the minutes considered by this Inquiry.

Information available to the committee

6.204 In theory, the Borough Council's OSC received information from the Trust through the Trust's Executive team, the PPIF, the PCT, the media and individual members of the public. Perusal of the minutes (see above), suggests that there were communications from all these sources from time to time, but that the principal source of information was the Trust itself. Councillor Edgeller could only recall three occasions on which members of the public had raised a concern, and only one of these related to the quality of the service. The OSC was therefore very dependent on the accuracy, completeness and insight of the information conveyed to it by the Trust.

208 Phillip Jones T36.93

6.205 As noted above, the DH guidance suggested that information from PALS and ICAS about complaints was "crucial". However, this was not made available to the OSC, and it did not ask for it.[209]

6.206 Likewise, the committee does not appear to have received information from the HCC, apart from AHC ratings, or Monitor.

Public participation

6.207 The public were allowed to attend committee meetings and ask questions, but these had to be tabled seven days in advance of the meeting. Councillor Edgeller said it was difficult to know if this procedure inhibited the raising of concerns because members of the public so rarely attended meetings, before the problems of the Trust became widely known. The procedure was relaxed after the publication of the HCC report.[210]

6.208 Roger Dobbing told the Inquiry that the rule had been far too restrictive:

> *because what it meant was that that incident that may have occurred over the weekend could not be addressed for another four weeks, minimum, by which time it had lost all relevance.*[211]

6.209 He considered that no attempt was made to elicit information from the public.[212]

Committee activity

2003

Liaison with the Trust

6.210 At its first meeting on 10 July 2003, the Borough Council's OSC agreed to accept an invitation for members to attend a board meeting at the Trust and to inspect facilities at the two hospital sites. The invitation from the Trust Chief Executive suggested that this would provide:

> *An opportunity to build a constructive relationship between our organisations and begin to have a more meaningful understanding of the way we work and major issues facing each of us.*[213]

6.211 On 16 October 2003, it was reported that the County Council's representative on the Borough Committee had been appointed to liaise with, and have responsibility for, relevant issues

209 Edgeller T36.41–42; Jones T36.164
210 Edgeller WS0000003043, paras 6–9
211 Dobbing T17.150
212 Dobbing T17.150–151
213 SBC00010000066

arising from the Trust. It was noted that members had attended part of a Trust Board meeting, which had lasted all day, and this had been found *"interesting"*. Members were able to attend the next Board meeting if they wished.[214]

2004

Consideration of first application for Foundation Trust status

6.212 On 23 March 2004, the committee received a presentation from an Executive Director of the Trust on its proposal to apply for FT status. The 32 page consultation document described the Trust as having already made "significant progress" and had achieved three star status. It claimed that the Trust had adopted a proactive approach to clinical governance:

> *... with clear structures and reporting lines through to the Trust Board identified and adopted.*

6.213 And that following the Commission for Healthcare Inspection's (CHI's) report of 2002, they had:

> *... identified plans to overcome identified areas of weakness.*[215]

6.214 The current programme of work was said to include continuing to meet CHI recommendations. The minutes record that during the oral presentation, the Trust Director recognised that the key risks of becoming an FT included:

> *... a diversion of management and clinical time away from delivering services to patients during the process of application as deadlines were extremely tight.*

6.215 Members raised issues about a number of matters, including the:

> *... staffing and resource implications of the proposals particularly if it leads to competition between Trusts.*[216]

6.216 At the conclusion of the presentation, the committee resolved to support the Trust's application in principle, although members had been invited to a further presentation at a County HSC meeting at the end of the month.[217]

6.217 This support appears to have been given immediately after the presentation, with no further opportunity for members to reflect on the matter. This contrasts with the later consideration

214 SBC0001000030-31
215 SBC00010000343, Health Scrutiny Committee (23 March 2004)
216 SBC0001000065, Minutes of the Health Scrutiny Committee (23 March 2004)
217 SBC0001000065, Minutes of the Health Scrutiny Committee (23 March 2004)

on 22 September 2005 of an application by the South Staffordshire Healthcare NHS Trust: on that occasion the committee did not offer support immediately after the presentation but resolved to develop a response at a further meeting.[218]

Withdrawal of foundation trust application

6.218 By the time of the meeting on 4 November 2004, the Trust's CHI star rating had collapsed from three to zero stars, and the FT application had been withdrawn. Mixed messages were sent to the committee about the reasons for the withdrawal. A letter from the then Trust Chief Executive, Mr O'Neill, in July 2004 claimed that the decision:

> *... was made following a recent Board meeting when it was felt that due to funding difficulties in the local health system, deferment makes the most sense at the present time.*[219]

6.219 Reference was made to:

> *... an underlying shortfall ... in the region of £15 million. Of this £6 million is the cost of hospital care, which is not currently covered ... As the financial issues are resolved the application process will be resumed.*

6.220 In contrast, the officer's report of a meeting of the County HSC suggested it had been informed that it was:

> ... [the Trust's] *performance against the Star Ratings system which ultimately led to the deferral of their Foundation Trust application.*

6.221 And that it had resolved to write to the [Health] Minister expressing its support for the Trust's efforts to regain their three star status, referring to the:

> *... unfairness of the Foundation Hospital Initiative.*[220]

6.222 Members were also given copies of the Trust's slide presentation on the star rating system. This also addressed the staffing and financial positions. It stated that a shortage of clinical staff had been addressed by increasing clinical staff from 179.86 WTE in 2001/02 to 223.92 WTE now, and nursing staff from 853.81 WTE to 1,044.83.[221] There was said to be a £7.34 million deficit. The Trust had agreed a £1.5 million "brokerage" and would be allowed to overspend by £1 million the following year.

218 SBC0004000161, *Report to the Health Scrutiny Committee* (22 September 2005)
219 SBC00010000354, *Report to the Health Scrutiny Committee* (4 November 2004)
220 SBC00010000366-367; SBC0001000071, *Stafford Borough Council Health Security Meeting* (4 November 2004), para 1.6
221 SBC00010000361, *Report to the Health Scrutiny Committee* (4 November 2004)

6.223 As it was stated these sums had to be repaid, it might be thought to result in an increased planned deficit of £8.84 million.[222] It is unclear from the evidence that the committee reacted to these apparent problems at the Trust in any way other than receiving the presentation.

2005

Consideration of proposed cost savings

6.224 On 14 January 2005, the Trust issued a press release detailing its financial recovery plan. On 22 February 2005, at the express request of a resolution of the full council, the Borough Council's OSC considered the service implications at the Trust arising from proposed financial cuts. It was reported[223] that the Trust Board had approved a financial recovery plan to address a £6 million recurring deficit. It was forecast that it would be necessary to remove 180 WTE posts to save £4 million. The hope was expressed that the number might be less if some senior posts could be identified to be cut, and by means of skill mix adjustments. The Borough Council's Chief Executive's report to the OSC stated:

> *The Trust is clearly concerned to ensure that the clinical quality of care provided is not adversely affected and the process adopted will look to minimise the impact specifically on patient care. It is possible that the Trust may have no choice but to lose some members of staff, but this will be only as a last resort and the Trust will be doing everything possible to avoid such measures.*[224]

6.225 No record survives of the questions asked at the meeting, which was attended by the Chair, Chief Executive and another Executive Director of the Trust, but the minutes record that:

> *Members particularly noted that the Trust had no plans to close wards or discontinue services.*[225]

6.226 The minutes recorded that the committee resolved to note the Trust's response and to thank the Trust's representatives for attending. In other words, the committee merely received the report and took no further action to delve into the problem or express a view about it.

6.227 On 21 April 2005, the OSC considered the "possible implications of the trust's recovery plan"[226] and resolved to invite the Trust to a special meeting to discuss the issue.

6.228 Trust representatives attended the committee meeting on 30 June 2005. Again, the minutes do not record the substance of any discussion, but it is recorded that among matters referred

222 SBC00010000362, *Report to the Health Scrutiny Committee* (4 November 2004)
223 SBC00010000012, *Report to the Health Scrutiny Committee* (25 February 2005)
224 SBC00010000013, *Report to the Health Scrutiny Committee* (25 February 2005)
225 SBC0001000093, Minutes from the Health Scrutiny Committee (25 February 2005)
226 SBC0002000010/11, Minutes from the Health Scrutiny Committee (21 April 2005)

to by the Trust was a "reduction in establishment".[227] It was resolved that the Trust be invited to attend the committee on a regular basis.

6.229 At the same meeting, a report was received from the PPIF for the Trust.[228] The health officers of the councils with scrutiny committees had met earlier (on 13 April) and noted that training in inspections was to be made available to Trust PPIF members. It was also agreed that "clarification" needed to be sought from the Trust about various proposed changes on which it was thought that consultation was required.

2006

Further issues about cost savings

6.230 The Trust approved its cost improvement plan for the coming year, involving the loss of about 150 posts, at a board meeting in April 2006.[229]

6.231 On 27 June 2006, the committee received a presentation from Mr Yeates on:

> *... the issues facing the Trust, including NHS configuration and a new Strategic direction that involved achievement of Foundation trust status in November 2007, workforce reductions and a new management structure.*[230]

6.232 The minutes do not record the content of the presentation or the discussion, and there is no other evidence to suggest that this plan was subjected to any level of scrutiny.

Annual report from the Public and Patient Involvement Forum

6.233 At the same meeting, the committee received the report of the Trust's PPIF for 2005/06.[231] This reported that the forum had noticed that general cleanliness at the hospital had improved. The report stated that the forum felt proud of the way in which the Trust had addressed its concerns arising out of its monitoring visits.[232] What those concerns might have been was not specified.

227 SBC0001000097, Minutes from the Health Scrutiny Committee (30 June 2005)
228 SBC0001000098, Minutes from the Health Scrutiny Committee (30 June 2005)
229 ESI00217868, Minutes of a Meeting of the Mid Staffordshire General Hospital's NHS Trust (6 April 2006)
230 SBC0001000190, Minutes of the Health Scrutiny Committee (27 June 2006)
231 SBC0004000200, *Report to the HSC* (27 June 2006)
232 SBC0004000204, *Report to the HSC* (27 June 2006)

Concern about children's services

6.234 On 7 September 2006, the committee resolved to contact the Trust:

> *... in order to clarify the reasons as to why the Trust attained such a low score following the Commission's recent assessment of Children's Services at the hospital.*[233]

6.235 The HCC had published a rating for children's services the previous month, awarding the Trust a score of one out of a maximum of four, largely because the Trust had failed to supply the relevant information.[234]

6.236 The Trust's response came from the interim Director of Nursing, Gill Landon, in a letter dated 26 September 2006. In near identical terms to a letter sent to the SSPCT, Ms Landon described the score as "disappointing" and that it had resulted from the failure to supply information in time. She offered reassurance:

> *I am sure you know that our hospitals and staff provide an excellent service to children and young people. Had we provided the information by the deadline, we believe that this may well have resulted in a higher score in this review ...*
>
> *... I assure you that you can continue to have confidence in the high quality services we provide for children and young people.*[235]

6.237 The committee was unaware of the West Midlands peer review expressing similar concerns and identifying immediate concerns.

2007

Consideration of Foundation Trust application

6.238 On 20 February 2007, the committee received a presentation from Mrs Brisby and Mr Yeates on the renewed application for FT status. From the slide presentation,[236] it appears that the committee was informed that it was being consulted on the Trust's proposals for governance, its priorities and a suggested new name. The slides on governance refer to the constitutional structure (members, governors, directors), but there is no explicit reference to clinical governance. The aims of the Trust included:

> *expanding and improving the range, nature and quality of services;*
>
> *further developing specific services into centres of excellence; and*

233 SBC0001000111/113, HSC Minutes (7 September 2006)
234 S Hawkins WS0000026347, para 45
235 AE/8 WS0000003101-02
236 SBC0001000119, HSC Minutes (20 Feb 2007)

aiming to be the cleanest place in town.

6.239 At the conclusion of the presentation, the committee resolved to support the proposals and to convey its best wishes for the application.[237] It proposed a different name for the FT to that proposed.[238] Thus, while there may have been some discussion at the meeting, which lasted about two hours, the committee did not take the opportunity to pause for reflection before offering its approval as it had done when considering the application of a neighbouring trust in the previous year. It is unclear what questioning or challenge took place.

6.240 Councillor Edgeller, who had attended this meeting, told the Inquiry that she could not recall what questions had been asked, but pointed out that the meeting lasted for two hours. As to the value of the consultation process, she had this to say:

> *THE CHAIRMAN: I mean, would it be fair to categorise what really happened on that day as your committee just rubber stamping the proposal, rather than there being any critical analysis of it?*
>
> *A. I would say that, all right, the PowerPoint presentation was given and at the end of it there would be questions asked. But I can't recall what questions.*
>
> *THE CHAIRMAN: But just as you say that as you had been told of no concerns on other matters, they wouldn't really be looked into by the committee, you would have had no basis at all to do anything other than accept what was being said to you by the trust which was that this application was, putting it broadly, a good idea; would that be fair?*
>
> *A. Yes.*
>
> *THE CHAIRMAN: Does that mean that the process of consultation in this particular instance therefore is meaningless?*
>
> *A. Yes, I would say that. I would.*[239]

Report from the Public and Patient Involvement Forum

6.241 The committee received a presentation of the PPIF's annual report in June 2007.[240] The report contained a reference to the three inspection visits which have been described above in the PPIF section. It also recorded that, following a meeting with the County HSC Chair, plus press articles and public concerns about *Clostridium difficile*, a second series of visits had been arranged. The outcome of the visits was:

237 SBC0001000116/117, HSC Minutes
238 In fact, neither the Trust's original proposal nor that of the committee were adopted.
239 Edgeller T37.38-39
240 AE/10 WS0000003131

As reported previously, general cleanliness of all areas of Stafford Hospital has noticeably improved. Additional funding has been released to increase the frequency of cleaning from two to three sessions a day. As a result of these visits named Champions within the Trust are leading by example and promoting all issues relating to cleaning and cleanliness.[241]

6.242 Councillor Edgeller confirmed that the issue of cleanliness was raised at this meeting.[242]

6.243 On 22 November 2007, the Borough Council's OSC received a presentation from the Chair of the PPIF in relation to its inspections of the cleanliness of the hospital and also heard from Mrs Perrin, the Trust's Head of Marketing. There is an implication that members were concerned at what they heard, as they resolved to receive regular reports on the monitoring of *C. Difficile* from the Trust and recommended that when LINks were set up, they should retain the power to inspect.[243]

Questions from Cure the NHS

6.244 On 19 February 2008, the OSC received an update report from the Trust. This included the news that the FT application had been successful following what it described as:

A lengthy, detailed and searching investigation by ... Monitor to make sure that the Trust is well managed and financially strong so that it can deliver excellent healthcare for patients.[244]

6.245 Details, including figures, were given on the progress being made to reduce hospital acquired infections.

6.246 For this meeting Councillors Edgeller and Tabernor submitted three questions received from Julie Bailey and other members of CURE and the public. These raised, for the first time so far as can be discerned from the documents seen by the Inquiry, the type of concern that has featured so largely in the HCC report and the report of the first inquiry. They are worth setting out in full:

1. We understand a review on staffing levels was taking place in December 2007. Could you please advise as to what levels the staffing has been increased to and, as from what date are the changes to take effect. We refer directly to the problems relating to wards 10, 11 and 12. SDGH as highlighted recently.

241 SBC0004000243, *Report to HSC* (26 June 2007)
242 Edgeller WS0000003050, para 33
243 SBC0003000028/29, HSC Minutes (22 Nov 2007)
244 SBC00010000072, *Mid Staffordshire General Hospitals Trust Progress Report* (19 February 2008)

2. Could you advise as to the level of competence/training staff are given to be able to deal with patients suffering from dementia. You will appreciate that this used to be a more specialised nursing aspect, but, with the demise of the specialist hospitals and the movement into general hospital wards, can you advise as to what specialist training the general staff nurses receive.

3. Can the Chief executive of the SDGH, confirm that when a patient is unable to feed themselves through illness that their needs are addressed and that they do not miss their nourishment.

6.247 These questions had been submitted slightly too late to comply with the committee's requirement of seven days' advance notice, but Councillor Edgeller considered they ought to be answered and submitted them as a members' item.[245]

6.248 While the questions are recorded in full in the minutes, all that is said about an answer is that Ms Dunne, the Trust's Deputy Director of Nursing and Governance, Ms Williams, Head of Governance, and Ms Perrin, Head of Marketing, provided what was described as a "comprehensive" response.[246] Quite what that was is not recorded.

6.249 The committee resolved to congratulate the Trust on its achievement of FT status. In addition, it resolved to receive a further report on infection control, as well as details of its uniform policy. Concern about nurses wearing their uniforms outside the hospital is known to have been expressed in the context of its impact on infection control.[247] Therefore, it would be wrong to infer that no concern was raised following on from the questions asked. However, it does not appear that any member thought that there was any incongruity in conveying their congratulations to the Trust and the concerns underlying Julie Bailey's questions.

6.250 However, whatever was discussed did not satisfy Julie Bailey. She had not been allowed to speak at the meeting, although Trust representatives were allowed to respond to her written questions. Those responses were not minuted.

6.251 Julie Bailey wrote a long letter to all members of the committee on 20 February 2008.[248] In it, she recounted what is now the well known, but appalling story of the care received by her late mother at the hospital and enclosed a list of 66 points of general concern, including lack of assistance with feeding, and bowel and bladder care.[249] Familiar as Julie Bailey's complaints now are, some of the more striking general observations are worth repeating here:

245 CLO0000003241–42, *Counsel to the Inquiry Closing Submission*, Chapter 4
246 SBC0001000150–151, Minutes from the Health Scrutiny Committee (9 February 2008)
247 SCC00050000125, *Literature Search 'Nurses as a Possible Source of Infection'*; SCC00100000365 Letter to Jan Harry (Director of Nursing) from Mr Lindon (Deputy Corporate Director) (5 April 2005) attaching document *Literature Search 'Nurses as a Possible Source of Infection*
248 CURE0023000412, Letter from Julie Bailey (undated)
249 CURE0025000001, List of 66 complaints (undated)

We sadly lost my Mother, I believe to the culture of neglect and disregard for the vulnerable within that hospital.

On her ward (11) there was complete disregard for a patient's well-being, they were basically left to fend for themselves. I do believe that if it wasn't for me and another patient's relative, two other patients on my Mother's ward would not be alive today. We fed and toileted them and kept them going.

It seemed that very few of the staff actually cared.

We found the staff to be totally demoralised.

Vulnerable people deserve better. They are entitled to respect and dignity but even their basic rights were denied them.

Other families had relatives who like my mother have suffered due to the unacceptable standards that are practised ... once you spend any length of time within that institution you see and hear it.

Once you spend any length of time in that hospital you see and hear things that disturb you.

6.252 Julie Bailey received two contrasting responses. On behalf of the Borough Council, a letter sent out in the name of the Head of Law and Administration, but not written by him, replied in what can fairly be described as dismissive language.[250] It included advice "that it is not the role of the health scrutiny committee to pursue individual cases from members of the public" and referred to the services of PALS and the regulations under which OSCs worked. The letter concluded "However, your letter will have alerted Members of the Health Scrutiny Committee to your concerns and the general nature of these may be taken into account during any future discussions held with the ... Trust."

6.253 Councillor Philip Jones, on the other hand, was much more responsive. He replied in a letter of 5 March 2008 which included the following sentiments and statements of intent:

I am so deeply touched and sorry that you had to endure such a truly awful experience ...

You might remember that at the meeting I called for openness and the Governors to be given the right to make unannounced visits to the hospital. The Committee urged me to take this to the next Council of Governors. I have therefore put down an agenda item for the Governors' meeting on 20 March ...

I will do all I can to improve patient care and dignified treatment.[251]

250 CURE0023000415, Letter from A Welch (Stafford Borough Council) to Julie Bailey (6 March 2008)
251 CURE0023000414, Letter from Philip Jones (Stafford Borough Council) to Julie Bailey (5 March 2008)

6.254 Mr Thompson explained that he thought the committee had found it difficult to reconcile the knowledge that the Trust had just been authorised by Monitor as an FT with the complaints made in Julie Bailey's letter:

> *I think they would have found it difficult to come to terms, as indeed they had to face in 2008, the fact that Monitor could give the hospital foundation trust status and there could still be significant issues with the hospital. And, you know, I think I have to say the second letter which I think Julie sent to the scrutiny committee – this is the one that refers to the 66 points – did come as a real bombshell. And I said this morning I think members were genuinely confused by the award of foundation trust status, I think it was in the December 2007, and a letter from Julie relating to issues – to issues that took place at that time, the 66 points, and I think they found it very difficult to reconcile those issues. I think they were – the issues obviously were discussed at the February 20 meeting 2008, and in many ways that sort of reconciliation process, coming to terms with that, was taken out of their hands because I think less than a month later, or around a month later, the HCC inquiry was announced.*[252]

2008–2009

Interaction with the Healthcare Commission's investigation

6.255 By the time of its next meeting on 17 April 2008, the HCC had announced its investigation, and Mrs Brisby had written to Councillor Jones (in his capacity as an FT governor) informing him of this.[253] The Trust had issued a press release in which it was asserted that the hospital's services were "safe" and that the explanation of the mortality figures was coding.[254] The only reference to this in the minutes is that the committee resolved to add:

> *... the results of the Healthcare Commission's investigation into mortality rates* [at the Trust] *... to the work programme.*[255]

6.256 At the same meeting, a presentation from Dr Helen Moss was received on infection and prevention control. There is no record in that context of the HCC investigation. There is no reference in the minutes to any discussion of the letter from Julie Bailey, and it is to be assumed that there was none.

6.257 Councillor Jones told the Inquiry that he received no information about the progress of the HCC investigation apart from that offered by the Trust; as far as he was aware, the Trust was the OSC's only source of information about the investigation. It did not receive copies of the letters

252 Thompson T35.117–118
253 PJ/3 WS0000001812
254 PJ/6 WS0000001822
255 SBC0001000158, HSC Minutes (17 April 2008)

written by Dr Heather Wood the HCC's lead investigator, alerting the Trust and others to the concerns being uncovered.[256]

6.258 At the committee's meeting on 24 June 2008, it was reported that Trust representatives were unable to attend, and as a consequence, members had been invited to visit the hospital to meet directors. This took place on 13 August 2008, and members received a presentation from Mrs Brisby and Dr Moss. There were a number of concerning features about this presentation:

- The presentation suggested that under the previous management in 2005/06, the Trust had suffered from a major financial deficit, a lack of governance, questions over its future viability, an inward looking culture, a lack of leadership and quality issues.[257] The HCC report, and the report of the first inquiry, suggest that this frank, retrospective assessment was correct, but there is no indication in committee reports and minutes that this dire state of affairs had been detected by the committee or that any concern was now being expressed that these very serious concerns had passed unnoticed by those responsible for local health scrutiny;
- It was asserted that in 2006/07 the Trust had obtained a new senior team, governance structure, and that there had been a major skill mix review, a focus on quality, investment in capital and clarity on the future. It was claimed that the Trust now welcomed scrutiny.[258] The plan for 2008/09 included £2.47 million for 188 new and additional nurses (by September), a:

  ... focused review and development of A&E services (including recruitment of a new matron and two consultants and an extended triage service), investment in gaining immediate patient feedback, and enhancing and developing quality, safe services for local people.[259]

6.259 Even without the benefit of hindsight, the OSC might have been expected to ask how good quality care could have been provided with such an apparent shortage of staff and how such a rapid increase in numbers was to be achieved:

- Information designed to reassure about the reported mortality rates was given. The overall (ie not the acute admissions) Hospital Standardised Mortality Ratio (HSMR) for 2005 to 2009 were given, showing a decline from 127 to 99 in April 2008. Reference was made to "independent" reviews of the rates by the SHA and Birmingham University.[260] This

256 Jones T36.72–74
257 SBC00010000109, Presentation by the Trust given to Members of the Committee when they visited the hospital (13 August 2008)
258 SBC00010000109, Presentation by the Trust given to Members of the Committee when they visited the hospital (13 August 2008)
259 SBC00010000110–111, Presentation by the Trust given to Members of the Committee when they visited the hospital (13 August 2008)
260 SBC00010000117, Presentation by the Trust given to Members of the Committee when they visited the hospital (13 August 2008)

suggests, as confirmed by other evidence,[261] that the concerns about mortality were explained away by reference to the coding explanation. Councillor Jones recollected that:

both of them put a brave face on the matter and said that they – the hospital would emerge with a fairly clean bill of health and that really there was nothing wrong, underlying the operations and the performance of the hospital;[262]

He felt that the Borough Council's OSC received these assurances with a degree of scepticism.[263]

6.260 The committee was also told of results from the Ipsos MORI survey carried out by the Trust in May 2008. This had followed a concerning 2007 HCC inpatient survey result, also published in May. The latter had placed the Trust in the lowest 20% of trusts in the country for cleanliness, treatment of patients with privacy and dignity, and involvement of patients in their care. There is no record either in the presentation or in the minutes that these results were drawn to the committee's attention. If the presentation slide is a correct summary of what the committee was told, the results of the Ipsos MORI survey were presented in a manner calculated to put the best "spin" on them:

Overall 92% rated the care provided as "excellent", "very good" or "fairly good".

6.261 This left 7% saying care was "fairly poor" (4%), "very poor" (2%) or "terrible" (1%).

97% said they or the patient they were visiting – were treated with respect and dignity.[264]

6.262 As reported to the Trust's Hospital Management Board, the overall total of 97% reflected those who reported that patients were so treated "at least some of the time".[265] Only 74% said that patients received such treatment "all of the time", whereas 15% only accepted that this occurred "most of the time", and 5% "some of the time" or "rarely". A scrutineer might reasonably have expected dignity and respect to be accorded to everyone at all times.

89% rated the hospitals as "very clean" or "fairly clean".

6.263 The Trust's Hospital Management Board heard that, of the overall total of 89%, only 44% thought the hospital "very clean", whereas 45% thought it "fairly clean", 5% "neither clean nor dirty", 4% "fairly dirty" and 1% "very dirty", ie a majority of 55% thought it was less than excellent, and 11% thought it was not clean.[266] The survey report noted that there were

261 Jones T36.81
262 Jones T36.76
263 Jones T36.77
264 SBC00010000126, *Delivering the difference* (12 August 2008), Toni Brisby and Helen Moss
265 ESI00047139, Agenda of Trust meeting (6 December 2007); ESI00047142–143 *Report to Hospital Management Board re Final Ipsos MORI Poll Report* (6 December 2007), Deputy Director of Nursing
266 PCT0010000326 Mid Staffordshire NHS FT, Patient Visitor and Carer Survey (May 2009), Ipsos MORI

significant differences in perception between inpatients and others, male and female respondents, social classes B–D and A, those aged over 75 and those younger. In each case, the first mentioned group were more likely to perceive cleanliness favourably.[267]

6.264 The committee does not appear to have been totally persuaded by the presentation. Councillor Jones, who by this time had not only received Julie Bailey's letter but also had been present at the governor's meeting which had been addressed by CURE members, told the Inquiry:

> *The general feeling was that maybe they weren't telling us the whole story here.*[268]

6.265 Possibly as a result of the scepticism generated by the presentation at its meeting on 4 September, the committee agreed that a letter should be sent to the Trust raising, among other issues:[269]

- Staffing cover and its effect on staff morale;
- Inconsistency of approach in different areas of the hospital;
- Waiting times in A&E.

6.266 It asked for clarification or assurances for its next meeting.

6.267 Councillor Jones explained that the reference to staff morale had been intended to refer to A&E, where committee members had observed problems.[270] He thought the terms of his letter were fairly clear and explained that he was keeping to himself at that stage the true extent of his unfavourable views about the leadership of the Trust, which had been informed through his observation of Trust meetings.[271]

6.268 Responses to the matters raised were given by Mrs Perrin in a report prepared for the meeting of 20 November 2008.[272] With regard to staffing issues, she said that over £1.5 million had been invested in additional nurses and that various other steps had been taken. It was said that sick leave had improved since this additional recruitment. This does not seem to be entirely consistent with information given to the Joint Negotiation and Consultation Committee (JNCC) on 27 November to the effect that there had been an "in-month rise" to a monthly average of 4.67% and a moving annual average of 5.21%.[273] Care pathways were being introduced for specific conditions to reduce inconsistency of approach, and the Trust was

267 PCT0010000320 Mid Staffordshire NHS FT, Patient Visitor and Carer Survey (May 2009), Ipsos MORI
268 Jones T36.76–77
269 Jones WS0000001783 and WS0000001811, Letter dated 8 September 2008
270 Jones T36.91–92
271 Jones T36.87
272 SBC00010000140 *Report to the Health Scrutiny Committee re the Trust's campaign to reduce healthcare associated infection* (20 November 2008), Helen Perrin, Marketing and Business Development
273 TRU00010003344, Minutes of JNCC Meeting (27 November 2008)

working on plans to improve A&E, but had not achieved the target of 98% patients seen, treated and admitted within four hours. Steps were being taken to improve this.

6.269 At the 20 November meeting, the Borough Council OSC received a question from Mr Lownds about North Staffordshire Hospital's proposal to apply for FT status in which he protested about the possible restriction on public access to directors' meetings. The OSC resolved to request that the Trust hold board meetings in public if it became an FT.[274]

6.270 The meeting also received AHC ratings for 2007/08; those for the Trust were said to be "good" for both quality of service and use of resources, and core standards were said to be "almost met". There appears to have been no consideration of the potential inconsistency between such a rating and the ongoing HCC investigation.[275]

6.271 The committee's meeting on 12 March 2009 took place five days before the publication of the HCC report. A progress report was received from Mrs Perrin, focusing on HCAI figures. The meeting was attended by Mr Morton, the new interim Chief Executive of the Trust.

6.272 By the committee's meeting of 30 April, the HCC report had been published, and this was addressed in the Trust's regular report. The meeting was attended by Mr Stone, Interim Chair of the Trust, and Mr Court, Director of Strategy, Planning and Performance. The minutes record that there was a "detailed and frank" discussion in which a number of issues were examined, including infection control, mortality, governance, the improvement plan and recruitment.[276]

6.273 On 23 June 2009, the OSC received a report from the Trust on its transformation programme, HCAIs, mortality statistics and the case note reviews.[277]

6.274 On 27 August 2009, the committee discussed the Trust's report with Dr Obhrai, the Trust's Medical Director, who was newly in post. As in the previous report, detailed figures were given for mortality as well as HCAIs.[278]

6.275 Thus, the pattern was established of each meeting being addressed by senior management of the Trust with an update of the Trust's progress. Detailed information was presented.

274 SBC0001000214–215, Minutes of the Health Scrutiny Committee Meeting (20 November 2008)
275 CURE00330012796, Health Scrutiny Committee Agenda and Minutes (20 November 2008)
276 SBC0001000232, Minutes of the Health Scrutiny Committee (30 April 2009)
277 SBC00010000167, code of joint working arrangements; SBC0001000240, Minutes of the Health Scrutiny Committee (23 June 2009)
278 SBC00010000176, Minutes of the Health Scrutiny Committee (24 June 2009); SBC0001000249, Minutes of the Health Scrutiny Committee (27 August 2009)

Conclusions on Stafford Borough Council's Overview and Scrutiny Committee

6.276 The legislation and guidance make it very clear that OSCs have an important role to play in looking at safety and quality issues affecting their community.

6.277 Mr Thompson, Stafford Borough Council's Chief Executive, initially took the position that the committee had undertaken an "effective and robust" scrutiny of the hospital.[279] Any deficiencies which were known about were pursued by questioning of the Trust officers, and any lack of awareness regarding matters of concern was due to the committee not having been informed about them. It was not the role of the committee to performance manage the Trust, and it was not equipped to do so. The committee had many areas of health service activity to scrutinise, and the hospital was not near the top of subjects of interest until Julie Bailey communicated her concerns in late 2007 and the HCC started its investigation.[280] Thereafter, the focus on questioning the Trust was more intense. He accepted that the minutes do not give this impression because they are formalistic and do not give details of the discussion and questioning that took place.[281] Whether that impression of the scrutiny activity of the Borough Council is justified must be considered against the evidence. Mr Thompson's position was that, essentially, the council was given no cause for concern until Julie Bailey's intervention.

6.278 In his oral evidence, he was more circumspect:

> *I think there's going to be very few heroes come out of this Inquiry. We're certainly not going to be acclaimed with that. So ... I think looking back and in hindsight, then clearly, at various times, with the benefit of hindsight we could have done more. And I'm not seeking to argue – argue differently. I think we did in our own way the – you know, what we felt was the most appropriate level of ... scrutiny.*[282]

6.279 He accepted that the committee had a role to play in looking at the quality of the service delivered, as well as more strategic matters, while emphasising that there were limits to what a small committee with limited resources could achieve.[283]

279 Thompson T35.172
280 Thompson T35.37
281 Thompson T35.107
282 Thompson T35.156
283 Thompson T35.156

6.280 Councillor Edgeller accepted that the committee:

> *... did not get underneath what the representatives from the Hospital were telling it ... Chief Executives usually talk up an organisation and put on a positive gloss. If the same happened again, then I would look deeper and ask questions to the people below ... e.g. the nurses, doctors and consultants.*[284]

6.281 Councillor Jones told the Inquiry that the reaction of committee members to the HCC report when it was published was that they "felt vindicated" because they had been asking the right questions.[285]

6.282 Whatever lack of clarity there was in the committee's terms of reference, examination of the activity of the committee confirms that there was some level of scrutiny directed at the Trust. When concerns were raised in 2005, about its cost cutting proposals, the Trust's executive team was requested to attend and explain themselves. However, neither the committee itself nor the Borough Council had the expertise to mount any effective challenge to the proposals. They were bound to accept the assurances of the Trust that services would not be affected in the absence of an informed understanding of the effect of staff reductions. There was no easily accessible guidance or benchmarks to refer to, which might have assisted them in this task.

6.283 Likewise, in relation to the concerns raised about children's services, an attempt was made at scrutiny by asking the Trust for an explanation. The committee was not to know that there were grounds for challenging the explanation and reassurance offered, because it was left unaware of the West Midlands peer review findings which had been made almost simultaneously.

6.284 The scrutiny of the Trust's FT application was similarly unchallenging. The evidence does not show what, if any, questions were asked of the Trust following its presentation, but no steps were taken to seek to confirm what it was being told before resolving to support the application. Once again it had little choice but to accept what it was being told. Councillor Edgeller was therefore right to accept that this process was meaningless.

6.285 It is clear that concerns about cleanliness at the Trust came to the attention of the committee in the course of 2007 if not before. Not only did it receive the PPIF annual report referring to this but also officers would have been aware of the contact between the Stafford County Council HSC Chair, Councillor Muir and the PPIF through the regular officers' meetings. For example, its notes of a meeting on 21 April 2006 refer to a presentation by the PPIF about its work on cleanliness. Scrutiny committees had to rely on the PPIF to inspect, as they had no

284 Edgeller W0000003055, para 50
285 Jones WS0000001789, para 26

power of their own. However, sufficient concern was raised in the mind of Councillor Muir to intervene and trigger further activity by the PPIF. Nonetheless, the Borough Council OSC appears to have remained a mere spectator to these events, receiving reports without comment or suggestions for action.

6.286 The official response of the Borough Council to Julie Bailey's questions and her letter of 20 February 2008 was quite unacceptably dismissive. Mr Thompson told the Inquiry that the OSC had not detected cause for concern about the issues she raised before because it relied on the public and other bodies to raise such matters, and none had.[286] From then on, he claimed:

> *HSC members began to ask further questions relating to basic patient care ... Therefore, the Borough HSC was already aware of, and dealing with the issues at the Hospital by the time the Healthcare Commission ... started its investigation in March 2008.*[287]

6.287 Unfortunately, the letter he wrote at the time suggests that the official position he adopted was that it was not for his committee to take any action but for Julie Bailey to approach others. He appears to have confused the duties of others to process individual complaints with the task of his committee to scrutinise the Trust. It should have been quite clear that Julie Bailey and her group had raised serious cause for concern about the general standard of service and management at the Trust, albeit understandably based on their own experiences. That is surely the most likely way in which such concerns will come to light. If ever there was an issue on which local politicians were entitled to involve themselves and make demands of the authorities for information and action, this was surely it.

6.288 Fortunately for the public interest, Julie Bailey was not lightly deterred from pursuing what she knew was right, but there is a considerable danger that less robust individuals would have been discouraged from taking further action by this formalistic and unhelpful letter.

6.289 In contrast, Councillor Jones' response was sympathetic and encouraging, as one would expect of a conscientious councillor. As it happens, any contribution he and like-minded colleagues might have made was overtaken in the event by the announcement of the HCC investigation.

6.290 Councillor Jones made it clear that once he became aware of serious concerns, he and the committee decided that they could make a contribution to scrutiny by pursuing issues about mortality rates, and HCAIs. However, prior to that date, there is an almost complete absence of evidence of scrutiny, in the sense of any challenge, to what they were being told by the Trust. The absence of clarity in what was delegated and terms of reference to govern the scope of scrutiny might have contributed to this state of affairs, but it is not the whole

286 Thompson WS0000002314, para 30
287 Thompson WS0000002313–314, paras 28–29

explanation. As pointed out by several witnesses, scrutiny committees have many areas for scrutiny and have to prioritise between them. There is certainly evidence that insufficient significance was given to information coming from the public. In any event, there may have been a lack of understanding about what scrutiny of an acute hospital actually entailed.

6.291 There are clearly limits on what a committee of elected councillors can be expected to do in scrutinising a hospital. As Councillor Edgeller put it when pointing out that the committee had no power to enter and inspect premises:

> *... the HSC can only do so much and though it continues to ask questions, it ultimately has to trust that the picture portrayed of the Hospital by its representatives is honest and accurate unless there is evidence to the contrary. It has no mechanism to make sure the representatives do this nor does it have any authority to investigate the situation at the Hospital itself.*[288]

6.292 Mr Thompson made a similar point:

> *... clearly ... we have not got the resources, our members don't have the background and training to do the ... in-depth scrutiny in the same way as, say, the HCC can do.*[289]

6.293 Councillor Shelton-Baron said:

> *... there was nothing that – because we don't have the power as a district council, there was nothing the council did which we couldn't have – that you know, any different that, you know, than we've – than we've done, because we don't have the power to do it.*
>
> *THE CHAIRMAN: So your answer is that faced with the same situation again, the same thing would happen?*
>
> *A. It would if we had the same people there.*[290]

6.294 Nonetheless, there was more that they could have done. The committee had the ability to seek information about the Trust and its activities from PALS, the PCT, the PPIF or constituents, among others. Instead it waited for such bodies and individuals to come forward. It received annual reports from the PPIF but appears to have been unaware of how ineffective it was in general, likewise its successor, LINks. The committee never considered exercising or asking the County Council HSC to exercise the power to submit a report and recommendations to any NHS body, or the Secretary of State.

288 Edgeller WS0000003053, paras 42–43
289 Thompson T35.156
290 Shelton-Baron T37.166–167

6.295 An increase in the amount of consideration given to the Trust is evident from the date of the publication of the HCC report. There were regular reports from the Trust, and these contained more detail and were more wide ranging than those seen before. The minutes continued to be uninformative as to the content of any discussions about issues raised, in contrast to the County Council's HSC minutes which give a fair idea of what points were made by councillors. While the level of questioning after the start of the HCC investigation increased, no attempt was made to contact the HCC or to offer assistance. It relied on the HCC approaching it, which did not happen.

Staffordshire County Council Overview and Scrutiny Committee

Delegation

6.296 Councillor Muir was adamant that it was the Borough Council's committee which carried out all scrutiny of the Trust.[291] While, as already observed, that committee did in practice undertake a degree of scrutiny, it does not necessarily follow that the County Council had divested itself of its responsibility. Until 2010 there was no formal delegation, and as will be seen, on occasion Mr Muir himself intervened in relation to the Trust.

6.297 Councillor Eagland, who succeeded Councillor Muir as Chair of the HSC, accepted that as Borough Council Committee members were uncertain about this, there was at least a failure of communication between the two councils.[292]

Training

6.298 Councillor Muir received one day's training for his role in addition to other opportunities to attend seminars. He felt that he was constantly reading medical material to improve his understanding of issues being discussed, and he brought to bear his previous experience as a board member of a health authority. However, he was of the view that the whole point of a scrutiny committee was that members were elected to represent their communities, and there was no need for them to have expertise or experience in health matters.[293]

Scope of committee's remit

6.299 The County Council HSC had a responsibility to provide an overview of the health service throughout the county, in which there were eight trusts, as well as trusts outside the county which took patients from within it.[294] While the committee would scrutinise matters relating to the Trust, where it had potential to affect the area as a whole, such as the application for FT

291 Muir WS0000034482, para 33
292 Eagland WS0000003548–549, para 31
293 Muir WS0000034476, paras 10–15
294 Muir WS0000034478, para 17

status, it was not its role to "micro-manage the Trust" or any other health service organisation in the county.[295]

6.300 Unusually for a County Council committee, from 2007 the HSC was authorised by the council to issue its own reports and correspond with third parties in its own right and without the authorisation of the Leader or Chief Executive of the Council.

6.301 Councillor Muir also persuaded the Council to pay the Chair and Vice Chair of the HSC at a higher level than the officers of other scrutiny committees to reflect the additional work and responsibility involved.[296]

The committee's approach

6.302 Councillor Muir supported the approach to the role of a scrutiny committee as indicated in the DH guidance of being a "critical friend". He felt that attempts at scrutiny would be ineffective unless there was a relationship of trust between the committee and providers as opposed to antagonism. It was more likely that providers would be open and honest in providing information:

> *I felt that if I couldn't go into a hospital and speak to the senior management in a friendly way, in order to draw out problems I would not be doing my job properly.*[297]

6.303 Councillor Ellis, who became Cabinet Member for Health after the publication of the HCC report, took a different view of how such a committee should operate:

> *... I believe that the HSC thought its role was to show an interest in the Hospital and encourage it, rather than to challenge. I fundamentally disagree with this approach ... known as "scrutiny as the critical friend" ... which ... sends out the wrong message.*[298]

6.304 Councillor Jones, who became Vice Chair of the County Council's HSC in 2009 after a period as a member, also disagreed with Councillor Muir and refused to participate in relationship management meetings with the Trust, which he characterised as having:

> *... a cup of tea and a chat.*[299]

295 Muir WS0000034481, para 28
296 Muir WS0000034477, para 15
297 Muir WS000003479-480, paras 22-23
298 Matthew Ellis WS0000002763-764, paras 5-6
299 Jones WS16; WS0000001787

6.305 He thought such meetings gave the impression that there had been scrutiny when in fact none had taken place. Councillor Muir disputed this characterisation and insisted that while meetings might have been informal, they were effective.[300]

6.306 It appears to have been a deliberate policy of the committee under the leadership of Councillor Muir not to proactively seek the views of the public. He thought this would not be a worthwhile exercise:

> *I do not think it was the County Committee's responsibility to go and find out what the views of people were. In a sense it would have been pointless to do this given the vast and frequently diametrically opposed range of views amongst different members of the public.*[301]

6.307 If a member of the public had come to him with concerns, he would have looked into them, but if he had been told to canvass views:

> *I would have gone home.*[302]

6.308 He considered it was not the role of the County Council's committee to voice the views of others as opposed to "respond to the interests of the community" in an objective manner. He felt the DH guidance was incorrect in this regard.

6.309 There was no provision in the committee's procedure for members of the public to ask questions, and therefore it was not surprising to hear from Councillor Eagland that she could not recall a member of the public attempting to ask a question at a meeting.[303]

6.310 The principal source of information for the committee was trusts' management teams. On occasions, expert assistance was sought.[304]

6.311 The HSC worked to a programme set annually and focused on regional matters, such as the merger of the local ambulance trusts. If it looked at the affairs of a particular trust, it was because of the relevance to the region as a whole.

300 Muir WS0000034495, para 84
301 Muir WS0000034480, paras 25–26
302 Muir WS0000034480, para 26
303 Eagland WS0000003544, para 14
304 Muir WS0000034487, para 53

Staffordshire County Council Health Scrutiny Committee's scrutiny of the Trust

Proposed service changes at Cannock Hospital

6.312 In September 2005, a special meeting was held to consider the Trust's proposals for service changes at Cannock. The HSC was concerned that the Trust had not complied with its obligation to consult the committee about significant changes as required by statute. Consideration was given to reporting the concerns to the Secretary of State, but it was decided that formal questioning of the Trust leadership would be a preferable course to take. At this meeting, Mr Yeates was allowed to give a presentation, during which he apologised for not having contacted the committee earlier about developments and promised to do so in the future. Members made numerous criticisms of the Trust's approach and asked challenging questions. For example, the view was expressed that the Trust would have to communicate a great deal better if it was to obtain the committee's support for a renewed application for FT status, and Mr Yeates was questioned about concerns over the Trust's ability to deal with an increase in emergency admissions.

6.313 After the Trust representatives withdrew, following deliberation between members, the committee resolved to require the Trust to provide a number of specific items, including: an undertaking that clear lines of communication be maintained with the committee; reassurance that robust systems for patient, carer and public involvement were being developed; and details of the services being currently provided.[305]

Clinical floors project

6.314 The clinical floors project was mentioned in the presentation given in September 2005. At the HSC's meeting on 16 November 2005, Councillor Wilkinson expressed his concerns about the service reconfiguration and the consequent part closure of the gynaecological ward. He was concerned at the effect on patients' recovery. It was resolved to write to the Trust to seek clarification.[306] At the next meeting, it was reported that Mr Yeates had accepted all points raised in a response described in the minutes as "very positive".[307]

6.315 In passing, there was reference in the minutes to issues of a personal nature raised by a member of the public, presumably not in connection with the Trust, but another one. It was reported that the Health Scrutiny Manager had taken up the matter with the Chief Executive concerned.

6.316 The floors project was referred to again during a further presentation by the Trust on its strategic direction to the committee at a meeting on 16 January 2006.[308] Councillor Wilkinson,

305 SCC00060000032, Staffordshire HSC minutes and presentation
306 SC00060000096, SCC HSC minutes (September 2005)
307 SCC00060000112, SCC HSC minutes (16 November 2005)
308 SCC00070000003, SCC HSC Minutes (16 January 2006)

the Borough Council representative on the committee, expressed concern at the effect on services of the closure of certain wards involved in the project and on training capacity.

6.317 The Trust was also challenged on whether it had contingency plans for the possibility of a failure of its financial strategy. The Trust representative assured the committee that there were such plans.

6.318 Another councillor expressed concern that the strategy was cost not patient led. He was assured that the plan was clinically led, although due regard had to be paid to financial considerations.

6.319 Councillor Eagland asked about the process of quality of service benchmarking and was assured that the Trust had employed specialist assistance to provide information on a "patient basis" and that an improvement team was "to take the findings forward".

6.320 The committee resolved to note the presentation.

6.321 Councillor Muir did not consider it his committee's role to confirm whether a project such as this was supported by the clinical staff or whether an appropriate risk assessment had been carried out.[309]

Concern about cleanliness and infections

6.322 The liaison between the County Council HSC, Messrs Deighton and Bastin and the Borough Council OSC has been noted above. Additionally, at the County HSC's meeting on 15 November 2006,[310] concerns were raised about the increased rate of *Clostridium difficile* at the Trust. Councillor Muir was aware this was an issue at other trusts as well, and he felt a comparison exercise was necessary. He sought information and received the letter from the Trust referred to above. He felt its figures were not notably different from the other trusts, and as a result he felt no need to delve deeper.

Contribution to Annual Health Check declarations

6.323 The committee considered what comment it should make for the HCC's AHC for 2005/06 at a meeting on 24 April 2006. It was aware that the Trust's score had slipped but understood that this was due to a failure to submit information. Councillor Muir regarded this as a matter for disciplinary action not scrutiny.[311]

309 Muir WS0000034494, paras 78–80
310 ESI00015194, Minutes of the Stafford Health Scrutiny Committee (15 November 2006)
311 Muir WS0000034496, para 87; JM/19 SCC0007000077

6.324 The committee commented as follows:

> *The Staffordshire Health Scrutiny Committee welcomes the opportunity to discuss with the trust the areas where they are non-compliant with the final declaration and proposes that a meeting be set up with the Trust to discuss how to take these matters forward.*[312]

6.325 The committee's comments for the 2006/07 declaration was a positively expressed description of the process of consultation in connection with the Trust's application for FT status, its work in relation to cleanliness and infection (see above) and general liaison.[313]

6.326 In retrospect, Councillor Muir did not believe that the AHC had "any real purpose", nor did he believe that it had addressed the issues brought to light by the HCC investigation.[314]

Observation on the Trust's Foundation Trust application

6.327 In connection with the Trust's application for FT status, Martin Yeates gave a presentation to the County Council HSC on 14 February 2007, at one point in the meeting reading out the email from Helen Jenkinson of the HCC making approving comments about cleanliness at the Trust. Members asked questions and made observations about the constitutional structure of the FT, its name, the future of PALS and financial freedom. The committee agreed to set up a sub-group to prepare its observations.[315]

6.328 The formal response, submitted to the Chair of the Trust on 4 April 2007, expressed the HSC's support for the application and congratulated the Trust on the presentation of its application.[316]

6.329 Councillor Muir explained that the committee did not see this consultation process as an occasion for asking fundamental questions:

> *... members were primarily concerned about how the Trust Board would be structured if the application was successful and whether or not there would be representatives from both South Staffordshire and Cannock on the board. Those were the sort of issues ... rather than any more fundamental questions as to whether or not the Trust was sufficiently equipped to be a Foundation Trust.*[317]

312 JM/19 WS0000034781
313 CURE0023000149–150, Trust core and developmental standards declaration 2006/2007
314 Muir WS0000034497, para 89
315 SCC00080000063–066, Committee minutes, 14 February 2007
316 TRU0005000276, Letter from Councillor Muir to Toni Brisby on the FT application, 4 April 2007
317 Muir WS0000034504, para 114

I don't think you could say that it was the role of the County Committee to specifically test whether the Trust was performing to the highest standards in order to achieve Foundation Trust status. They had to provide us (and others) with the presentation as part of the consultation.[318]

6.330 He believed that by this stage the previous concerns at the Trust's reluctance to engage with the community had been resolved, and he had been impressed at the care with which it engaged local organisations in the consultation process.[319] He could not recall the issue of the mortality statistics having any impact at the time on the issue of the application.

6.331 Councillor Eagland gave evidence to like effect: she believed the committee had relied on Monitor's assessment process. In hindsight, she accepted that the committee should have sought the views of others. She also told the Inquiry that the Trust's success in gaining FT status led it to believe it was justified in accepting the Trust's responses to its questions.[320]

Reaction to mortality statistics, the Healthcare Commission investigation and public concerns

6.332 Councillor Muir said he had asked Martin Yeates about the HSMR ratings at one of their meetings, and had been advised that it was a coding issue. He understood that the Trust was looking into the issue, and therefore he waited for the outcome of that process.[321]

6.333 During the course of 2008, Councillor Muir had relationship meetings with Martin Yeates, but the subject of the HCC investigation was not raised at any of them.[322] He told the Inquiry he would have been loath to take action during the investigation as the HCC had much more information than the committee and greater powers and resources.[323]

6.334 There was also little reaction to the approach that had been made by Julie Bailey and her colleagues to the Borough Council OSC in February 2008. At the County Committee's next meeting, on 31 March, there is a record of the county councillor who sat on the Borough Council OSC having earlier raised a question to the Council's cabinet/health trusts regarding mortality rates:

In view of the concerns raised by residents of the Borough, I would like clarification from the relevant authorities over the apparent confusion vis a vis mortality rates at the Staffordshire General Hospitals in Stafford.[324]

318 Muir WS0000034504, para 118
319 Muir WS0000034504, para 115
320 Eagland WS0000003545-546, paras 19-22
321 Muir WS0000034505, paras 121-122
322 Muir WS0000054508, para 135
323 Muir WS0000034508, para 134
324 SHA0003000236, Minutes of the Staffordshire Health Scrutiny Committee, 31 March 2008

6.335 A response from Martin Yeates was circulated at a meeting on 28 April 2008.[325] The reply stated that it was aware that Dr Foster's report had given the Trust a Standardised Mortality Rate (SMR) for 2005–2006 of 127, higher than the national standard of 100.[326] It explained that this had been investigated, and the Trust had concluded that the high rate was due to:

> *... problems in the way we were recording and coding information about patients.*

6.336 It asserted that this view was supported by independent analysis and a detailed review of individual patient case notes, and that further the Trust had worked closely with the SHA which had also researched SMR statistics for four trusts in the West Midlands. The reply stated that Dr Foster had confirmed the Trust's overall mortality was within national norms. The reply went on to say that more clinical coding experts had been employed and, as a result, the SMR had dropped to 100.4 between May and October 2007 for emergency admissions and 101 for all admissions. It concluded with the assertion that the Trust believed its mortality rates to be normal in light of the Trust's size, type and locality and that it would "continue the drive to improve the range and quality of their services".

6.337 Councillor Muir did not consider this was a matter requiring scrutiny by the committee during the HCC investigation as he relied on the assurance he had been given by Mr Yeates, and felt that the HCC had access to information and powers beyond its remit.[327]

6.338 Members were informed of the announcement of the HCC investigation, but the report from the committee is not recorded as containing any mention of this. No discussion of the issue seems to have occurred.

Reaction to the Healthcare Commission report

6.339 The report "horrified" Councillor Muir:

> *The things that were reported in relation to poor clinical care I would never have expected to have happened.*[328]

6.340 On 9 April 2009, a short time after publication of the report, the HSC held a meeting at which it received a presentation from the Interim Chief Executive of the Trust, Eric Morton. Members were recorded as asking questions about many aspects of the care and service at the Trust and the future role of the committee. Some members expressed concern at the ability of lay people to interpret information without expert assistance. A series of joint meetings with other scrutiny committees was agreed to.[329]

325 ESI00016197 Minutes of the Staffordshire Health Scrutiny Committee, 28 April 2008
326 ESI00016119–120, Question and answer from Councillor Amyas, 23 March 2008
327 Muir WS0000034508, para 134; JM/41 WS0000035001
328 Muir WS0000034511, para 145
329 JM/45 WS0000035035

6.341 Members of CURE attended this meeting and were approached by Councillors Muir and Eagland but did not want to engage. Councillor Eagland understood this reaction:

> *... more could have been done to get them to engage* [in the past].[330]

6.342 At its meeting on 9 July 2009, the first chaired by Councillor Eagland, a presentation was given by the Interim Chair of the Trust, David Stone. Members raised issues about the number of complaints received, the impact of the serious nature of some complaints, staff morale, the quality of information provided by the Trust in the past, the need to restore public confidence and calls for a public inquiry.[331]

6.343 Thereafter, joint accountability sessions were arranged with the Borough Council's OSC. A draft joint code of working explicitly made the scrutiny of the Trust the responsibility of the County Committee.[332] The code had just been agreed at the time relevant witnesses gave evidence, though the first meeting had not yet taken place.[333]

Conclusions on the Staffordshire County Council Scrutiny Committee

6.344 Councillor Ellis accepted that the overview and scrutiny committees had failed to uncover the deficiencies at the Trust. He attributed this principally to three factors:

- An adoption of the role of "critical friend" rather than a more robustly challenging attitude of the type he was used to in the scrutiny of his own work as health and social care lead within the council. He felt, looking back at the minutes, that while the right questions may have been asked, the reassuring answers given were accepted too readily. His sense was that committee members showed:

  > *... overt and uber respect ... to individuals and an assumption was made that they were being entirely accurate, but I don't think* [they were] *tested.*[334]

  > *... I believe that the HSC thought its role was to show an interest in the Hospital and encourage it, rather than to challenge. I fundamentally disagree with this approach ... known as "scrutiny as the critical friend" ... which ... sends out the wrong message.*[335]

- A lack of clarity of the role of scrutiny: he was critical of the guidance referred to above. He interpreted it as steering committees away from safety and quality issues and towards more strategic issues;

330 Eagland WS0000003544, para 15
331 ESI00016921, Minutes, 9 July 2009
332 WS0000002325 IT/2, para 2.3
333 Edgeller WS0000003054, para 45; Eagland T41.21
334 Matthew Ellis T34.19; WS0000002763, para 4
335 Matthew Ellis WS0000002763-766

- The committee received no information which would have led it to suspect the depth of problems at the Trust.

6.345 His view was necessarily a remote one: he had not been personally involved in health oversight and scrutiny, and the events now under review occurred under a previous administration run by a different party.

6.346 His criticism of the guidance was not well grounded on a close reading of it. Indeed, it was apparent in the course of his evidence that he had not read it. However, it would be fair to comment that the guidance tends to emphasise the need for constructive dialogue and does not make it entirely clear that the committee can examine a specific issue of safety and quality at one provider, although there is nothing to suggest this cannot be done either. The guidance does not offer a committee any excuse not to launch a scrutiny of a serious concern of which it becomes aware concerning the safety and quality of a service being provided in its community. Indeed, it will have been failing in its duty if it did not do so.

6.347 Councillor Muir rejected the suggestion that his committee could have found out what was happening at the Trust:

> *I think that this would have been impossible. You would have needed to be a god to be able to monitor in such detail across the breadth of service providers which fell within our remit.*[336]

6.348 He pointed out that it had no power to undertake unannounced visits, and the issues raised in the HCC report were never raised by members. They could not see what nurses saw on wards. He felt that it would not be appropriate to give scrutiny committees more powers as he saw their role as being to deliver a "slap" or a "punch", by which he presumably meant a public rebuke.[337]

6.349 Councillor Eagland thought that more could have been done:

> *In relation to the criticism that the Committee failed to respond to patient concerns in relation to the Trust, I would have to agree. What became extremely apparent after reading the HCC report is that we, along with other agencies, could have been more involved with what was going on at the Trust at the time ... I wish that we had dug deeper ... there should have been more scepticism of what we were told by the Trust.*[338]

336 Muir WS0000034511–512, para 150
337 Muir WS0000034512, paras 151–153
338 Eagland WS0000003551, para 35

6.350 Although some attempts were made to downplay the responsibility of scrutiny, as well as taking an overview a health overview and scrutiny committee has clear statutory responsibility to scrutinise the provider trusts in its area. Scrutiny ought to involve more than the passive and unchallenging receipt of reports from the organisations scrutinised. That this is possible is demonstrated to some extent by the approach taken by the County Council HSC since the publication of the HCC report. It has required regular meetings and reports, as before, but the members clearly ask more challenging questions, often based on concerns that they perceive are shared by the public. Previously, the scrutiny performed by this committee was deficient in a number of respects:

- It failed to make clear where the responsibility lay for scrutinising the Trust, a major provider of healthcare in the county. In spite of claims to the contrary, it did not divest itself of its responsibility to involve itself in the scrutiny, either in theory or practice.
- Having maintained such a role, it confined itself to the passive receipt of reports.
- It made no attempt to solicit the views of the public. It had no procedure which would have encouraged members of the public to come forward with their concerns.
- It made little use of other sources of information to which it could have gained access, such as complaints data or even press reports.
- It showed a remarkable lack of concern or even interest in the HSMR data. Difficult though statistics can be to understand, it should have been possible to grasp that they could have meant there was an excess mortality that required at least monitoring by the committee, with challenge being offered to the coding explanation.
- It showed little reaction to the concerns expressed by CURE to the Borough Council OSC, even though they were at least in general terms brought to its attention.
- It took no steps to consider the implications of the announcement of an investigation by the HCC or to follow its progress.

6.351 In short, this committee appears to have been wholly ineffective as a scrutineer of the Trust. Councillors are not and cannot be expected to be experts in healthcare. They can, however, be expected to make themselves aware of, and pursue, the concerns of the public who have elected them. That is surely the intended purpose of giving a local scrutiny role to councillors.

6.352 It has been suggested that they could not have done more because they lacked the power of entry and inspection. This did not prevent Councillor Muir, very properly, coordinating inspections by the PPIF in response to concerns communicated to him by Messrs Deighton and Bastin. In any event, the power of summoning the leaders of provider trusts to give an account of their actions in public is a powerful tool, which, if used properly, proportionately and after preparation, could act as an incentive towards improvement and as a challenge to the public being offered inaccurate or superficial information.

6.353 These criticisms must be levelled collectively at a committee membership with a changing membership rather than at individuals.

Local Members of Parliament

6.354 The Inquiry heard from four former or current local MPs:

- David Kidney, MP for Stafford (Labour) May 1997 to May 2010;[339]
- Dr Tony Wright, MP for Cannock (Labour) 1992 to 2010;[340] Dr Wright had also been Chair of the House of Commons Public Administration Select Committee and a prominent campaigner for the protection of whistleblowers;
- William Cash, MP for Stafford 1984 to 1997 and for Stone (Conservative) since 1997;[341]
- Jeremy Lefroy, MP for Stafford (Conservative) since 2010.[342]

6.355 It is right to place on record that all gave evidence willingly and were conspicuous in being obviously keen to assist the Inquiry with their experience and not to make party political points. All three who were sitting MPs at the time of the first inquiry had provided considerable assistance in disclosing to it the complaints they had received from constituents and in obtaining permission for this step from the complainants.

The role of Members of Parliament

6.356 It is necessary to make clear at the outset that MPs are not regulators or healthcare experts, but represent their constituencies and constituents in Parliament. Therefore, while they necessarily have to develop an understanding of local affairs and will represent the expression of concern or requests for assistance when asked to do so by a constituent, they have no direct responsibility for the performance of healthcare organisations in their constituency. However, because of their position, they might be expected to become aware of concerns about a hospital from their constituents. Further, as more than usually well informed local figures, they can offer a helpful perspective on the significance that was attached at the time to various developments of which they were aware.

6.357 A code of conduct for members, approved by the House in 2012, provides that:

> *Members have a general duty to act in the interests of the nation as a whole, and a special duty to their constituents.*[343]

339 Kidney WS0000002771, para 1
340 Wright WS0000003640, para 1
341 Cash WS0000003385, paras 1-2
342 Lefroy WS0000002600, para 1
343 *The Code of Conduct* and *The Guide to the Rules relating to the Conduct of Members 2012*, www.publications.parliament.uk./pa/cm201012/cmcode/1885/1885.pdf

committees. However, differing perceptions of what was observed and a diffidence toward the Trust muffled any real consideration being given to what its findings signified about the general running of the hospital. As indicated above, this is not the fault of any of the conscientious volunteers who gave up their time to help others, or the host staff who were expected to create a working organisation with little background structure or guidance from which to work.

Local Involvement Networks

6.458 If anything, LINks were an even greater failure. The, albeit unrealised, potential for consistency represented by the CPPIH was removed, leaving each local authority to devise its own working arrangements. Not surprisingly in Stafford, the squabbling that had been such a feature of the previous system continued, and no constructive work was achieved at all. Thus the public of Stafford were left with no effective voice – other than CURE – throughout the worst crisis any district hospital in the NHS can ever have known.

Local authority scrutiny committees

6.459 The local authority scrutiny committees did not detect or appreciate the significance of any signs suggesting serious deficiencies at the Trust. The evidence before the Inquiry exposed a number of weaknesses in the concept of scrutiny which may mean that it will be an unreliable detector of concerns, however capable and conscientious committee members may be:

- The combination of responsibility for scrutiny of performance and for representation of the public view on strategic health issues is a demanding one for lay councillors with limited or no expert support;
- Councillors are by the nature of their position more likely to respond to concerns raised with them by constituents than to feel able to make proactive inquiries;
- As politicians dependent on local votes, councillors will be subject to a conflict between the duty to offer criticism and challenge and the need to be seen to support important local institutions. It is a conflict which will reinforce the tendency to receive and accept assurances from organisations such committees are meant to scrutinise;
- The distribution of powers necessary for scrutiny is at best confusing and at worst an inhibition on effective performance of these duties.

Local Healthwatch

6.460 The DH provided the Inquiry with a briefing paper on Healthwatch in October 2011.[433] It has not been informed of any developments since. Under the new reforms, Local Healthwatch is intended to be the "local consumer voice" with a "key role" in influencing local commissioning

433 DH00000004590

- Such a body needs to have authority and a means of exerting it. This requires independence and a clear right to have its findings taken into account by the healthcare system. This can best be achieved by:
  - Accountability to a national independent body or the healthcare regulator;
  - A separate constitutional structure ensuring its independence of judgement and action;
  - Ring-fenced financial resources to ensure parity of the patient and public involvement throughout the country, the stewardship of which is accountable to the local authority (if that is the route through which the funding is channelled);
  - Powers to require information from all parts of the system, including access to complaints information;
  - Powers enabling it to verify what it is told by patients and the public which may include questioning of relevant officials, and inspections of premises;
  - An entitlement to report to the regulator and have its findings and recommendations examined by the regulator, in particular where direct communication with providers or commissioners has failed to have that effect.
- Being a body for involving the public, its business must be conducted with transparency; its meetings should be open to the public, who should be entitled to contribute and also have access to the organisation's working documents.

Summary of recommendations

Recommendation 43

Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they have responsibility.

Recommendation 145

There should be a consistent basic structure for Local Healthwatch throughout the country, in accordance with the principles set out in *Chapter 6: Patient and public local involvement and scrutiny*.

Recommendation 146

Local authorities should be required to pass over the centrally provided funds allocated to its Local Healthwatch, while requiring the latter to account to it for its stewardship of the money. Transparent respect for the independence of Local Healthwatch should not be allowed to inhibit a responsible local authority – or Healthwatch England as appropriate – intervening.

Recommendation 147

Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.

Recommendation 148

The complexities of the health service are such that proper training must be available to the leadership of Local Healthwatch as well as, when the occasion arises, expert advice.

Recommendation 149

Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks.

Recommendation 150

Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate, rather than receiving reports without comment or suggestions for action.

Recommendation 151

MPs are advised to consider adopting some simple system for identifying trends in the complaints and information they received from constituents. They should also consider whether individual complaints imply concerns of wider significance than the impact on one individual patient.

North and East London Commissioning Support Unit on behalf of Barnet, Camden, Enfield, Haringey and Islington CCGs	**BOROUGHS**: BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL
REPORT TITLE: Update on NHS 111	
REPORT OF: Neil Kennett-Brown Programme Director, Change Programmes North and East London Commissioning Support Unit	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**MEETING DATE:** 6 June 2013

SUMMARY OF REPORT:

About NHS 111

NHS 111 is a new non-emergency telephone service designed to help people access local health services. Local residents are able to call 111 when they need medical help or advice, but it isn't a 999 emergency, or they do not know who to call. For less urgent health needs, residents should still contact their GP, dentist or local pharmacist. NHS 111 replaces NHS Direct as the single number to call for urgent care advice. Most existing out-of-hours services have been diverted to the new 111 number and information about the number is now being promoted to the wider public.

NHS 111 is staffed by a team of fully trained advisers, supported by experienced clinicians, who ask callers questions to assess symptoms, give healthcare advice and direct to the right local service as quickly as possible. This can include a local GP, GP out of hours service, urgent care centre, community nurses, emergency dentist or late-opening pharmacy.

Call handers undergo an extensive training and induction programme. This includes six weeks' training to use NHS pathways, plus additional training and coaching as part of their induction. On average, there is one clinician to every 3.5 call handlers in north central London.

When someone calls 111, they are assessed straight away. If it is an emergency, an ambulance is despatched immediately without the need for any further assessment. For any other health problems, the NHS 111 call advisers are able to direct callers to the service that is best able to meet their needs.

NHS 111 is staffed around the clock, 365 days a year. Calls from landlines and mobile phones are free.

We welcome feedback from patients on their 111 experience: patients can give their views via email: LCW111@nhs.net or telephone 020 8962 7766.

Commissioning responsibility

The NCL NHS 111 service has been jointly commissioned by the five North Central London (NCL) CCGs (Enfield, Barnet, Haringey, Camden and Islington), with Islington CCG as 'host commissioner'. London Central & West Unscheduled Care Collaborative (LCW) is the provider.

The North and East London Commissioning Support Unit supports CCGs in the commissioning and performance management of NHS 111 services locally.

LCW is an established provider of unscheduled care in the inner North West London area with a 16 year history of delivery against contracts. Inner North West London (three boroughs) went live with a 111 service in May 2012 with consistently good service against KPIs, where LCW is both the 111 provider and the OOH provider.

Performance

NHS 111 launched to the public in NCL on 12 March 2013 following a 'soft launch' period which allowed call volumes to build up gradually.

The services was launched in line with the national and London NHS 111 service specification and initially showed good performance. Following the switch over of the NHS Direct 0845 line in London 21 March, all NHS 111 providers across the country experienced a significant increase in demand. This presented a number of capacity and operational challenges with meeting the KPIs around access, service level and clinical call back times for the NHS 111 service in NCL. While challenges were more pronounced outside of London, it was clear that call answering performance was below expectations.

LCW, commissioners and out of hours providers have worked in partnership to improve performance across all KPIs and patient satisfaction. This has involved better matching staff capacity with incoming demand, productivity improvements and improvements to call backs by out-of-hours providers (Harmoni and Barndoc). A contingency arrangement has been established, whereby clinical call backs can be diverted directly to an alternative provider at peak times. However, this contingency has not been required.

As a result of measures taken, LCW is delivering a clinically safe service and meeting the majority of their KPIs on a regular basis. We are continuing work to improve resilience, particularly at times of peak call volumes.

Providers and commissioners maintain regular reviews of performance measures. Sitrep reports are reviewed internally by LCW senior management on a daily basis and reviewed twice weekly with commissioners. On behalf of commissioners, the CSU undertakes weekly reviews of projected and actual calls, rostering patterns and individual performance metrics.

National context

NHS England is to conduct an urgent review of the sustainability of NHS 111 and the market of providers delivering the service. This review will include assessing the 'ability of some providers to maintain delivery of these services and 'an appraisal of the likely market of providers'. Given the interdependencies of a number of sites and providers this programme will be coordinated nationally.

CONTACT OFFICER:
Neil Kennett-Brown
Programme Director, Change Programmes
North and East London Commissioning Support Unit

RECOMMENDATIONS: The Committee is asked to note the update on the NHS 111 service in north central London.

Attachments include: NHS 111 performance report

Neil Kennett-Brown
Programme Director, Change Programmes

DATE: 22 May 2013

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Barnet Clinical Commissioning Group
Camden Clinical Commissioning Group
Enfield Clinical Commissioning Group
Haringey Clinical Commissioning Group
Islington Clinical Commissioning Group

Briefing – NHS 111 in north central London

Date: 22 May 2013

Overview
The NHS 111 service in north central London was 'soft launched' on 19 February 2013 and went live to the public on 12 March 2013.

This briefing note provides an update on performance between 19 February and 16 May 2013.

With the planned switch over of the NHS Direct 0845 line in London on 21 March, all 111 providers saw an increase in the volume of calls coming in to the service. While challenges were more pronounced outside of London, the increase in demand presented a number of capacity and operational challenges with meeting the KPIs around access, service level and clinical call back times in north central London. Commissioners and providers have jointly worked to improve performance of NHS 111 services locally.

As a result of measures taken, the local 111 provider, London Central & West Unscheduled Care Collaborative (LCW), is meeting the majority of their KPIs on a regular basis. We are continuing work to improve resilience, particularly at times of peak call volumes. Commissioners are assured that LCW is providing clinically safe services for local patients.

We expect to report on a regular basis to support the Joint Health Overview and Scrutiny Committee to monitor performance of the service to the public.

Key performance indicators
Following the launch of the service, LCW showed good performance. Following the switch over of NHS Direct 0845 line in London, the service did meet challenges and performance was below expectations. The NHS 111 service has since shown marked improvement. Performance against KPIs during the period 19 February and 16 May 2013 is provided below:

Performance indicator	Total	Target
Total number of calls received	33,795	
Percentage of calls answered in 60 seconds	79.8%	>95%
Percentage of calls requiring a call back from a clinician completed within 10 minutes	60%	
Ambulance dispatch as a percentage of all triaged calls	12%	<12%
Percentage of calls referred to 'speak to a GP' or 'see a GP'	33%	
Percentage of calls referred to 'speak to a GP' or 'see a GP' out of hours	55%	

Complaints/incidents and professional feedback

We encourage healthcare professionals and patients to provide feedback on their experience of the NHS 111 service so that we can improve the service. All healthcare professional feedback is reviewed and approved by one of NCL's clinical leads.

The number of complaints, incidents and healthcare professional feedback is summarised below.

Complaints	27	Most complaints related to the Directory of Services referring patients to inappropriate services. A number of amendments have been made to the Directory of Services to rectify these issues. The specific complaints have been responded to accordingly by LCW.
Incidents	12	Incidents related to either technical issues around 111 call routing, directory of services referrals, or acceptance of 'handovers' by out of hours services. There has been one serious incident reported; while the incident did not result in harm to a patient, it has been externally reported and is currently subject to an end to end multi agency review of the case to identify any learning The technical issues have now been resolved. Information and mapping in the Directory of Services has been corrected. We have clarified the process for NHS 111 referrals with out of hours services.
Healthcare professional feedback	62	Health care professional feedback has related to directory of services information, appropriateness of referral by call handler's use of pathways and operational handover of services between the 111 provider and the two GP OOHs.

Communications update

NHS 111 patient information leaflets, wallet cards and posters have been widely distributed across NHS and community venues in north central London. Information about the new NHS 111 service has been distributed to all local stakeholder groups, together with information for websites, newsletters, intranet and social media channels. We are also promoting the service at public engagement events across the local area.

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North and East London
Commissioning Support Unit

NHS 111 update

June 2013

About the service

- NHS 111 is a new non-emergency telephone service when people need medical help or advice, but it isn't a 999 emergency
- Replaces NHS Direct as the single number to call for urgent care advice
- Staffed by a team of fully trained advisers, supported by experienced clinicians
- NHS 111 gives healthcare advice and directs patients to the right local service e.g. a local GP, another doctor, urgent care centre, community nurses, emergency dentist or late-opening pharmacy
- If it is an emergency, an ambulance is despatched immediately without the need for any further assessment
- NHS 111 is staffed around the clock, 365 days a year. Calls from landlines and mobile phones are free

Launch of NHS 111

- Service went live to the public on 12 March 2013 following a ‘soft launch’. Soft launch allowed call volumes to build gradually
- Service is provided by London Central & West Unscheduled Care Collaborative (LCW) which is an established provider of unscheduled care in the inner North West London area
- Local service developed jointly with CCGs and GPs. Extensive engagement with stakeholders in the 18 months prior to launch
- Call operators undergo extensive training – 6 weeks’ pathway training plus additional training as part of an induction
- Service is now being promoted to the wider public – public information distributed to all GP practices, pharmacies, dentists, hospitals, health centres, town halls, libraries and community venues

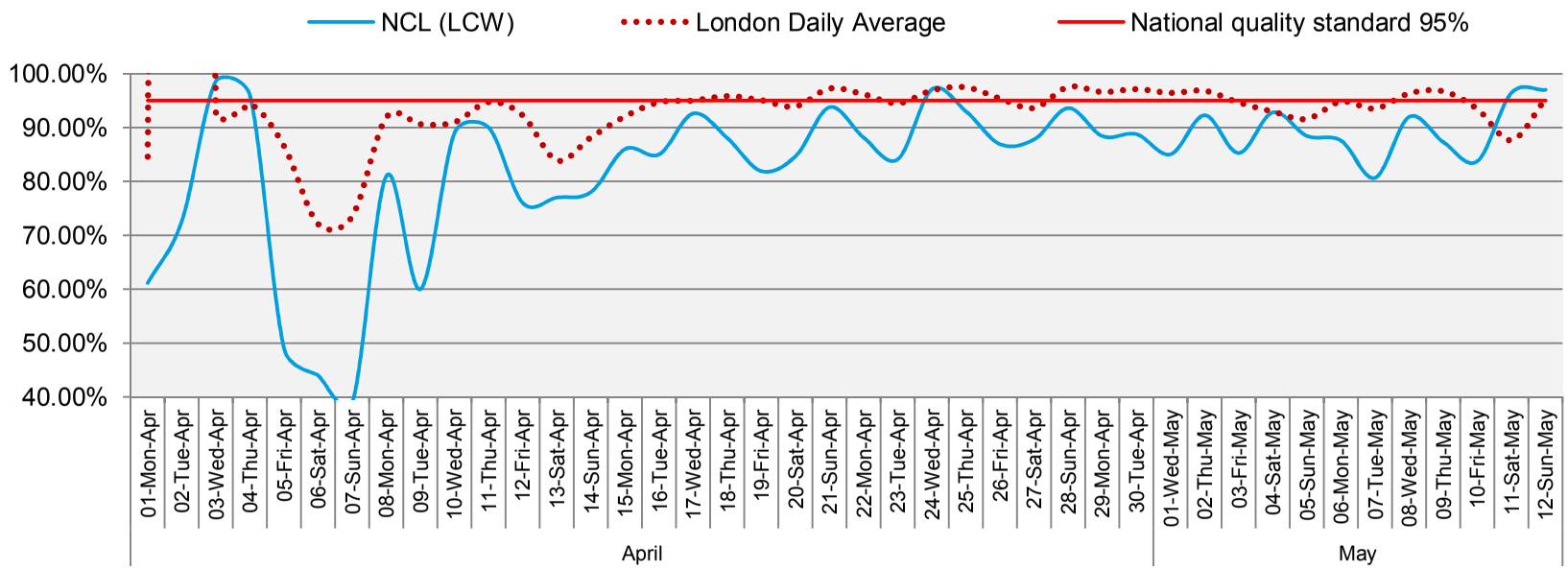
Monitoring performance

- There are regular reviews of performance measures – LCW reviews sitrep reports daily and twice weekly with commissioners. The CSU reviews projected and actual calls, rostering patterns and individual performance metrics weekly.

- LCW's performance is measured against national KPIs including:
  - The number of calls answered in 60 seconds: national standard is more than 95%
  - The number of calls abandoned
  - The number of calls where clinician callback was achieved within 10 minutes
  - The number of triaged calls which result in an ambulance dispatch: national standard is fewer than 12% of triaged calls

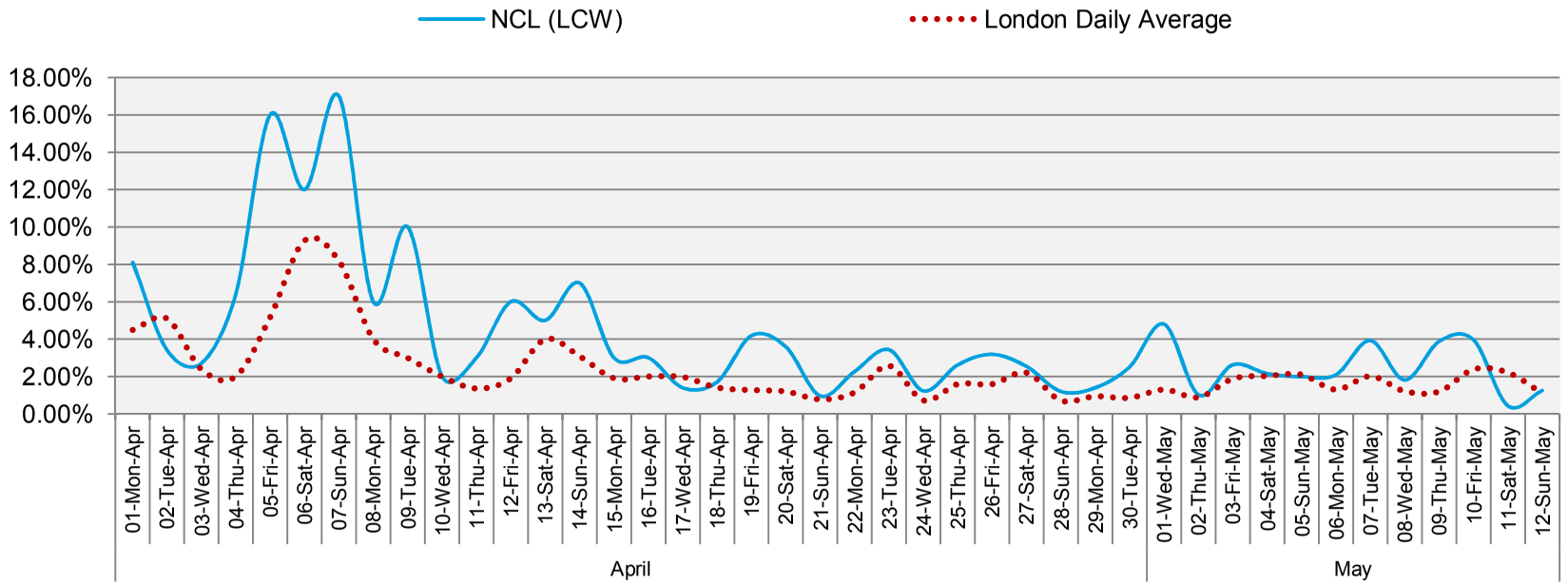
- Performance is continuing to improve against the key indicators since go live (see next slides)

Calls answered within 60 seconds



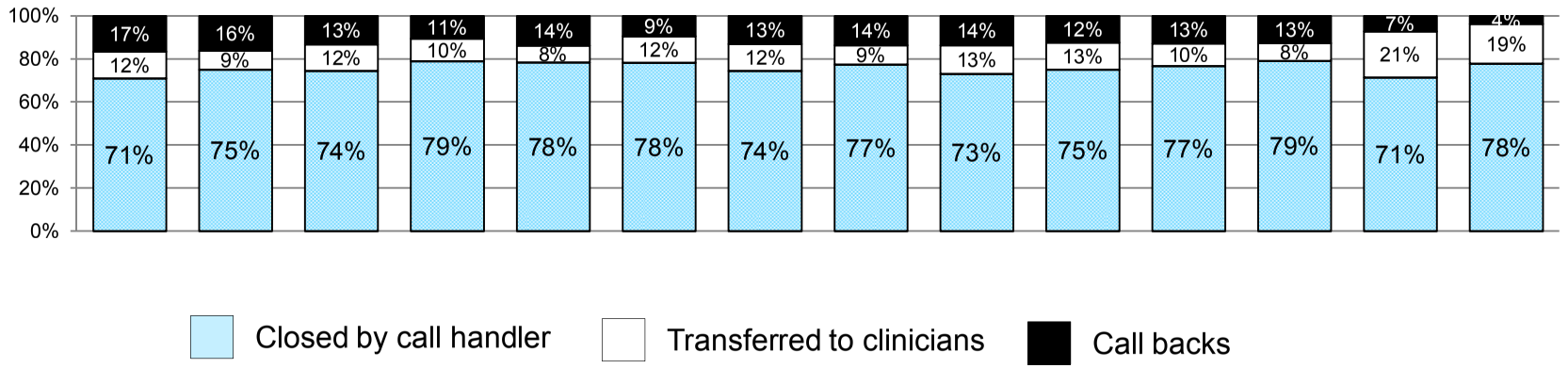
Significant improvement in calls being answered within 60 seconds moving towards national standard of 95% of calls being answered within 60 seconds

Percentage of calls abandoned



Significant improvement seen; national indicator for abandonment is under 5%

Total call journey – north central London



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North Central London Joint Health Overview and Scrutiny Committee – Meeting of Barnet, Enfield and Haringey Members

Notes of the informal meeting of the NCLS Joint Health Overview and Scrutiny Committee held in the Conference Room, Enfield Civic Centre on 23 April 2013

Present

Councillors	**Borough**
Anne Marie Pearce	LB Enfield
Cllr Ingrid Cranfield	LB Enfield
Alev Cazimoglu	LB Enfield
Alison Cornelius	LB Barnet
Graham Old	LB Barnet
Gina Adamou	LB Haringey

Support Officers	
Melanie Ponomarenko	LB Haringey
Andrew Charlwood	LB Barnet
Linda Leith	LB Enfield
Mike Ahuja	LB Enfield

1. **APPOINTMENT OF CHAIRMAN FOR MEETING**

Anne Marie Pearce (LB Enfield) was appointed as Chairman for the meeting.

2. **WELCOME AND APOLOGIES FOR ABSENCE**

Apologies for absence had been received from Councillor David Winskill (LB Haringey).

3. **BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY – UPDATE ON MATERNITY SERVICES, AMBULANCE SERVICES, ACCIDENT & EMERGENCY AND TRANSPORT**

Dr Nick Losseff (Medical Director at NHS North Central London) advised Members that the Barnet, Enfield and Haringey (BEH) Clinical Strategy was on schedule to be delivered by November 2013 with recruitment and communications/engagement activity now taking place. Members noted that leadership of strategy implementation was now the responsibility of Enfield CCG under the direction of Liz Wise, their Chief Officer. It was noted that liaison would continue to take place through individual borough CCGs. Dr Losseff reported that the Clinical Cabinet had been meeting on an ongoing basis to ensure clinical quality, adding that external assurances would be obtained later in the year.

Maternity Services

Theresa Murphy (Nurse Director, North Middlesex NHS University Hospital NHS

Trust) provided an update on maternity services. She presented projected births for Barnet, North Middlesex and Edgware maternity units post BEH Clinical Strategy implementation. Members were advised that that the Clinical Strategy would deliver the required ratio of staff to patients (1:30) and ensure that all maternity units had high calibre, competent midwives. Ms Murphy reported that workforce plans were in development and undertook to report back to the JHOSC as these evolved. Members noted that a new birthing centre would be opening at North Middlesex in 2014. In addition, community midwives geographical areas had been mapped, taking into account GP locations.

The Head Midwife at Barnet and Chase Farm Hospitals NHS Trust advised Members that recruitment was ongoing to assist in managing the transition up to November 2013. She reported that North Middlesex was now being offered to expectant mothers as a birthing option.

Cathy Geddes (BEH Programme Director for Barnet and Chase Farm) reported that Barnet and Chase Farm maternity units currently had a ratio of staff to patients of 1:32. Members noted that BEH Clinical Strategy would result in 98 (instead of 60) hours of consultant support and an additional building which would provide additional beds and ward space. In terms of the remodelled maternity services, Members noted that there would be an extra delivery suite at Barnet Hospital which would include a triage area, a revised out-patients department, expanded ante-natal and post-natal services. Outpatient services would continue to be provided at Chase Farm Hospital including midwives, obstetrics, scanning and post-natal care. It was noted that two weeks after birth responsibility for post-natal care passed to health visitors. Members were informed that in the new maternity model more care would be provided in the community. In addition, Members were informed that the same team would care for mothers across the hospital sites.

A member of the public expressed concern that the number of births requiring medical intervention was increasing and that this was not reflected in the BEH Clinical Strategy. She added that Barnet could not currently cope with patient numbers resulting in over 150 diverts between the Barnet and Chase Farm hospital sites. It was noted that transfers between the sites had taken place to deliver the highest standard of care possible, rather than due to capacity issues.

Responding to a public comment, health partners clarified that the Edgware Birthing Centre was not closing.

Siobhan Harrington (BEH Clinical Strategy Programme Director) advised Members that BEH were developing a fact sheet regarding maternity services which would detail the changes for the trusts. She added that Victoria Ward at Barnet Hospital would increase from 30 to 48 beds.

Health partners emphasised that the implementation of the BEH Clinical Strategy would improve maternity services, resulting in an improved quality of care, increased hours of consultant access, a better midwife to patient ratio and new facilitates including increased theatre capacity.

Members and the public noted that maternity services demand projections had not

included cross boundary admissions from Hertfordshire. Modelling data had used statistics from Barnet, Enfield, Haringey and North Middlesex. A member of the public commented that there had been very little communication with Hertfordshire residents (particularly Broxbourne) on changes to maternity services in North London. Siobhan Harrington reported that they had been engaging with all of the Hertfordshire Clinical Commissioning Groups (CCGs) on the changes, adding that it was recognised that there needed to more detailed engagement with the Broxbourne and Hertsmere CCGs.

Ambulance Services

Katy Millard (Assistant Director of Operations (East), London Ambulance Service) provided Members with an update on ambulance services in the context of the BEH Clinical Strategy. She reported that London Ambulance Service received 1.7 million calls per annum and that approximately 25,000 of those related to maternity. The Ambulance Service received around 1,300 calls per day which were classified as life threatening. These were prioritised through the Medical Priority Dispatch System an evidence/risk based system. Members were informed that approximately 300 patients were taken to Chase Farm Maternity Unit via ambulance in 2012/13. It was reported that the anticipated additional journey time for patients to travel to North Middlesex instead of Chase Farm was expected to be 5 minutes.

Mark Docherty (Ambulance Commissioner – London, National Ambulance Commissioners Group) advised Members that there had been significant changes to the local health economy. He reported that paramedics were skilled in identifying the most appropriate clinical care setting for patients, even if this resulted in longer transfer times. Commissioners were currently completing a review of London Ambulance Service capacity which utilised real time data and journey times. Mr Docherty undertook to share the findings of the review with Members once this had been considered by the Board. He acknowledged the requirement to increase the capacity of the service, adding that there would be an increase of approximately 600 more ambulance staff across London. Members were informed that commissioners and the London Ambulance Service were committed to providing additional resources to meet demand (circa £15 million in 2013/14).

Responding to a comment from a member of the public in relation to the commitment for an additional two ambulances to be provided in the Enfield borough, the Ambulance Service reported that they used a dynamic deployment technique rather than providing specific numbers of ambulances in given locations. Members were advised that vehicles would not be ring fenced to a specific area and would be deployed based on need. It was noted that there were a number of types of vehicles available including cars, ambulances, urgent care crews, motorbikes and bicycles to respond to incidents.

Transport

Dr Nick Losseff provided an update on transport in the context of the BEH Clinical Strategy. Members were advised that Dr Tim Peachey (Interim Chief Executive at Barnet and Chase Farm Hospitals NHS Trust) had been chairing the Barnet and Chase Farm Hospitals NHS Trust Transport Group which had been meeting

monthly. Dr Losseff advised that any impact on patients as a result of the BEH Clinical Strategy implementation was expected to be positive or neutral.

Siobhan Harrington advised Members that as part of the Transport Review, the most affected wards had been identified as Southbury, Enfield Highway, Enfield Chase, Enfield Lock and Enfield Town. She reported that they had been working with Transport for London to revise public transport routes wherever possible. A Member commented that these were three of the most deprived wards in Enfield and questioned what activity was taking place to target services and communications at these communities.

A Member of the public commented that the road layouts on the Barnet Hospital site required revision to be able to manage the increased vehicle movements on the site.

Members questioned when the 202 additional parking spaces would be available on the Barnet Hospital site as the area in question was currently housing construction site plant equipment. Health partners advised that site plant equipment was currently being stored on site whilst building construction works were being carried out, adding that there were some drainage issues that needed to be resolved before the car park construction began.

Joint Health Overview and Scrutiny Committee (JHOSC) for North Central London

6 June 2013

Future Dates/Work Plan

1. Introduction

1.1 This report outlines proposed future date(s) for the JHOSC and outlines issues that have been identified as possible future items.

Next Meeting

1.2 It is proposed that future meetings of the Committee take place as follows:

18 July – Camden

10 October – Haringey

28 November – Barnet

30 January – Enfield

13 March - Islington

1.3 Issues identified as potential future items for meetings are currently as follows:

- Transition programme progress/costs
- Ownership of strategic direction
- CCGs commissioning – quality/cost criteria.

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