North Central London Sector Joint Health Overview and Scrutiny Committee

19 September 2014

Minutes of the meeting of the North Central London Joint Health Overview and Scrutiny Committee held at Haringey Civic Centre on 19 September 2014

Present

Councillors	**Borough**
Gideon Bull (Chair)	LB Haringey
Alev Cazimoglu (Vice Chair)	LB Enfield
Alison Cornelius	LB Barnet
Graham Old	LB Barnet
Anne-Marie Pearce	LB Enfield
Pippa Connor	LB Haringey
Martin Klute	LB Islington
Jean-Roger Kaseki	LB Islington

1. WELCOME AND APOLOGIES FOR ABSENCE

An apology for absence was received from Councillor Alison Kelly (LB Camden).

2. DECLARATIONS OF INTEREST

The following personal interests were declared:

- Councillor Bull declared that he was an employee of Moorfields Eye Hospital; and
- Councillor Cornelius declared that she was an Assistant Chaplain at Barnet Hospital.

3. URGENT BUSINESS

None.

4. MINUTES

In respect of the item concerning the acquisition of Barnet and Chase Farm Hospitals by the Royal Free (item 6), the Committee were of the view that it was important that site specific data was provided on performance so it was possible to monitor performance at each individual hospital site owned by the Trust.

RESOLVED:

1. That the minutes of the meeting of 27 June 2014 be approved; and

2. That a letter be sent to the Chief Executive of the Royal Free on behalf of the JHOSC requesting that site specific performance data continue to be

produced and shared for all hospitals that are now part of the Trust and that the letter be copied to relevant Healthwatches.

5. LONDON AMBULANCE SERVICE (LAS) – UPDATE

The Committee received a presentation from Steve Colhoun from the London Ambulance Service. He had been invited to attend in response to a number of issues that had been raised by JHOSC Members.

He presented data regarding handover performance at Barnet and the North Middlesex Hospital (NMUH). There had been a big difference in performance between the two hospitals in respect of the time from hospital arrival to trolley clear but NMUH had made significant improvement after work had been undertaken with them. The standard length of time that it should take was made up of two elements - hospital arrival to trolley clear 15 minutes and trolley clear to green and available 14mins. Any waits of over an hour for hospital arrival to trolley clear are reported upwards.

The standard length of time from trolley clear to green was intended to be 14 minutes. Current figures showed that the time for this being taken was getting longer due to increased pressures on the service. However, it was currently difficult for crews to get a rest break and times could not be reduced without unduly exhausting staff.

In answer to a question, it was noted that it was not possible for readings taken by ambulances to be automatically transferred to receiving hospitals.

Mr Colhoun acknowledged that staff were currently under immense pressure. The service was 480 staff short but measures had been taken to address the situation. He hoped that this would lead to improvements in 6 to 8 months time. The longest shifts that staff worked were for 12 hours. The service was not necessarily of the view that it was in the interests of staff to work such long shifts but most staff lived outside of London and preferred to work fewer but longer shifts. If staff on 12 hour shifts got a call towards the end of their shift which overran, this could result in them being at work for a very long time overall.

The service had considered reducing the length of shifts but this would not have been popular with staff. The service was nevertheless subject to the European Working Time Directive and could not schedule shifts longer than 12 hours. However, the LAS was an emergency service and allowances could be made for this. Staff could work up to five 12 hour shifts in a period. The current staffing rosters had been designed by the staff. Some stations, such as Edmonton, were able to offer shorter shifts and these could be popular with older staff. Younger staff generally preferred the longer shifts. He agreed to share the current staff rosters with Committee Members.

He reported that the shortage of staff was the biggest issue facing the service. Calls had risen by 10% per year whilst the service was 480 staff short of full establishment. The new role of Emergency Ambulance Crew had recently been advertised and there were now 200 candidates for positions. There would be a

26 week training process and the new staff would be available next spring. Recruitment of paramedics had also taken place. The service had been caught out by the level of demand for paramedics from services such as 111 call centres and had found themselves 350 short. They had sought to recruit from a range of countries, including New Zealand, Australia and Denmark. 180 offers of employment had already been made and it was hoped that the new recruits would be in post in two to three months time.

In answer to a question, Mr Colhoun stated that it was not clear why call levels had been increasing by 10% each year. However, it was likely that at least some of this was due to a lack of understanding amongst patients of where the right place to go was for particular ailments. It had been suggested that it was partly due to the ageing population but Mr Colhoun stated that highest service user group by age came from younger people.

The opportunities that had arisen for paramedics in the 111 service and urgent care centres had offered higher grading levels without the need to work nights. In response to this, a new paramedic post had been created which paid a higher grade and matched the grades being offered for paramedics elsewhere. All ambulances were staffed by a paramedic and a technician except where there were issues relating to staff sickness or leave.

Unfortunately, the service was having to use private ambulances. There would be large gaps in service without this. All providers were vetted and all staff were required to be at least at technician level. Private ambulances were generally used for lower level work, and there were LAS fast response units available to provide support.

Mr Colhoun reported that the LAS had taken action to manage demand. Paramedics were being used in call centres and could call patients back and refer them to the best service for addressing their needs. If need be, taxis could be sent to transport patients but only after consultation with a clinician.

Intelligent Conveyancing was concerned with managing surges in demand. It had met with varying degrees of success so far. It had worked well at the North Middlesex Hospital but had not been so successful at Barnet. Measures had been taken to address issues in relation to specific care homes. The establishment of the Older Persons Assessment Unit at Chase Farm had also been successful in reducing the need for ambulances.

The Committee thanked Mr Colhoun for his assistance.

AGREED:

1. That the LAS be invited to present an update on progress to the Committee in six months time;

2. That the new LAS staff rosters for the Barnet and Enfield be shared with Committee Members; and

3. That the LAS be requested to undertake further work to determine the reasons for the increase in demand for ambulances amongst young people and report back to the Committee in due course.

6. WHITTINGTON HEALTH NHS TRUST: FIVE YEAR PLAN/DEVELOPMENT OF INTEGRATED CARE

Siobhan Harrington, the Director of Strategy and Deputy Chief Executive of Whittington Healthcare, gave a presentation on future plans for Whittington Health and their development of integrated care.

The Trust employed over 4300 staff. In addition to being an acute general hospital, it provided community health services in Haringey and Islington. It had recently opened an ambulatory care centre which aimed to treat people and send them home without the need for admission. Based on Standard Hospital-level Mortality Indicators, the Whittington was now also one of the safest hospitals in the country

The trust included several centres that provided particularly good services, such as the Simmons House Adolescent Unit, the ambulatory care centre, the Michael Palin Centre and the TB service. Performance was also good against key national targets. There were several areas of innovative practice, such as the N19 project. This brought together health and social care and would be rolled out across Islington. Consideration was being given to extending it to Haringey in due course.

The Trust still faced challenges in respect of its financial situation but these were being addressed. It had a relatively new board and was in the process of building a new executive team. In addition, a number of high calibre non Executive members had recently joined the board.

In terms of the development of a five year strategy, she reported that a review was underway with the King's Fund exploring the integrated care journey and the progress that had been made to date. Engagement with staff, stakeholders and the public was planned as well as work with partners and commissioners. A draft of the strategy would be produced by December. A long term financial model would also be developed. Quality, safety and the patient experience would be at the heart of the future strategy for the trust. There would be a particular focus on prevention and self management.

In answer to a question regarding the prevalence of TB, she reported that one factor was the mobility of the population. The service provided by the Whittington provided direct access and was a partnership with UCLH. There was also another centre at the North Middlesex Hospital. In respect of district nursing, she reported that considerable improvements had been made to the service, including a large recruitment campaign. She acknowledged that there had been issues with the rheumatology service and an improvement plan was currently being worked on. The Trust had not yet been subject to a major Care Quality Commission (CQC) inspection done under the new format but were preparing for

this. They were currently categorised as low risk by the CQC and were not aware of when they might be inspected.

In answer to another question, she reported that time limited contracts had been offered to some senior staff as the Trust did not yet have a permanent Chief Executive. However, the Trust was working towards having a permanent senior management team. In respect of staff morale, she accepted that it had been quite low. However, the interim Chief Executive was of the view that good staff morale was critical to the organisation and was aware of where there were issues. The Trust was having to make savings of £15 million and this had an impact on morale. The aim was to bring the Trust back into balance and to achieve a surplus by the end of the process. In terms of the transition to foundation trust status, they had to go through the CQC inspection first. Having a stable senior management team was critical to progressing the transition.

In response to a question regarding foot care, she stated that the podiatry service was focussed on prevention. Consideration was being given to providing podiatry as part of integrated care. She would look at including it within the protocols of the service.

The Committee thanked Ms Harrington for her presentation.

7. WINTER A&E PRESSURES AT BARNET HOSPITAL - ADMISSIONS FROM CARE HOMES

Fiona Jackson from the Royal Free reported on work that was being undertaken by the Trust to minimise admissions from care home residents, particularly at Barnet and Chase Farm hospitals. There was now an Older Person's Assessment Unit (OPAU) at Chase Farm Hospital, which had been successful in preventing admissions. One particular element of this was a care homes hotline which provided access to an appointment with a consultant within 24 hours. There was also a care home assessment team that could go out and visit patients if necessary. The Trust now wished to extend the OPAU to five days per week.

She stated that there was a high turnover of staff in care homes, particularly in Barnet and therefore continued support was necessary to assist them. Barnet CCG had developed an enhanced service for care home residents which included a six monthly review for all residents. Care plans would be developed for all residents. It was hoped that work undertaken with care homes would help to increase the confidence of staff working in them to deal with issues themselves, thus reducing admissions. All care homes were now linked to a specific GP practice.

In answer to a question, Ms Jackson stated that discussion was needed with CCGs on what action it might be possible to take to put pressure on care homes to co-operate if they were not assisting sufficiently. The Trust discharged patients to a wide variety of care homes and there was high demand for placements. It was hoped that patients would choose the better homes but a bit of leverage over the less co-operative homes would be of assistance.

Councillor Cornelius reported that Healthwatch in Barnet had conducted "Enter and View" visits to care homes and, amongst other things, had specifically asked about hydration as dehydration had been common cause of admissions. She felt that it was important the relevant information about care homes was shared effectively.

The Committee thanks Ms Jackson for her contribution.

8. NORTH MIDDLESEX UNIVERSITY HOSPITAL - CARE QUALITY COMMISSION INSPECTION

Julie Lowe, the Chief Executive of the North Middlesex University Hospital, reported on the outcome of the recent inspection by the CQC of the hospital. It was necessary for a trust to be rated as either good or outstanding in order to obtain foundation trust (FT) status. 8 particular services had been inspected. Of these, 4 had been classified as good whilst 4 required improvement. The services that required improvement would need to be re-inspected. However, this did not mean that the 4 areas rated as good could not also be improved. She hoped that it would be possible to get all of the services requiring improvement up to good by December. It would not be possible for the trust to progress to foundation status without this. The inspection result was likely to delay progression to FT status by six months.

She stated that the process for the implementation of the BEH Clinical Strategy was not fully completed. There were a few other issues that required particular attention:

- The number of local residents that accessed healthcare through emergency care;
- The high number of outpatient appointments, which was up to 800 per day. Work was being undertaken with local CCGs to see if this number could be reduced through measures such as seeing patients in the community. Non attendance rates were high and a better system for follow up appointments was necessary;
- Ambulatory care. The Older Person's Assessment Unit (OPAU) was not working as well at NMUH as at Chase Farm. Action needed to be taken to ensure that pathways were right and improved accommodation identified.

The level of support that had been provided by partners had been good and it was hoped that the trust would achieve the necessary "good" CQC rating. The outcome of the inspection had been disappointing though. The trust had already been addressing some of the issues raised and it was hoped that the others could be quickly brought up to speed.

In respect of palliative care, the trust had been surprised by the rating that was given. The Liverpool Care Pathway was no longer used following negative publicity but this had left staff with no framework to work with. A more individualised approach was now being used. A balance had to be struck between sending patients home too early or leaving it till it was too late. She reported that patients with dementia who were treated at NMUH generally went

home four days later than other patients. She noted that there was not the same difference at the Royal Free and this needed to be addressed.

Councillor Cazimoglu stated that NMUH was a good hospital but the impact of the implementation of the BEH Clinical Strategy had been as many people had feared. It had been accepted that the transition would be difficult but the trust had been insufficiently prepared. The issues raised by the CQC were linked to capacity. Local people wanted the hospital to remain good.

Ms Lowe responded that the implementation was always going to be challenging and all presentations beforehand had stated that there would be a period of transition. In particular, the trust had needed to recruit 500 new staff. A lot of additional activity had come from areas that had not been anticipated. For example, many additional patients had come from Haringey rather than being displaced from Chase Farm. In addition, Enfield had an ageing population.

In terms of staffing, Chase Farm had been carrying a high level of vacancies. Most remaining staff from Chase Farm had chosen to transfer to Barnet Hospital, which enabled them to remain with the same employer, rather than the North Middlesex. Training was being strongly encouraged for all staff and the trust was moving towards e-learning. However, many staff were not computer literate and the trust was now looking at providing greater choice of formats.

In answer to a question, Ms Lowe reported that delayed transfers of care remained an issue and could increase pressures on A&E. Discussions had taken place with CCGs to address the issue. In some instances, the trust had had to pay for nursing home accommodation.

The Committee thanked Ms Lowe for attending.

9. DISTRICT NURSING

Sarah Hayes from Whittington Health and Stephen Meechan from Central and North West London reported on district nursing services in Islington, Haringey and Camden respectively.

Ms Hayes reported that Whittington Health provided the district nursing services across Islington and Haringey. These were 24 hours per day and 365 days per year. There were 113 clinical staff in Islington and 87 in Haringey, with four daytime teams in each borough. Each team was linked to a GP network or collaborative. There was an evening team in each borough and a night team working across Islington and Haringey who had a particular focus on providing end of life care and interventions to avoid hospital admission and A&E attendance.

The teams were made up of nurses with a wide range of skills and knowledge. In line with national trends, service activity had increased over recent years. The service was committed to joint working with local GP practices, particularly through regular attendance at practice meetings, primary care enhanced

meetings, case finding and multi-disciplinary teleconferences. The service also worked as an integral part of the Whittington Health virtual ward team.

The issue of recruitment had been addressed with vacancies down to 7%. Measures were also being taken to increase productivity by the greater use of technology and reducing travel times. Mr Meechan reported that recruitment in Camden had also improved with vacancies now down to less than 5%.

Mr Meechan stated that the service in Camden worked along similar lines. The service was able to provide rapid response where necessary in order to avoid hospital admission. In addition, they also operated a hospital at home scheme in liaison with the Royal Free Hospital.

Ms Hayes reported that parking was a particular problem to district nurses. The Whittington had funded parking permits but had cost £80,000 per year. This money was needed for spending on clinical purposes now. Any help that could be provided by Members in response to this issue would be welcome. The Chair agreed to take up the issue with relevant boroughs and local authority organisations.

AGREED:

That the issue of parking for district nurses be raised by the Chair with relevant boroughs and local authority organisations.

10. WORK PLAN AND DATES FOR FUTURE MEETINGS

In reference to the proposed agenda for the next meeting, it was agreed that the issue of spend levels between primary and secondary care be subsumed into the item on Primary Care – Case for Change. It was also noted that the 5 year plan referred to CCGs across north central London rather than the Commissioning Support Unit. It was also agreed that the progress report on the acquisition of Barnet and Chase Farm hospitals by the Royal Free would not be considered at the next meeting as it was already on the agenda for the meeting in January.

AGREED:

That, subject to the above mentioned amendments, the work plan be approved.

Gideon Bull
Chair