

Meeting of the

HEALTH SCRUTINY PANEL

Tuesday, 19 April 2011 at 6.30 p.m.

A G E N D A

VENUE

M72, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London,
E14 2BG

| Members: | Deputies (if any): |
|---|--|
| Chair: Councillor Tim Archer Vice-Chair: | |
| Councillor Abdul Asad Councillor Lutfa Begum Councillor Anna Lynch Councillor Lesley Pavitt Councillor Rachael Saunders Councillor Kosru Uddin | Councillor Dr. Emma Jones, (Designated Deputy representing Councillor Tim Archer) Councillor Mohammed Abdul Mukit MBE, (Designated Deputy representing Councillors Abdul Asad, Anna Lynch, Lesley Pavitt, Rachael Saunders and Kosru Uddin) |
| [Note: The quorum for this body is 3 Members]. | |
| Co-opted Members: | |
| Myra Garrett | - (THINK) |
| Dr Amjad Rahi | - (THINK) |

If you require any further information relating to this meeting, would like to request a large print, Braille or audio version of this document, or would like to discuss access arrangements or any other special requirements, please contact: Zoe Folley, Democratic Services, Tel: 020 7364 4877, E-mail: zoe.folley@towerhamlets.gov.uk

LONDON BOROUGH OF TOWER HAMLETS

HEALTH SCRUTINY PANEL

Tuesday, 19 April 2011

6.30 p.m.

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF INTEREST

To note any declarations of interest made by Members, including those restricting Members from voting on the questions detailed in Section 106 of the Local Government Finance Act, 1992. See attached note from the Chief Executive.

| | PAGE NUMBER | WARD(S) AFFECTED |
|--|------------------------|-----------------------------|
| 3. UNRESTRICTED MINUTES | 3 - 12 | |
| To confirm as a correct record of the proceedings the unrestricted minutes of the ordinary meeting of Health Scrutiny Panel held on 25 th January 2011. | | |
| 4. REPORTS FOR CONSIDERATION | | |
| 5.1 Excellence in Quality Strategy Report | 13 - 14 | |
| 5.2 Focus on dementia | 15 - 32 | |
| 5.3 New Residents and Refugee Forum - access to healthcare | 33 - 44 | |
| 5.4 Visit to Barts and the London Trust - Verbal update | | |
| 5.5 Cancer - the development of early diagnosis and preventative services - Scrutiny challenge session report | 45 - 56 | |
| 5.6 Health Scrutiny Panel response to Health Lives Healthy People White paper | 57 - 60 | |
| 6. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT | | |

Agenda Item 2

DECLARATIONS OF INTERESTS - NOTE FROM THE CHIEF EXECUTIVE

This note is guidance only. Members should consult the Council's Code of Conduct for further details. Note: Only Members can decide if they have an interest therefore they must make their own decision. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending at a meeting.

Declaration of interests for Members

Where Members have a personal interest in any business of the authority as described in paragraph 4 of the Council's Code of Conduct (contained in part 5 of the Council's Constitution) then s/he must disclose this personal interest as in accordance with paragraph 5 of the Code. Members must disclose the existence and nature of the interest at the start of the meeting and certainly no later than the commencement of the item or where the interest becomes apparent.

You have a **personal interest** in any business of your authority where it relates to or is likely to affect:

- (a) An interest that you must **register**
- (b) An interest that is not on the register, but where the well-being or financial position of you, members of your family, or people with whom you have a close association, is likely to be affected by the business of your authority more than it would affect the majority of inhabitants of the ward affected by the decision.

Where a personal interest is declared a Member may stay and take part in the debate and decision on that item.

What constitutes a prejudicial interest? - Please refer to paragraph 6 of the adopted Code of Conduct.

Your personal interest will also be a prejudicial interest in a matter if (a), (b) and either (c) or (d) below apply:-

- (a) A member of the public, who knows the relevant facts, would reasonably think that your personal interests are so significant that it is likely to prejudice your judgment of the public interests; AND
- (b) The matter does not fall within one of the exempt categories of decision listed in paragraph 6.2 of the Code; AND EITHER
- (c) The matter affects your financial position or the financial interest of a body with which you are associated; or
- (d) The matter relates to the determination of a licensing or regulatory application

The key points to remember if you have a prejudicial interest in a matter being discussed at a meeting:-

- i. You must declare that you have a prejudicial interest, and the nature of that interest, as soon as that interest becomes apparent to you; and
- ii. You must leave the room for the duration of consideration and decision on the item and not seek to influence the debate or decision unless (iv) below applies; and

- iii. You must not seek to improperly influence a decision in which you have a prejudicial interest.
- iv. If Members of the public are allowed to speak or make representations at the meeting, give evidence or answer questions about the matter, by statutory right or otherwise (e.g. planning or licensing committees), you can declare your prejudicial interest but make representations. However, you must immediately leave the room once you have finished your representations and answered questions (if any). You cannot remain in the meeting or in the public gallery during the debate or decision on the matter.

LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY PANEL

HELD AT 6.30 P.M. ON TUESDAY, 25 JANUARY 2011

**M73, 7TH FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT,
LONDON, E14 2BG**

Members Present:

Councillor Tim Archer (Chair)

Councillor Abdul Asad
Councillor Lutfu Begum
Councillor Lesley Pavitt
Councillor Rachael Saunders
Councillor Kosru Uddin

Co-opted Members Present:

David Burbidge – (THINK)
Dr Amjad Rahi – (THINK)

Guests Present:

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Caroline Alexander – (Director of Quality Development, NHS Tower Hamlets)
Paul James – (East London NHS Foundation Trust)
Bethan George – (NHS Tower Hamlets)
Christine Bevan-Davies – (Barts & the London Trust)
Sandra Reading – (Barts & the London Trust)
Kay Riley – (Barts & the London Trust)
Annaliese Weichart – (Tower Hamlets PCT)

Officers Present:

Rachael Chapman – (Strategy & Policy Officer, Adults Health & Wellbeing)
Jebin Syeda (Scrutiny Policy Officer)
Caroline Chalklin – (Democratic Services Officer)

1. APOLOGIES FOR ABSENCE

Apologies were received from Councillors Anna Lynch, Dr Emma Jones and Bill Turner .

2. DECLARATIONS OF INTEREST

Councillor Lesley Pavitt declared a personal interest in Agenda item 4.6 “Response to THINK recommendations” as she was a member of THINK.

Councillor Begum declared a personal interest in all items on the agenda as she was an employee of Tower Hamlets PCT.

Councillor Abdul Asad declared a personal interest in the report on ‘Ocean Estate GP Update on consultation’ as he was a patient at the Harford Street Practice.

Councillor Rachael Saunders declared a personal interest in the Agenda as a member of the Tower Hamlets PCT Board.

3. UNRESTRICTED MINUTES

The minutes of the ordinary meeting held on 26th October 2010 were **agreed** as a correct record of the proceedings, with the addition of Councillor Kosru Uddin to the list of Members recorded as present.

4. REPORTS FOR CONSIDERATION

4.1 Ocean Estate GP Update on consultation - NHS Tower Hamlets

The report on the Harford Street Health & Wellbeing Centre – Patient and Public Engagement was presented by Ms Bethan George of NHS Tower Hamlets, who gave a presentation using power point slides.

Members raised a number of points in response:

- Councillor Pavitt expressed concerned that the services of the practice were not recognised by its patients. A booklet should be produced annually or every six months
- Councillor Pavitt also expressed concern that people do not go to the dentist unless there is a crisis. Tower Hamlets children have dreadful teeth
- Councillor Pavitt expressed concern that the EMS system was almost impossible to use
- In response to Councillor Begum, Ms George said that Tower Hamlets NHS was working to ensure the PMS contract for the Harford Street practice reflected the needs of local people. The practice is an NHS practice
- In response to Mr Burbidge of THINK, Ms George said there would be greater emphasis on user involvement
- Mr Burbidge also asked if the pharmacist could undertake some of the routine tests, such as urine and blood testing. Ms George said that it was critical to make all the services work together, but there could be logistical issues with this type of testing

- Councillor Asad said that 60 responses was a low return when there were approximately 9000 patients, it was less than 1%. Ms George said that the survey was set against the Health and Wellbeing Strategies
- Mr Rahi asked what would happen when the consortia took over; Ms George responded that the practice would be transferred as it is
- The Chair asked about the timescales and the involvement of communications. Ms George responded that the building work would be finished by mid June, and the GPs would move in first. The Dental and Pharmacy contracts would start in mid April. The Communications Team would be working with the practice from the week beginning 31 January 2011, so everyone would be aware of the move and the plans.
- Members requested that Ms George keep local Councillors informed and try to engage them earlier in the process

The Chair agreed to accept a question from the floor:

- Dr Anna Livingstone, a local GP asked if Health Visitors and District Nurses were going to be integrated on the site; Dr Livingstone expressed concern that there were plans for separate organisations. Ms George said there were no plans for accommodation for District Nurses or Health Visitors on the site, but there were plans for network working
- Councillor Saunders welcomed the move

4.2 Complaints services in Tower Hamlets- NHS Tower Hamlets

The Chair said that it was quite hard to make concerns known. Ms Alexander said that the Working Group had discussed the issues, and the report indicates the new approach. Bangladeshi complaints are low, although there were a number of queries received by PALS. Unfortunately, the recording of ethnicity had not been prioritised, but would now be more explicitly solicited from complainants. The statistics should then give Members more confidence that all ethnic groups are able to access the complaints procedures.

Councillor Archer also raised the issue of the East London Mental Health Trust (ELMHT) website; this had no complaints form. There were different abilities to complain for each organisation, so it would be helpful if the complaints channels could be aligned. Mr James from the ELMHT said that 80% of complaints received by the Trust were from inpatients. Complaints forms for the community needed to be made more user-friendly.

Ms Bevan-Davies of the Barts & London Hospitals Trust (BLT) said that the website for the BLT was being simplified.

Councillor Asad said that the numbers of complaints from the Bangladeshi community were very low; however the community may not be aware of the ways to make a complaint. Trusts could consider using more electronic media and the Bangladeshi press.

Mr James of the ELMHT said that the Bangladeshi Mental Health Association was very active with feedback.

Councillor Pavitt commented that many complaints were going to the Ombudsman. Ms Kay Riley of BLT said that the Trust's Chief Executive had said that many complaints were referred to the Ombudsman, rather than being referred back to the Trust to deal with. Unfortunately, the Ombudsman would not give each Trust feedback; this was to preserve confidentiality. Many complaints were not made in writing. It was noted that only 3 complaints about BLT were accepted for investigation by the Ombudsman: the others had not followed the Trust's Complaints Procedure or failed for other reasons.

Councillor Pavitt said that the BLT website did not make it clear how to complain; users had to choose between making a 'comment/suggestion/complaint'. The choice of making a complaint should be made clearer. Ms Bevan-Davies said the Trust did receive a trickle of complaints through the system.

Councillor Begum said that it was not just Bengalis who needed to complain; members of the Somali and Chinese communities also needed more assistance. Cards should be available in receptions with the complaints procedure; many patients were computer illiterate.

Mr Burbidge asked how voluntary advocacy services were being developed, and those for ethnic communities. Mr James said that advocates used by ELMHT were provided by Tower Hamlets and Newham MIND, who provided an excellent service and engaged with patients in a very sensitive way.

Ms Cohen commented that Tower Hamlets Council was conducting a complete review of advocacy. Ms Riley said that BLT spent £1 million on advocacy services; these were mainly taken up in Accident & Emergency and Maternity Services. Ms Bevan-Davies said that patients were signposted to the independent ICAS service.

On the Mile End site, patients were signposted to PALS. It was also noted that THINK was developing voluntary advocacy services. Ms Alexander suggested that all the providers could work together to provide consistency.

Mr Rahi said that it was as well the Council was involved in advocacy; the funding for PALS and ICAS was being transferred to the Council.

Councillor Uddin said he was still concerned at the low numbers of complaints from Bengalis. If complaints were dealt with early, it could be that there were fewer recorded. Ms Alexander said that improving ethnic reporting should show increased numbers of complaints from Bengalis.

It was **agreed** there should be a report containing an update on complaints to PALS by ethnicity at the next meeting of the Panel.

Action: Jebin Syeda, Scrutiny Policy Officer

4.3 Maternity Service - Update - BLT - Briefing Paper incorporating comments from the recent CQC Survey

Ms Reading, the Head of Midwifery and Women's Health, presented the report on the Picker Survey of Maternity Services in Tower Hamlets, which had been carried out in 2010. This Survey was in contrast to a survey carried out in 2007, and showed definite improvements, and this report was being given 11 months after the Survey was carried out, so the situation was even better now.

Improvements made included:

- Access to services, which needs to be as early as possible, this can be done online, by telephone or via the patient's GP. It was noted that 92% of patients did access the services early. This meant that women could be put on the appropriate pathway for their individual needs. It was noted that care offered by midwives and GPs was low risk
- The Services were working on normalising the experience of labour, and it was possible to offer 100% one to one care
- The Tower Hamlets Birth Centre had low take up in its first year with 200 births, but there were 400 births last year
- 81% of mothers rated their care as 'excellent' during pregnancy
- 85% of mothers rated their care as 'excellent or good' during labour
- 29% of mothers rated their postnatal care as 'poor'

Councillor Pavitt commented that she had been active in the Community Health Council, and the quality of maternity services had been an issue. This Survey compared well to the survey in 2007.

Councillor Pavitt expressed concern at the number of women who felt they were not treated with kindness or not spoken to in a way they understood. Ms Reading said that it had been noted that 'kindness' had not improved as much as the services would like, and work was being done to improve women's experience. Specifically, work was being done on improving the antenatal experience; the Talbot Ward was now there for women in early labour who did not want to go home. Modernisation was taking place in the light of the local population.

Mr Rahi said that he remembered the 2007 report. Midwives who trained in Tower Hamlets were now being recruited and staying, and the challenge was now to retain them in the borough. Maternity support workers were being recruited locally.

Mr Burbidge said that the report reflects attitudes, and he wondered what patients expected of staff, and asked what use was being made of volunteers. Ms Reading responded that the main focus of the report was on the attitude of the staff. Attitudes have changed since 2007, patients are spoken to

appropriately, dealt with quickly and efficiently. Work was being done on a volunteer Doula scheme, when a volunteer would support a woman through labour.

Women's groups feed into maternity services. There is a Women's Information Group which provides information on what services are available and how to self-care. There is also a Gateway Team who are experienced in working with vulnerable women.

Councillor Begum said that women should have the choice of home births, and Bangladeshi women liked to have their babies at home. However, there are not many Bangladeshi midwives. There are many young people in Tower Hamlets, and the population is increasing; young people need to be recruited from schools. Ms Reading said that women have advocates to ensure they get the choice of hospital/home births.

Councillor Uddin noted that there had been the smallest change in antenatal services, but women should be comfortable from the start of their pregnancy. Ms Reading said that a huge amount of effort was made to ensure women accessed services early. It was to be hoped that women's experiences were better since the Survey.

The Chair noted that the process for testing for Down's Syndrome and the cleanliness of premises were poor. Mr Reading said there was an ongoing review and much effort made to improve these areas.

The Chair invited Dr Livingstone to comment from the floor: Dr Livingstone asked what were the areas of risk? Health visitors and continuity of primary care were important. Services such as Gateway could increase risks, because of delays in referrals. It would be better if patients used local services.

4.4 Joint Report on the Public Health White Paper- NHS Tower Hamlets

Dr Somen Bannerjee, the Co-Director of Public Health, presented a report on the White Paper on Public Health.

Public Health in England faced a number of challenges; these included:

- Increased life expectancy, but increasing ill health as people age
- Rise in obesity and Type 2 Diabetes
- Alcohol and substance misuse, and the consequences for others
- Poor mental health
- Infectious diseases and the environment
- Health inequalities between the richest and the poorest

The Radical New Approach

- Public health resources would be 'owned' by the local population
- Resources would be 'ringfenced' from other services
- Public health would be professionally led and evidence based

- Protection would be strengthened against threats
- Public Health England would be established with national responsibility for research and commissioning.
- Local authorities would take over some responsibilities and local Health & Wellbeing Boards would be established.

A sector stakeholder workshop is planned for 9th March for key partners, such as Councillors and GPs representatives to explore the implications of the White Paper.

Issues included the unknown budget available for 2012/13, the move of Public Health to Local Authorities and the disentangling of commissioning.

Councillor Pavitt asked where Health Visitors were going to be placed. She also noted that Think was going to be replaced by 'Health Watch'; local people needed to be involved from the start to shape the new services.

Dr Bannerjee said that Health Visitors would be commissioned.

Mr Rahi said that the Health & Wellbeing Board would consist of: the Mayor or Chief Executive of Tower Hamlets, 3 Directors (Public Health, Social Services and Children's Services), but no Councillors, although the Board will have powers to co-opt members. Once the PCT has gone, assessment will be done through the Council.

Councillor Saunders said there was no form of democratic involvement. This meant that the Health Scrutiny Panel would become increasingly important as an accountability mechanism. The Panel's powers would need to be strengthened to hold the Health & Wellbeing Board to account. It would be better if the Health & Wellbeing Board was more open.

Mr Burbidge said that the region containing Hackney, the City, Tower Hamlets and Newham would be all one. It was important that local issues did not get lost, local people need a bigger say as the sector will have control. Ms Cohen said the membership of the Health & Wellbeing Board was not finalised, and needed approval of the Council's Cabinet.

Mr Burbidge said that the membership of the Health & Wellbeing Board was likely to be as stated for cost-saving reasons, so it was important that it dealt with local issues.

Dr Bannerjee did not agree that the membership of the Health & Wellbeing Board was already fixed. The tenor of the White Paper was about doing things locally. Directors of Public Health were needed at both sector and local levels.

Mr Burbidge said that there was confusion about what public health actually was and how services would be accessed. A Board was needed to coordinate.

It was agreed that a response to the White Paper be coordinated. Anyone with comments should send them in.

Action: Jebin Syeda, Scrutiny Policy Officer

4.5 Transformation of Adult Social Care & the Personalisation Agenda - NHS Tower Hamlets

Ms Cohen introduced the report which reflected the huge change in adult social care. The driving vision was to provide a personal budget to meet social care needs. There would be a Home Support Plan with funding towards needs, and help would be given to those who were in need of safeguarding, together with risk assessment for vulnerable adults.

The new way forward in provision would be driven by individuals, and not by social services. There were major consequences for commissioning; there would be fewer block contracts and more market driven contracts. The change would also lead to mainstream services being made accessible to disabled people.

Adult social care would be divided into 3 areas:

- First response and hospital care
- Re-ablement – after illness/accident with the aim of rehabilitation
- Long term care

This model needs to fit in with Tower Hamlet's ageing population, and the large learning disabled population (Tower Hamlets has the largest population of people with learning disabilities in the UK). Ms Cohen said it was hoped to shelter funding for re-ablement and carers from the efficiency cuts.

The programme would finish at the end of March 2011 and then the pathway would be in place. The commissioning of Learning Disability Day services would be modernised, and this will go to Cabinet In February.

Mental health service users would also be able to take up personal budgets. Those who did not want to take the budgets up would be able to access traditional care.

Mr Burbidge commented that the support planning document was 100 pages long; and this was just to reach the indicative budget, there were even more questions after that had been settled. Ms Cohen said that this process had to be slimmed down.

Mr Burbidge also said there was no right of appeal should a user have an agreement with a social worker, when a trained volunteer advocate might be used. Ms Cohen said that the Independent Living Social Services were social workers who were training as support planners. It was noted that Suffolk CC had outsourced all its social work.

Mr Burbidge asked that there be support in the form of handymen for small repairs, electronic people to help set up televisions etc, heating engineers to balance heating and accounting technicians to help with the paperwork involved in the claims – receipts, invoices, cheques etc.

Ms Cohen said there was no system in place for appeals as yet but that this would be taken back to the service. She agreed there was a need for a Handyman Service.

Mr Rahi said that currently, services were registered with the CVC, how would quality be controlled in the new model.

Ms Cohen said that this was a difficult question, possibly an accreditation system could be set up, and accredited services listed in a catalogue. There needed to be a balance between choice and control. The Support Planners could encourage users to ensure the provider had a CRB check. Risk assessments would be needed.

4.6 Response to THINK Recommendations

Mr Burbidge said that the report was for information.

The Chair commented that there were very good observations, but he had concern that changes would not take place in response. He asked that problems be flagged up and regular reports brought to the Health Scrutiny Panel.

Councillor Pavitt felt that a report should be brought back every 3 months.

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

Flu and Swine Flu

The incidences of flu/swine flu peaked at Christmas; since the New Year the trajectory had fallen and it was felt that this was the end of the episode. From 20th December 2010 the PCT had weekly meetings to assess the situation.

Issues of concern included:

- Availability of vaccines and anti-virals
- Midwives were not able to give vaccines legally
- Problems with getting vaccine to the vulnerable groups under 65, both in identifying and immunising
- Tower Hamlets figures for immunisation acceptable but needs to be higher

Mr Burbidge asked if the Health Scrutiny Panel could be issued with statistics on the causes of death within the borough from flu and other major diseases.

The meeting ended at 8.40 p.m.

Chair, Councillor Tim Archer
Health Scrutiny Panel

Agenda Item 5.1

| | | | | |
|--|---|--|-------------------|---------------------|
| Committee: Health Scrutiny Panel | Date: 19 th April 2011 | Classification: Unrestricted | Report No: | Agenda Item: |
| Report of: Corporate Director Steve Ryan Medical Director and Kay Riley Chief Nurse, Barts and the London Trust Originating officer(s) Judith Bottriel, Associate Director of Quality Improvement, Barts and the London Trust | | Title: Barts and the London NHS Trust strategic objective for quality and safety improvement in 2011/12 Wards Affected: All | | |

1. **SUMMARY**

This report sets out the headline objective and the quality improvement priorities for 2011/12 for Barts and The London Trust. An overview of the Trusts performance against 2009/10 objectives and Quality Account commitments will be presented to Health Scrutiny at the meeting April 19.

2. **RECOMMENDATIONS**

The Health Scrutiny Panel is recommended to note Barts and The London's quality objectives and priorities for 2011/12 and in the context of the planned Quality Account and annual quality review presentation on 19th April 2011.

3. **BACKGROUND**

Barts and The London NHS Trust's objectives for 2011/12 were approved by the Trust Board on 30 March.

Building on the 2010/11 objectives, the 2011/12 objectives will be fed into the Trusts Integrated Performance and Assurance Framework (IPAF) and will be cascaded through the organisation to inform the development of divisional, clinical academic unit and service level objectives for the coming year.

The headline objective for quality and safety improvement and the underpinning key priorities are outlined below. The priorities, individual projects and workstreams will be described in more detail in the Going Forward Section of the 2010/11 draft Quality Account.

| Headline Objective | Quality Improvement Priorities 2011/12 | Lead Executives |
|--|--|--|
| <p>Improve patient care, further improving safety, clinical outcomes and patient experience</p> | <p>Ensure ongoing CQC registration without conditions and compliance with national and local standards, including CQUIN targets.</p> <p>Improve patient safety and outcomes as measured by key indicators (including HSMR, allergy-related incidents and infection rates) and roll-out of the 'Safety Express' programme</p> <p>Embed the principles of compassionate care across inner north east London hospital and community services through the East London Compassionate Care Partnership, as part of enhancing the overall patient experience</p> <p>Improve the quality of information provided to patients and establish systematic mechanisms to obtain regular feedback from patients, staff and GPs</p> <p>Continue to improve the cleanliness of our hospitals</p> <p>Embed the outputs of the Outpatient Improvement Programme across the Trust</p> <p>Significantly reduce the rates of cancelled operations and cancelled clinics</p> <p>Ensure the timely review and adoption of NPSA and NICE guidance</p> <p>Agree priorities with stakeholders to develop our sites as health promoting hospitals</p> | <p>Chief Nurse</p> <p>Medical Director</p> |

Agenda Item 5.2

| Committee | Date | Classification | Report No. | Agenda Item No. |
|--|--------------------------------|---|------------|-----------------|
| Health Scrutiny Panel | 19 th April 2011 | Unrestricted | | |
| Report of: NHS Tower Hamlets and London Borough of Tower Hamlets Originating Officers: Richard Fradgley, Head of Mental Health Commissioning, NHS Tower Hamlets Barbara Disney, Service Manager, Strategic Commissioning | | Title: Commissioning strategy for people with dementia and their carers Ward(s) affected: All | | |

1. Summary

This report sets out the actions the Tower Hamlets Partnership will take forward to improve services for people with dementia and their carers from 2010 to 2013. It sets out the context of the strategy and details key areas of work and interventions needed. A table is set out detailing the care pathways and key interventions.

2. Recommendations

The Health Scrutiny Panel is asked to consider and comment on the information set out in the report.

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| Committee | Date | Classification | Report No. | Agenda Item No. |
|--|---------------------------------------|---|------------|-----------------|
| Health Scrutiny Panel | 19th April 2011 | Unrestricted | | |
| Report of: NHS Tower Hamlets and London Borough of Tower Hamlets Originating Officers: Richard Fradgley, Head of Mental Health Commissioning, NHS Tower Hamlets Barbara Disney, Service Manager, Strategic Commissioning | | Title: Briefing on the Commissioning strategy for people with dementia and their carers Ward(s) affected: All | | |

1. Summary

This report sets out the background and development of the Commissioning strategy for people with dementia and their carers. It details the progress made against the delivery of services to meet local need.

2. Recommendations

The Health Scrutiny Panel is asked to consider and comment on the information set out in the report.

Briefing on Commissioning Strategy for People with Dementia and their Carers

1. In August 2010, the London Borough of Tower Hamlets and NHS Tower Hamlets jointly published the attached *Commissioning Strategy for People with Dementia and their Carers*. The Strategy lays out a series of actions the partnership has committed to deliver over 2010 to 2013. The development of the Strategy was informed by *NHSTH & LBTH (2010) Joint Strategic Needs Assessment for People with Dementia and Older People with Mental Health Problems* and *NHSTH & LBTH (2010) Report on Service User and Carer Views on Services for People with Dementia*.

2. The partnership has established a *Dementia Strategy Implementation Group* to oversee the implementation of the Strategy. The Group comprises carers and service users and partners from commissioning and provider agencies, including the voluntary sector, and reports on progress to the Older Persons Partnership Board.

3. As part of the development of the Strategy, NHS Tower Hamlets committed £230,000 recurrently as part of its *2010/11 Commissioning Strategy Plan* for a Dementia Liaison Service at the Royal London Hospital, and a further £510,000 recurrently as part of 2010/11 commissioning intentions to develop and improve Memory Services in the borough.

4. Since the publication of the Strategy, the partnership has made considerable progress with its delivery, as detailed below:

- Commissioned a new Memory Service to be provided by East London NHS Foundation Trust with substantial additional capacity and new, clearer pathways in and out for service users and their carers. The aim of the Tower Hamlets Memory Service is to provide fast non-stigmatising access to specialist assessment for local residents with a memory problem, and to provide ongoing treatment, care and support when a service user is given a diagnosis of dementia and has a moderate to high level of associated need. The Service has been open since January 2011, and now has capacity for 8 new referrals per week, which it is currently receiving¹. The Service will be developing further support specific to primary care and to in-borough residential care homes during early 2011/12.
- Commissioned East London NHS Foundation Trust to sub-contract a new Dementia Adviser Service. The aim of the Dementia Adviser Service is to provide a point of contact and support for service users with a diagnosis of dementia but who have low to moderate associated needs. As a result of the fact that the Memory Service and the Dementia Adviser Service will

¹ The Joint Strategic Needs Assessment indicated that the likely incidence (i.e. new cases per year) of dementia in Tower Hamlets is in the region of 410, but that referrals to the Memory Service in 2009/10 were below half of this. As the Memory Service is now offering appointments for 8 new referrals per week, it is likely that significantly more people with newly presenting memory problems are already receiving an earlier diagnosis.

be co-located and work very closely together, over time every service user in the borough who has a diagnosis of dementia will have a named contact who is a dementia specialist worker and as a consequence will have rapid access to support, including in the event of a crisis. The Dementia Adviser Service tender is currently nearing completion, with the expectation that the tender will be awarded imminently and the team up and running by June 2011.

- Commissioned a new Dementia Liaison Service to be provided by East London NHS Foundation Trust at the Royal London Hospital. The Dementia Liaison Service will provide rapid specialist assessment to in-patients with dementia or possible dementia on general wards at the Royal London Hospital, with the aim of improving their experience and reducing their length of stay and as a consequence generating savings to the health economy. The Service is currently being recruited to and it is anticipated will be fully operational by May/June 2011. In addition, during the course of 2010/11, Barts and the London NHS Trust have made significant improvements in the care offered to patients with dementia or suspected dementia, through a programme of service improvement related to their 2010/11 CQUIN².
- Commissioned an extra care supported accommodation scheme specifically for service users with dementia, with 13-19 units. Building has very recently begun at the Shipton Street site, and procurement processes for the care provider are underway, with the expectation that the tender will be awarded by the end of May 2011, and the aim of the scheme opening by the end of 2011.
- Developed and begun to implement a three year Dementia Awareness Raising Strategy, with a focus on improving both local knowledge on dementia as a condition, and access to local services. The Strategy aims to deliver targeted messaging to older people, carers and the general population via a number of mechanisms including local publicity, structured workshops, drop-in sessions, information stalls³.
- Developed with service users and carers a set of person-centred care standards for staff working with service users with dementia, whatever the setting. Subject to final agreement by the Older Person's Partnership Board, these standards will be explicitly referenced in all contracts for services that provide specific support for people with dementia.
- Included a specific dementia care skill-set within the specification for Domiciliary Care providers in order to improve the experience of service users with dementia who receive home care support.

² CQUIN (Commissioning for Quality and Innovation) means that provider Trusts are paid a percentage of the overall contract value for delivering specific quality improvement initiatives or innovation. Improvements at BLT include, for example, front-line staff trained in dementia awareness, patients with dementia who have had their spells coded as such have almost doubled from 285 during 2009/10 to 435 YTD to February 2010/11, and average length of stay has reduced from 13 to 11.8 days.

³ For example, the Alzheimer's Society in conjunction with NHS Tower Hamlets Public Health have delivered three successful workshops to older people and carers groups, these have been very well attended and participants have found them to be engaging and useful.

- Included within the annual GP Practice Prescribing Audit, questions regarding prescription of anti-psychotic drugs to service users with dementia. The results of the audit will not be available to 2012, however some practices that cover care homes have undertaken audits during the 2010/11 audit cycle, for which results are expected by May 2011.
- Promoted better end of life care for people with dementia through ensuring that there are specific dementia care competencies built into the job description/person specification of End of Life Care Facilitator posts.

5. The Partnership is continuing to work on the following priorities:

- Residential care: The Partnership recognises the significant emphasis service users and carers have placed on the importance of quality of experience in residential care. Commissioners are in the process of updating the residential care specification to ensure it contains sufficient emphasis on quality in dementia care, and has commissioned the new Memory Service to provide liaison support to residential care homes where service users with dementia live. It is anticipated that residential care providers, Memory Service clinicians and commissioners will meet in the very near future to agree further measures to improve the experience of people with dementia in care homes.
- Respite: The Partnership is currently undertaking work to scope the range of respite options available for service users and carers, with the intention that this is published widely, both amongst staff and service users and carers.
- Development of interface between the Memory Service and GP practices: The Memory Service has been explicitly commissioned to improve communication between primary and secondary care clinicians, and is currently working with the GP Lead for Mental Health to agree measures to do so.
- Inpatients: NHS East London & The City and East London NHS Foundation Trust are currently developing a business case to support the potential reconfiguration of in-patient beds for people with dementia, including those which are currently provided within City & Hackney, Newham and Tower Hamlets. This business case will be tabled for discussion at the Health Scrutiny Panel at a later date.
- Personalised care: LBTH is committed to maximising the take up of personal budgets for all service users, including service users with dementia. Where people need assistance to exercise choice and control, and to plan and manage their support, advocacy and support services are available. There is currently underway work aimed to introduce personal budgets for carers by the end of 2011.

- Outcomes measures: The Coalition Government have published DoH (2010) *Quality Outcomes for People with Dementia: Building on the Work of the National Dementia Strategy*. This outcomes framework requires local partnerships to publish how they are providing better quality care for people with dementia against the outcomes. The Dementia Strategy Implementation Group is currently considering how to do so in Tower Hamlets.

6. In summary, considerable progress has been made in implementing the Commissioning Strategy for People with Dementia and their Carers in the borough, in the context of the cross sector support of the Dementia Strategy Implementation Group. Some of the developments already underway, such as the Dementia Liaison Service at the Royal London Hospital, potentially place Tower Hamlets at the cutting edge of dementia care in London. The Partnership intends to hold a conference/launch day in Summer 2011 to celebrate its achievements and to help to plan further improvement for the future.

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Commissioning strategy for people with dementia and their carers 2010-2013

1. Introduction

1.1 This strategy details the actions that the Tower Hamlets Partnership will take to develop and improve services for people with dementia and their carers from 2010 to 2013.

1.2 The strategy has been developed with the involvement of a range of stakeholders across the Tower Hamlets Partnership, including service users and carers, NHS Tower Hamlets (NHSTH), the London Borough of Tower Hamlets (LBTH), East London NHS Foundation Trust (ELFT) and the voluntary sector.

1.3 The strategy has been developed in the context of a range of national, regional and local policy drivers, most notably *DoH (2009) Living Well With Dementia – A National Dementia Strategy*, *DoH (2009) New Horizons – Towards a Shared Vision for Mental Health and Healthcare for London (2009) Dementia Services Guide*. The strategy is informed by the in-depth analysis of need contained in *NHSTH & LBTH (2009) Older People's Mental Health Needs Assessment* and the in-depth analysis of the views of service users and carers in *NHSTH & LBTH (2010) Service user and carer views on services for people with dementia*.

1.4 The Partnership is highly committed to improving services for people with dementia, and will between 2010 - 2013 work through this strategy to ensure that the whole system of care works together effectively to deliver accessible, high quality and value for money services for people with dementia.

1.5 The Partnership is mindful that there is currently much attention nationally on the needs of people with dementia and that services for people with dementia have been identified locally as needing significant development (NHSTH & LBTH, 2009 & 2010). The Partnership is also, however, mindful that the relationship between dementia and functional mental health problems in older people can be complex and that service users often require a service that is able to support them across a range of mental and physical health needs. Whilst this strategy focuses on people with dementia and their carers, it should be noted that services for older people with functional mental health problems (OPMH) will be impacted upon by any developments in services for people with dementia, and that the Partnership is therefore committed to developing proposals for improving services for OPMH as part of a second phase of this strategy.

1.6 The Partnership is aware that as a result of the global recession and its impact on both NHS and local authority finance for the foreseeable future, there will be a number of significant financial challenges to delivering this strategy. However many of the actions contained in this strategy can be achieved without a need for additional investment. Others can only be achieved through new investment or service re-design, a process which the Partnership recognises can be complex and time-consuming. The strategy will therefore be realised over two phases. Phase One, including most of the specific actions detailed in the body of the strategy¹, will be delivered over the course of 2010/11. The broader Phase Two actions are dependent on further, more detailed, needs and capacity analysis, and will be developed into more specific commitments during the course of 2010/11. Phase Two actions include, for example, Commissioning capacity analysis for future demand for in-patient beds in the context of current low occupancy levels.

¹ Specific actions are numbered in the body of the strategy.

2. Raising Awareness and Prevention

2.1 The Partnership recognises the need to raise awareness about dementia amongst local communities, particularly the Bangladeshi community, where there is evidence to suggest low take-up of Memory Services at an early stage. The Partnership also recognises the importance of promoting lifestyle activities that may contribute towards the prevention of dementia. The Partnership will therefore develop a structured three year awareness raising plan (1) that will be based on the best available evidence and which will specifically address:

- The stigma and consequent poor access to services that people with dementia can experience
- The benefits of timely diagnosis and care
- Awareness of dementia in the Bangladeshi and Somali communities.

2.2 Locally and nationally, carers consistently report concerns about the awareness, attitudes, knowledge and skills of health and social care staff working with people with dementia across a range of health and social care settings. The Partnership will therefore review training currently available for staff across the main agencies including NHSTH, ELFT, LBTH, BLT and the voluntary and private sector with a view to ensuring that training is of a consistently high standard, and will examine possibilities for a more coordinated approach to commissioning pan-agency training (2).

2.3 The Partnership recognises the importance of good quality accessible information for service users and carers, both written and verbal. The Tower Hamlets Alzheimers Society currently provides advice and signposting to people with dementia and their carers and has in the recent past developed a Dementia Information Guide. To develop further the accessibility of good quality information for people who have been diagnosed with dementia and their carers, NHS Tower Hamlets will in 2010/11 commission a new Dementia Adviser service (3). The Partnership will at an appropriate time commission an updated Dementia Information Guide and consider other options for publishing information via an information strategy (4).

2.4 The Partnership will work to ensure that each of the main agencies maintains information that will promote more effective monitoring of demand on services in the future through agreeing a set of metrics for measuring activity and outcomes across services (5).

3. Early Intervention

3.1 The Partnership notes the comparatively low numbers of people with dementia recorded on primary care dementia registers in the borough and in coding of dementia in patients admitted to the Royal London Hospital, and recognises the significant benefits to service users and carers in identifying possible dementia early. Awareness raising in the health and social care workforce will help staff across settings to support service users into Memory Services where appropriate.

3.2 In primary care settings, the Partnership will work to integrate screening markers for memory problems into specific primary care packages for coronary heart disease, stroke and high blood pressure (6). The Partnership will also develop and roll out a referral pathway for people with memory problems including a brief screening tool for memory problems which will be made available for use across clinical settings (7).

3.3 The Partnership will develop a “gateway” function from within the Tower Hamlets Memory Service. The gateway function will include a regular drop-in clinic provided from within primary care network centres, and will support practices with case-finding and the identification of service users who should be recorded on the primary care dementia register (8) and thereby be identified as being eligible for a physical and mental health review by their GP every fifteen months. The Partnership will also commission a re-designed Memory Service to provide regular support via consultation to each care home supporting people with dementia in the borough (9).

3.4 People with learning disabilities are at greater risk of developing dementia than the general population. The Partnership is currently developing a Joint Strategic Needs Assessment of the needs of people with learning disabilities, and will consider the implications for services for people with dementia in the second phase of this strategy (10).

4. Memory Services

4.1 The Partnership notes that pathways into and within Memory Services in Tower Hamlets can at present be confusing for service users, carers and professionals, and that the dementia and functional elements of the community mental health service for older people with mental health problems would benefit from a clearer delineation between teams. The Partnership also recognises that awareness raising in local communities and amongst professionals and a re-designed Dementia Care Pathway incorporating case-finding, will increase potential demand on Memory Services, and that an effective Memory Service will need to have adequate capacity to manage potential future demand.

4.2 The Partnership will in 2010/11 commission re-designed Memory Services as part of a new dementia care pathway (11). This will include commissioning a re-design of the current community services for people with dementia and OPMH into distinct functions, ensuring that access arrangements are clear and unambiguous for service users, carers and other teams and professionals. It is anticipated that the functions of the community mental health service for people with dementia and older people will continue to be co-located, and continue to work closely together to ensure that service users with both dementia and a functional mental health problem receive the best possible support.

4.3 A re-designed Memory Service will be compliant with best practice guidance including NICE Quality Standards for Dementia. It will provide multi-disciplinary assessment for people with memory problems including a range of specialist assessments and investigations as required by individual service users. The Service will also provide a range of therapeutic interventions in line with the needs of individual service users and carers including anti-dementia drugs, diagnostic counselling, psychological therapies for service users and carers, compensatory strategies work incorporating skills and ADL maintenance, and peer and carer support groups. The Service will provide Care Coordination under CPA for people with dementia with high intensity needs, and provide less intensive support to people with dementia with more medium intensity needs.

4.4 A re-designed Memory Service will have within it the range of skills and knowledge necessary to ensure that people with dementia receive a high quality service regardless of their age, ethnicity, gender, sexual orientation, disability or religion. The Service will have access to bilingual support and the capability to support younger people with dementia.

4.5 As noted above (para. 2.3), NHS Tower Hamlets will in 2010/11 commission a Dementia Adviser Service. This service will provide advice, information and support to

people who have received a diagnosis of dementia who have low to medium intensity needs.

4.6 As part of Phase Two of this strategy, the Partnership will consider the extent to which extending the Memory Service to out of hours would potentially contribute to better outcomes for service users with dementia and their carers and in particular in supporting service users to avoid admission to hospitals and care homes (12).

5. Living well with dementia: personalised health and social care for people with dementia and their carers

5.1 The Partnership is acutely mindful of the central importance of personalised approaches to the support of people with dementia, from the early stages of diagnosis right through to end of life care, including the attitude, approach and orientation of health and social care staff; the systems, policies and procedures that support them in their practice; and the range of choices that people with dementia and their carers have available to them. The Partnership will work with service users and carers to develop a set of standards for the personalised support of people with dementia which will be relevant to all settings, from statutory NHS services to care homes and will encourage all key providers to adopt them in practice (13). The Partnership will ensure that emerging processes for personalising social care within LBTH are fully accessible to people with dementia and their carers and will develop a guide to personal budgets specifically tailored to people with dementia and their carers (14).

5.2 The Partnership notes service user and carer feedback regarding the importance of staff skills and knowledge in providing effective, person-centred dementia care in peoples' own homes. To this end, the Partnership will ensure that a specification for a specialist dementia care skill-set is incorporated into the 2010/11 LBTH framework agreement for tendering home care services (15), and will as part of Phase Two, consider options for re-designing in-house home care services to incorporate a specialist dementia home care skillset (16).

5.3 Feedback from service users and carers regarding their experience in care homes in the borough indicates that in order to promote high quality of care for people with dementia, there is a need to ensure that care homes employ staff with the right attitude, skills and knowledge to provide personalised support. As noted above, the Partnership will, as part of a re-designed Memory Service, commission regular specialist consultation support to care homes in the borough. The Partnership will ensure that all contracts with care homes specify that a senior member of staff must be identified to take the lead on quality improvement for people with dementia and to ensure that each provider has in place a plan to improve quality of care for people with dementia including personalised care and activities (17).

5.4 Carers consistently report that access to respite where staff have specialist skills and knowledge in dementia care, is a very significant issue in enabling them to continue to care for their relatives effectively. The Partnership acknowledges current gaps in specialist respite, and will during 2010/11 develop plans to ensure that specialist respite is available from 2011 onwards (18).

5.5 The Partnership has previously developed outline plans for commissioning specialist extra-care sheltered for people with dementia. During 2010/11, the Partnership will develop these outline proposals into a firm commissioning plan (19).

5.6 In the HfL (2009) Dementia Needs Assessment, Tower Hamlets is reported to have one of the highest rates of prescription of dementia related drugs in London. The Partnership is also aware of national and local concerns regarding the prescription of anti-psychotic medication to people with dementia across health and social care settings, including care homes and hospitals. ELFT has a contractual commitment in their 2010/11 contract to review anti-psychotic prescription for service users known to them. In addition, the Partnership will undertake an audit of anti-psychotic prescription of service users living in care homes and an audit of anti-dementia drug prescription (20).

6. Living Well with Dementia: Hospital Care

6.1 People with dementia and their carers consistently identify concerns with their experience in general hospitals, both locally and nationally. NHS Tower Hamlets will in 2010/11 commission a new Liaison Service to the Royal London Hospital, the aim of which will be to significantly improve care pathways, outcomes and the experience of people with dementia when they are admitted to the Royal London Hospital. The new Liaison Service will specifically target reducing length of stay in general hospital care for people with dementia, and in so doing will provide case-finding, clinical assessment and care planning, discharge planning, and awareness raising training for staff (21). In line with the National Dementia Strategy, Barts and The London NHS Trust will elect a senior clinician to take the lead for quality of care for people with dementia at the Royal London Hospital (22).

6.2 The Partnership will as part of Phase Two of this strategy undertake a detailed analysis of in-patient bed demand and supply in order to develop a model for the future design of in-patient services for people with dementia and OPMH which provides value for money, is evidence-based, high quality, and consistent with the needs of Tower Hamlets service users and carers (23).

6.3 The Partnership notes that there are potentially a significant number of people with dementia who are admitted to beds at the Bancroft Unit, Mile End Hospital, including intermediate care. NHSTH Commissioners are currently reviewing in-patient beds at the Bancroft Unit and intermediate care and the Partnership will consider the implications of the Review for people with dementia and their carers in the second phase of this strategy (24).

7. Living Well with Dementia: Carers

7.1 The Partnership is very aware that carers provide the majority of support received by people with dementia in Tower Hamlets, and that in order to support people with dementia effectively, the Partnership needs to ensure that their carers are also supported effectively.

7.2 Many of the areas that carers have raised as important to them have already been identified as actions above, e.g. better information, more effective co-ordination along an identified dementia care pathway, better awareness, attitudes and knowledge in health and social care staff, better general hospital care, specialist home care, and adequate access to specialist respite.

7.3 The Partnership will in the re-design of a dementia care pathway ensure that the needs of carers are taken fully into account, including access to carer's assessment, access to supportive therapies including psychological therapies and access to carers' peer support groups (25). The Partnership will undertake a review of the evidence of the effectiveness of

telecare for people with dementia and their carers and consider the implications for a more focussed roll-out of telecare to people with dementia and their carers as a result (26).

8. End of Life Care

8.1 The Partnership recognises that providing end of life care for people with dementia can be very complex and includes facilitating choice, promoting dignity and effectively managing complex physical and mental health problems in people at the end of life including pain management.

8.2 The Tower Hamlets Delivering Choice Programme is currently developing an end of Life Pathway which will provide good practice guidance for staff supporting people with any condition at the end of life. When complete, the Pathway will be rolled out to all teams working with people with dementia (27).

8.3 NHS Tower Hamlets is currently developing job profiles for two new “End of Life Care Facilitator” posts, one specifically for care homes and one for the community including ELFT and Community Services in-patient beds at Mile End Hospital. The post-holders will be responsible for supporting staff to provide effective end of life care, and this will explicitly include people with dementia (28).

9. Whole system effectiveness

9.1 People with dementia currently receive support across a number of health and social care settings. In the future, this will continue, according to the needs of service users and carers, but with staff across the board trained in dementia awareness and a named contact either in the Memory Service or Dementia Adviser Service, people with dementia and their carers will find the system easier to navigate.

9.2 In order to promote effective working across the whole system, however, there will need to be clear cross-agency protocols in place that ensure smooth transition for service users and carers, for example between the Dementia Advisers and the Memory Service, or District Nurses and Older Person’s Social Workers. For many service users, the Single Assessment Process and the Care Programme Approach will ensure that the service they receive is seamless. In order to ensure that the system is seamless for all service users and carers, the Partnership will consider commissioning the Memory Service to adopt the Single Assessment Process, which is currently used across other agencies that deliver care to people with dementia in the borough (29).

10. Governance

10.1 The NHS Tower Hamlets Mental Health Commissioning Team, as the Lead Commissioner for the dementia workstream, will report progress in delivering this strategy to the Joint (NHSTH & LBTH) Commissioning Executive and the (shortly to be established) New Horizon’s Partnership Board and the Older Person’s Partnership Board.

10.2 The Partnership will self-assess its performance against the NICE Dementia Quality Standards when published (30).

10.3 The Partnership will develop a Communications Plan, to ensure that service users and carers and other key stakeholders are aware of the detail of this Strategy (31).

CARE PATHWAY FOR PEOPLE WITH DEMENTIA AND THEIR CARERS

| CARE PATHWAY | Awareness Raising | Identification | Assessment & Diagnosis | Living Well with Dementia (Coordination of Care) | Living Well with Dementia (Personalised Health and Social Care in the Community) | Living Well with Dementia (Hospital Care) | Living Well with Dementia (Carers) | End of Life Care |
|--|---|---|---|--|---|---|---|--|
| <p>KEY INTERVENTIONS</p> | <p>Promotion initiatives aimed at general population</p> <p>Promotion initiatives aimed at targeted communities including BME communities and hard to reach groups</p> <p>Information strategy to include revision of Tower Hamlets Dementia Guide</p> <p>Front-line staff (including voluntary sector, care homes, home care) trained in dementia awareness and sign-posting</p> | <p>Screening for people at risk in primary care</p> <p>Use of standardised screening tool and referral protocol</p> <p>Memory Service Primary Care Liaison & Primary Care Clinics (to include case finding function & support with primary care dementia register)</p> <p>MHCOP Liaison Service at Royal London Hospital (to include case finding function)</p> <p>Memory Service support to care homes</p> | <p>Referral to Memory Service for full multi-disciplinary assessment including investigations and diagnosis, carers assessment</p> <p>12 week post-diagnosis care plan including treatment with anti-dementia drugs, diagnostic counselling, psychological therapies, compensatory strategy work including skills & ADL maintenance</p> | <p>A support plan for all service users with a diagnosis of dementia including named specialist follow-up, depending on need, by either Dementia Adviser (low intensity), Memory Service Out-patients (medium intensity), Memory Service Care Coordination under CPA (high intensity), reviewed regularly in line with service user and carer need</p> | <p>Peer support groups</p> <p>Specialist home carers skilled in supporting people with dementia</p> <p>Specialist respite care</p> <p>Specialist extra care sheltered housing</p> <p>Specialist day care</p> <p>Quality assured care homes with staff trained in person centred dementia care</p> | <p>Access to support in crises, including in-patient care</p> <p>MHCOP Liaison care & discharge assessment & planning, advice, consultation and liaison to service users and teams at the Royal London Hospital</p> | <p>Carer support groups</p> <p>Memory Service carer assessment and support planning including psychological therapies</p> | <p>End of Life Care Pathway for people with dementia across settings, including home, care homes and hospitals</p> <p>Community and Care Home End of Life Facilitators with skills in, and responsibility for, people with dementia who are dying to support people with dementias and the professionals directly involved in their care</p> |
| <p>Dementia Advisers providing advice, information, and support to people with a diagnosis of dementia with low to medium intensity needs via support plan.</p> | | | | | | | | |
| <p>Memory Service providing assessment, 12 week post-diagnostic care plan, periodic support for people with medium intensity needs, care coordination under the Care Programme Approach for service users with high intensity needs.</p> | | | | | | | | |
| <p>Primary care: maintenance of primary care dementia register, 15 month physical and mental health primary care review of people on the register</p> | | | | | | | | |
| <p>Clear cross-agency protocols to ensure smooth transition between agencies and services</p> | | | | | | | | |

Note: This care pathway details interventions specific to service users with dementia and their carers. Service users and carers will continue to be supported to access mainstream services wherever this is in line with their needs.

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Agenda Item 5.3

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| Committee Health Scrutiny Panel | Date 19th April 2011 | Classification Unrestricted | Report No. | Agenda Item No. |
| Report of: New Residents and Refugee Forum Originating Officer: Vaughan Jones, Vice Chair | Title: New Residents and Refugee Forum – Health report Ward(s) affected: All | | | |

1. Summary

- 1.1 This report sets out the background of the Tower Hamlets New Residents and Refugee Forum and sets out the findings of its work with residents looking at access to healthcare services.

2. Recommendations

- 2.1 The Health Scrutiny Panel is asked to comment on the findings and the recommendations of the Tower Hamlets New Residents and Refugee Forum.

Tower Hamlets New Resident and Refugee Forum Recommendations from Health Seminar, December 2009

The Tower Hamlets New Residents and Refugee Forum (NRRF) is a multi-agency forum which comprises of members drawn from the local authority, statutory services, third sector organisations (including faith and cultural groups) as well as direct community representatives. The NRRF convenes to allow members of new communities to have a voice within local services and policy areas.

In late December 2009 the focus of the NRRF was 'Access to Healthcare for New Residents'; over 70 participants attended to share their experiences of accessing healthcare and their views on current provision in the Borough. Key issues raised at the forum were then the focus of a Working Group in April, which met to outline next steps in improving services for these community members.

Included below are some specific proposals from the forum which we believe would contribute to direct improvement in the experiences of Tower Hamlets residents in accessing healthcare as well as sustaining costs savings by reducing the number of people who have to access healthcare inappropriately, such as through Accident and Emergency because it is their only alternative. The NRRF request the Health Scrutiny Panel note these key issues emerging from the Health seminar and consider ways it can support the NRRF to take forward these strategic recommendations.

Background

Major barriers in accessing healthcare exist for new residents and refugees who are often the most vulnerable members of our community. Some people do not know how to access NHS services. Others lack information in their own language and are unable to understand how the NHS works or how to register with a GP. Similarly, some are not clear about their rights to NHS treatment whilst some NHS staff are unclear about eligibility or entitlements to healthcare. Some GP surgeries, unaware of the discretion they are entitled to use have turned away new community members on the basis of immigration status incorrectly. If people are barred access to GPs, they will be left with no other choice than to seek care at A&E centres¹.

Race Equality Foundation (REF), provided a keynote speaker at the forum who outlined the regional policy context:

Stereotypes continue to prevail and BME communities continue to be perceived in a particular light. Ethnicity has both risk and protective factors, for example older people from BME communities have a stronger state of mental well being, and kin relationships constitute a protective hub for community members. At a community level, research shows that poor young males are more likely to be murdered if they live in a high crime area which should therefore be considered as a health factor/risk. Risk factors exist for those escaping war but health access can be improved if community members have access to education.

Evidence suggests that there are significant improvements but racism persists. Infant mortality continues to be present as an issue for the Pakistani and Caribbean community. Appropriate and accessible healthcare can and do transform healthcare experiences and improved services for BME communities translates into an improved service for all underlining the false misconception that BME communities are unfairly given too much attention in the tailoring of services.

Evidence must drive the tailoring of services – such an approach has seen improvements in smoking cessation amongst Bangladeshi men and a reduction in Prostate Cancer for

Caribbean men. Such an evidence based approach can lead to effective engagement; address access issues and; help to develop appropriate services.

Doctors of the World UK (formally Medecins du Monde) gave further insight into the experience and issues faced by new migrant in relation to accessing healthcare:

Doctors of the World's "Project London" is a Tower Hamlets based advocacy service for vulnerable communities including new and established migrant communities. Doctors of the World UK records the issues faced by vulnerable communities to further their advocacy work, and have highlighted the top five barriers to accessing healthcare which include (1) administrative difficulties, (2) knowledge of systems, (3) language barriers which leads to further problems in diagnosing and prescribing, (4) fear of reporting to the UKBA who have recently been writing to GPs/PCT requesting information on their patients, and (5) refusing to provide care.

The fact that Doctors of the World UK is needed to provide a service like Project London highlights the shortcomings of the NHS. Patients should only be turned away from GPs for 2 reasons; (1) the patient lives outside the GP catchment area and (2) the registration list is closed. There are high risks in people not being able to access healthcare, highlighted by the rise in measles due to people not accessing injections. A further risk lies in people accessing healthcare elsewhere. Apart from being unlawful (please see attached slides), refusing people healthcare is also uneconomic with the cost of a GP representing a quarter of the cost of A&E and also impeding national targets of seeing 4 patients an hour.

Findings and recommendations

1. Guidelines and Training for front-line staff

The first concern to new residents and those working alongside these communities is the lack of clarity which exists at the front line service provider level, particularly within GP practises, in relation to new communities and their entitlement and eligibility for primary care. Forum members shared experiences of secondary care rules being implemented at a primary care level. This was further substantiated by third sector advocates, particularly Doctors of the World UK who provide health advocacy to those unable to access healthcare services.

Although no definitive figures exist which quantify the number of people unable to access primary healthcare due to the often irregular and hidden nature of the most vulnerable community members, a recent Freedom of Information request revealed that the number of persons admitted to the Accident and Emergency department at The Royal London Hospital who were not registered with an NHS GP was 18,847 in the year 2008 and 17,075 in 2009ⁱⁱ. Please find attached anonymous case studies which point to current practise.

The forum recommends that simple guidelines which provide clarity be provided to front-line staff. Currently, confusion and misunderstanding cause people to be refused registration and treatment incorrectly. We are aware that such practises are creating misgivings and fear amongst the communities with an obvious impact on their health. Please find attached guidance produced by Doctors of the World UK, which may act as a guide and would constitute a step forward in tackling this issue. The forum also recommends this is complemented by training to all front line staff as part of their induction and to become a regular feature of any ongoing training programmes.

2. Enforcement of written confirmation of refusal to register

A second concern was raised in relation to community members being refused GP registration without a letter being issued to confirm the reason addressing why they could not register. This

should be standard practice, and whilst it is not put into practice the London Borough of Tower Hamlets is unable to keep track of the number of people who are being refused primary healthcare access. The forum hopes you will be able to take a lead to ensure all GP practices are fulfilling this statutory duty.

Other recommendations include providing GP registration forms in languages which reflect our diverse borough, and finding some measure of GP registration practises within the Quality and Outcomes Framework Assessment to ensure best practice is always implemented.

Representatives of the forum greatly appreciate the opportunity to come and discuss these concerns and recommendations with the Health Scrutiny Panel in further detail.

ⁱ Médecins du Monde UK Annual Report 2007

ⁱⁱ It should be noted that this figure also includes those who had no 'valid GP code' entered.

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| Committee Health Scrutiny Panel | Date 19th April 2011 | Classification Unrestricted | Report No. | Agenda Item No. |
| Report of: The Tower Hamlets New Residents and Refugee Forum Originating Officer: Vaughan Jones, Vice Chair | | Title: Addressing the issues of accessing healthcare faced by new migrants in Tower Hamlets Ward(s) affected: All | | |

1. Summary

- 1.1 The Tower Hamlets New Residents and Refugee Forum held a seminar exploring access to healthcare services for new residents and refugee. This report puts forward the detailed findings of the seminar.

2. Recommendations

- 2.1 The Health Scrutiny Panel is asked to discuss and contribute to the suggestions for addressing the barriers identified.

Addressing the issues of Accessing Healthcare faced by New Migrants in Tower Hamlets: Minutes from seminar held on 3rd December 2009

Background

Major barriers in accessing healthcare exist for new residents and refugees who are often the most vulnerable members of our community. Some people do not know how to access NHS services. Others lack information in their own language and are unable to understand how the NHS works or how to register with a GP. Similarly, some are not clear about their rights to NHS treatment whilst some NHS staff are unclear about eligibility or entitlements to healthcare. Some GP surgeries, unaware of the discretion they are entitled to use have turned away new community members on the basis of immigration status incorrectly. If people are barred access to GPs, they will be left with no other choice than to seek care at A&E centres (Médecins du Monde UK Annual Report 2007).

This seminar was coordinated to provide the space for a wide range of stakeholders from public and third sector organisations, and new migrants in Tower Hamlets to come together to explore the barriers in accessing healthcare faced by new migrants in the borough. The objectives of the event were to:

- better understand the healthcare experiences of new migrants living in the Tower Hamlets;
- hear from local organisations about the healthcare support provided to new migrants in the borough and the issues that they encounter;
- and finally, to explore how agencies can work together to better facilitate access to healthcare and other health needs of migrants in Tower Hamlets.

Core issues from buzz groups

1. The ability of new communities to access secondary healthcare
2. Who are new communities? A need for information sharing
3. Communication barriers – particularly amongst older residents
4. Lack of knowledge and understanding with regards to cultural issues
5. Tower Hamlets has a long history of migration; we need confidence in our ability to deal with new communities

Keynote Speakers

Jaberr Butt – Race Equality Foundation (REF)

REF established to (1) document and understand discrimination; (2) develop interventions that will overcome barriers and promote equality and; (3) disseminate information through training.

Stereotypes continue to prevail and BME communities continue to be perceived in a particular light. Ethnicity has both risk and protective factors, for example older people from BME communities have a stronger state of mental well being, and kin relationships constitute a protective hub for community members. At a community level, research shows that if poor young males are more likely to be murdered if they live in a high crime area which should therefore be considered as a health factor/risk. Risk factors exist for those escaping war but health access can be improved if community members have access to education.

Evidence suggests that there are significant improvements but racism persists. Infant mortality continues to be present as an issue for the Pakistani and Caribbean community. Appropriate and accessible healthcare can and do transform healthcare experiences and improved services for BME communities translates into an improved service for all underlining the false misconception that BME communities are unfairly given too much attention in the tailoring of services.

Evidence must drive the tailoring of services – such an approach has seen improvements in smoking cessation amongst Bangladeshi men and a reduction in Prostate Cancer for Caribbean men. Such an evidence based approach can lead to effective engagement; address access issues and; help to develop appropriate services.

Angie Heathfield and Mary Morgan – Tower Hamlets PCT

2007 saw a plethora of research become available which helped develop Tower Hamlet's access strategy. This research highlighted the issues of (1) citizenship training, (2) health literacy, (3) quality interpreting and (4) flexible appointments. This research also indicated that A&E services are inappropriately accessed due to dissatisfaction with GPs and the assumption that the service at A&E will be more thorough. The issue of convenience was also raised as a reason why people inappropriately access A&E care.

In response to this research a number of TH PCT initiatives have begun, including a Multilanguage guide on how to access healthcare, a partnership with London Muslim Centre through the faith and health project, training for front line staff and investment in an interpreting service.

A policy for registration has also been drafted which provides clarity for registration, with particular reference to the issue of what documentation is needed. Within this policy is the outline for registration to be available everyday as opposed to particular days of the week, with guidance for appointments not to be held back whilst patients have not yet had their medical check. This guidance advises GPs that services should be made available to ordinary residents which includes refugees and asylum seekers, where refusal can only be made on suitable grounds. This policy also outlines the discretion GPs have to treat visitors if GPs are satisfied that the visitor lives in local area.

Amanda Troughton and Penny Louch – Health E1

Health E1 is a PCT managed nurse led health practice for street homeless and hostel dwellers – an excluded group which includes those without addresses or identification. The service was set up to address the inappropriate use of A&E. Health E1 operates a walk in clinic and has a resident mental health nurse; unheard of in primary care. The aim of the surgery is to provide healthcare for those who cannot access mainstream healthcare without a fixed address. Health E1 has interpreters to help overcome language barriers and has won several awards for reducing health inequalities.

Patients present with a number of health concerns though there is a high prevalence of severe depression and post-traumatic stress disorder amongst refugees and asylum seekers. Often, patients also present with other issues such as housing or welfare advice. Therefore Health E1 has built a good relationship with other services such as the Dellow Centre, Whitechapel Mission, CRISIS and Praxis. Many of the patients are not entitled to secondary care or benefits which means that although they may be issued with a prescription they still do not have the means to pay for the prescription. Health E1 have taken on clients who have been to other practices and been turned away, highlighting that this is a practise which still exists.

Wayne Farah – MdM/Newham PCT

Medecins du Monde (MdM) is an advocacy service for vulnerable communities including new and established migrant communities. MdM records the issues faced by vulnerable communities to further their advocacy work, and have highlighted the top five barriers to accessing healthcare which include (1) administrative difficulties, (2) knowledge of systems, (3) language barriers which leads to further problems in diagnosing and prescribing, (4) fear of reporting to the UKBA who have recently shown to have been writing to GPs/PCT requesting information on their patients, and (5) refusing to provide care.

The fact that MdM is needed to provide a service like Project: London highlights the shortcomings of the NHS. Patients should only be turned away from GPs for 2 reasons; (1) the patient lives outside the GP catchment area and (2) the registration list is closed. There are high risks in people not being able to access healthcare, highlighted by the rise in measles due to people not accessing injections. A further risk lies in people accessing healthcare elsewhere. Apart from being unlawful (please see attached slides), refusing people healthcare is also uneconomic with the cost of a GP representing a quarter of the cost of A&E and also impeding national targets of seeing 4 patients an hour.

Workshop Feedback

1. Key issues for new community members in accessing healthcare for the borough

Language

Language barriers were consistently raised as a key issue. This issue was raised not simply in relation to the lack of English as a first language but also staff understanding of the language being used. This issue is compounded by high level of illiteracy within some communities (this issue was raised with reference to the traveller community). Both factors lead to lack of confidence to navigate system. Currently there are not appropriate systems in place between new communities and healthcare translators/interpreters

Knowledge and confidence in Systems

Knowledge about services was raised with reference to both new communities and GP and NHS staff. The issue of new communities not having an understanding of systems was raised e.g. what needs paying for; what is free; and location. This in turn led to the problem of new communities being unable to navigate the system, with a need to help people understand the system identified. This problem is exacerbated by the overwhelming number of services that are out there; confusion exists over which one to access, particularly as the appropriate service keeps, or is seen to keep, constantly changing.

Service providers also have a lack of knowledge of what they are obligated to provide. NHS staff do not have an understanding of policies or entitlement to services, particularly in relation to community members with no recourse to public funds, leading to assumptions with regards to access. A further lack of information also existed specifically with regard to new communities which were seen as creating additional obstacles in the access of services. Questions posed included 'who are new communities and have we registered them?' This lack of information led to misconceptions; younger generation minority staff not necessarily having the language skills they are presumed to have (e.g. Bengali, Sylheti). The broad definition of 'new community' was problematic in that established or fringe communities might not being recognised as a migrant community yet still have needs.

Other issues raised include:

- Lack of confidence in accessing services (not confidential) - Fear of being reported to UKBA
- Trust in the system still does not exist – some Spanish speaking migrants calling original countries
- People with learning disabilities – health trainers not having an understanding of the issues and communication breakdown

Cultural Awareness

The lack of cultural awareness was raised as an area of concern. This may be due to NHS/PCT/GP's staff not having the appropriate training or understanding of different culture/faiths/traditions in order to respond to new communities appropriately. A need was raised for appropriate cultural sensitivity in health services, including sensitivity in relation to religion and faith of service users.

Further, a need for particular training for staff working with communities likely to present with certain conditions was identified, such as PTSD.

Structural Barriers

Current systems in place were also discussed as posing difficulties for new communities to access health services. These included the:

- Barrier of geographical commissioning of services; doesn't fit these transient communities e.g. accessing mental health services across areas – barrier to integration of services
- Screening on arrival for new migrants and information and referrals into other programmes can lead to stigma regarding new communities and particular
- Lack of flexibility of appointments including time you call to make an appointment
- There was recognition that policy does exist but barriers persist, such as GPs continuing to ask for unnecessary documentation;
- 'Connecting for health' requires certain information for surgery to get paid
- Health professionals not signposting properly to GPs
- Systems that block people being registered i.e. computer database for registering patients

Other issues raised include:

- New communities may lack access to social networks that enable insular communities to access health services and health care
- New communities may face a lack of freedom. This was raised in reference to migrant groups who are controlled by third parties, such as within the informal employment sector. GP registration is not a high priority for these groups or those that employ them.

Despite the above issues raised it was felt necessary to understand the different pressures health services are under and the priorities on services placed upon them.

2. Methods to ensure discrimination does not happen in practice/surgery/workplace

Training and culture shift

The emphasis on training within health services was raised by a number of participants. It was felt there was a need to develop a 'culture shift' towards a non judgemental approach which has a

strong ethos of equalities and diversity. This needed to be reflected in the robustness of PCT commissioning, and could be made possible through the health networks. A change from the top must be combined with increased customer care training of front line staff. Standards at reception must be reinforced with a zero tolerance to discrimination, including tackling discrimination internal within communities' e.g. Bangladeshi discrimination against Bangladeshi.

In summary:

- GP training and education provided by PCT and/or voluntary sector e.g. MdM training; good training must be compulsory for all front line staff especially reception staff around entitlement and discrimination, equality, cultural awareness. This could be made a requirement through commissioning contracts e.g. access LES. PCT could provide obligatory training for all practice managers across the Borough – example of Newham training for receptionists was cited.
- We shouldn't have to depend on sympathetic doctors or other staff – how can we use sympathetic doctors to set standards
- Competency and training of all staff should be made available at all levels (also in relation to different cultures/faiths/traditions)
- Importance of engaging cultural/faith groups and in particular community leaders from within those groups

Other solutions

- People need more information of entitlement – being able to challenge knockbacks
- A 'statement of fact', using different mediums (leaflets, posters, DVDs) in each GP surgery and other service providers, about entitlement to healthcare services, translated into different languages for staff and patients.
- Good communication/information to patients about their rights and where they should be accessing healthcare (e.g. registering with a GP, not continually using walk in service)
- Focus on health advocacy and legal advocacy not just interpreting. Need system to get advocacy for treatment and advice about payments if patients can't afford it, as well as for issues about follow up and secondary care
- One clear guidance across all agencies and voluntary sector
- Specialist service for new communities
- PCT needs to have 1 point of contact when issues are being raised by advocates of new migrants

3. Tower Hamlets current local response and adequacy

This section received the least feedback which despite short time considerations seems telling in itself. One participant felt that there was no equity across Boroughs and different communities though this was not elaborated upon.

4. Methods to allow agencies to better work together to meet the healthcare needs of migrants in Tower Hamlets

A number of suggestions were made including:

- Better information sharing across Borough and pan-London for patients and service workers, including central points of information e.g. information about community groups, refugee centres, services, entitlements – possibility of web based resources which is easily accessible and available in different languages

- Partnerships between NHS and community organisations – closer working in areas such as needs assessment; Tower Hamlets needs to build better relationship with agencies such as MDM
- Look at what is successful in other Boroughs regarding these population groups and their access to services e.g. Newham has incredibly diverse populations groups – how do they do it?
- Joint information sharing between Newham and Tower Hamlets
- Free ESOL training for migrants
- One stop shop for migrants with no recourse to public funds
- Co-ordination of services – integrated care services
- Boroughs health line service could refer to other agencies – better joining up of help line
- Being able to provide better information to patients on service provision – waiting times etc.

5. Key issues to take forward and closing remarks

- Need for a specialist service
- PCT needs to have 1 point of contact when issues are being raised by advocates of new migrants
- Interpreting can improve confidence and quality of a service
- Need for understanding of changing systems –both staff and communities
- Lack of confidence to challenge practice – need to empower service users
- Mission statement – reminder of entitlement
- Need for audio materials and not just written (see Newham)
- Incorrect signposting
- Education of GPs by PCT – PCT blame GPs and vice versa. Need for training to change culture – administration desk not prepared to deal with complex issues patients present with. Training should start at what people really think to uncover prejudices and challenge misconceptions and then be moved towards what they should be thinking. Training must be enforced with a zero tolerance policy of discrimination
- IT failure
- Surveys which register patient satisfaction do not reach hard to reach communities
- Health hotline should have information on NRPF
- Children’s Centres can play bigger role in disseminating information
- Recognition of Tower Hamlets as place where new communities settle

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Agenda Item 5.5

| Committee | Date | Classification | Report No. | Agenda Item No. |
|---|-----------------------------|---|------------|-----------------|
| Health Scrutiny Panel | 19 th April 2011 | Unrestricted | | 1 |
| Report of: Service Head One Tower Hamlets Originating Officers: Jebin Syeda, Scrutiny Policy Officer | | Title: Scrutiny challenge session report – Cancer – the development of early diagnosis and preventative services Ward(s) affected: All | | |

1. Summary

- 1.1 This report sets out the outcome of the recent scrutiny challenge session on cancer – the development of early diagnosis and preventative services. The report identifies the reasons why cancer is a pressing health issue in Tower Hamlets and sets out the findings of the challenge session. It details a number of recommendations and the context in which they were made.

2. Recommendations

- 2.1 The report has been presented to the Overview and Scrutiny Committee. The Health Scrutiny Panel is asked to note this report.

3. Introduction

- 3.1 This report provides a summary of the scrutiny challenge session on the development of early diagnosis and preventative services for cancer in Tower Hamlets, held on 18th January 2011 at Mile End Hospital. The session provided councillors and local health professionals the opportunity to listen to the experiences of local residents using cancer related services, in the context of local service provision, to develop key recommendations to contribute to improving early diagnosis and preventive services for cancer.
- 3.2 The session was attended by 23 people and was chaired by Councillor Tim Archer and fellow councillors facilitated the smaller workshops. These Councillors were Cllr Anna Lynch, Cllr Gloria Thienel, Cllr Lesley Pavitt and Cllr Rachael Saunders. The session was also attended by health professionals, members of Tower Hamlets Involvement Network (THINK) and local residents who are cancer patients or are/have been involved in the care of someone with cancer.
- 3.3 The challenge session took place at Mile End Hospital to enable local residents and patients to come along. The session was structured to enable exchange of information about the local approach to addressing cancer issues and an opportunity to hear stories from residents and patients about their experience of using local health services. These were then further explored in group settings involving residents, health professionals and councillors to identify ways of improving services.

4. Purpose

4.1 Health scrutiny challenge sessions are designed as a quick way for Councillors to look at a key policy area in one meeting to ensure a robust check on NHS and Council policies in relation to health. They are also usually held outside of the town hall to encourage openness and enable community involvement. Local scrutiny will increasingly have a stronger role to play as the Public Health White Paper, 'Healthy Lives, Healthy People'¹ recognises that local government is best placed to influence many of the wider factors affecting peoples health and wellbeing, thereby promoting a central role for local authority in public health. More importantly, because decision making and commissioning will be managed at sector level, it will be important to strengthen local accountability to ensure local needs and local solutions are identified and implemented.

4.2 The purpose of this scrutiny challenge session was to:

Develop Members and residents understanding of cancer issues in Tower Hamlets and the development of early diagnosis and preventative services.

4.3 The key objectives of the challenge session were to:

- Support the improvement of life expectancy in the borough by contributing towards increasing cancer survival through improving early detection of cancer and addressing the low uptake of screening services;
- Improve resident awareness of cancer and the important role that councillors and residents have to play in their communities to encourage prompt diagnosis and treatment;
- Assist in tackling a challenging priority for the health and wellbeing of residents through the involvement of members of the community.

5 Cancer Strategy

5.1 Both the national and local cancer strategies have in place objectives for reducing the incidence of cancer by focusing on prevention in addition to managing cancer treatment and care.

5.2 Improving Outcomes: A Strategy for Cancer

5.3 The national strategy for tackling cancer sets out the need to achieve earlier diagnosis of cancer, it states that cancer diagnosis at a later stage is generally agreed to be the single most important reason for lower survival rates in England. Treatment is most effective and survival is better when cancer is detected and treated earlier. The national strategy Improving Outcomes: A strategy for Cancer², sets out the following aims in relation to cancer:

- Reduce the incidence of cancers which are preventable, through changes to behaviour and the environment such as stopping smoking, being more physically

¹ <http://www.dh.gov.uk/en/PublicHealth/Healthyliveshealthypeople/index.htm>

² http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123394.pdf

active, eating a healthier diet, moderate consumption of alcohol and reducing exposure to carcinogens;

- Improve access to screening for all groups and introduce new screening programmes where there is evidence they will save lives and are recommended by the UK National Screening Committee;
- Achieve earlier diagnosis of cancer, to increase the scope for successful treatment;
- Make sure that all patients have access to the best possible treatment;
- Address the challenge that inequalities in cancer mean that some groups in society have disproportionately poor outcomes.

5.4 **Reducing cancer mortality in Tower Hamlets – the local cancer strategy**

The local cancer strategy is currently in draft form, however in line with the national strategy 'Improving Outcomes: Improving Cancer', the key objectives the local strategy sets out are to:

- Reduce the number of people who develop cancer through prevention programmes that address both health related behaviours and the environment in which people live and work;
- Improve cancer survival by promoting early diagnosis and access to the highest quality treatment and care;
- Increase the uptake of screening;
- Increase early presentation by raising public awareness of cancer symptoms and the importance of seeking medical advice early;
- Identify and remove delays in referral for specialist diagnosis and treatment;
- Ensure that cancer patients in Tower Hamlets have access to the highest quality treatment and care, including support for cancer survivors to both improve their wellbeing and quality of life and to reduce the risk of recurrence of cancer;
- Ensure that cancer patients whose condition is no longer amenable to treatment receive the best possible end of life care when it is needed.

6 **Background**

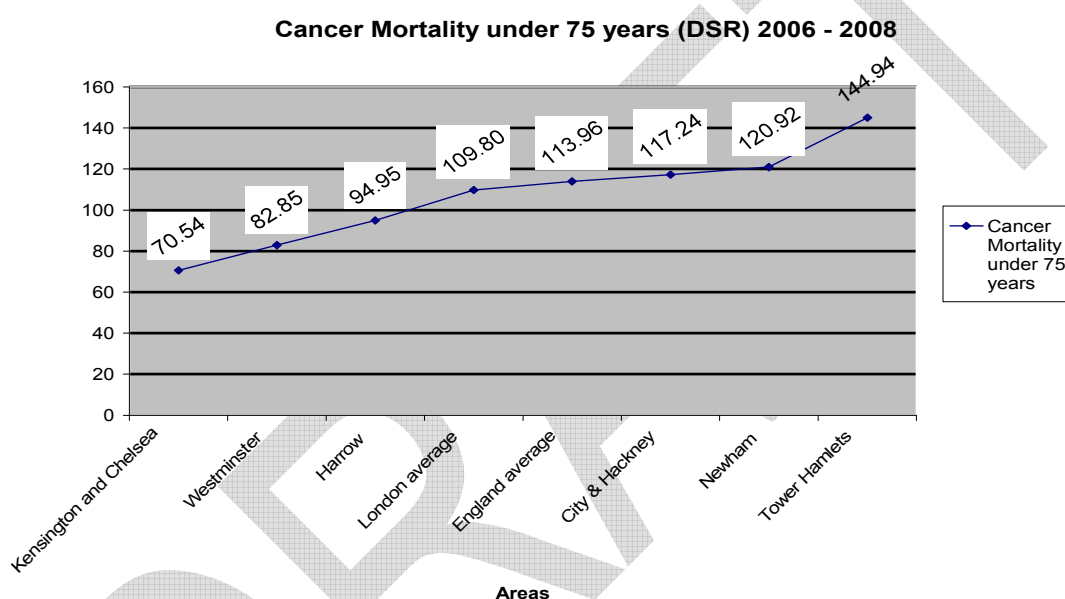
6.1 Cancer is a frightening term for people, even more so for people living in multiple deprivation in a borough like Tower Hamlets as it is the largest cause of premature death³. The individual loss of life impacts on a wide range of aspects in this borough which has a young population. Cancer not only has a high financial cost to society in terms of treatment but also to families where the loss of an adult often increases the need for support services, particularly in cases where young families are involved. In addition to the devastating human impact, cancer also has a significant financial

³ Reducing Cancer Mortality in Tower Hamlets: a strategy for improvement 2011 - 2015

impact on the NHS and the wider economy. The cost of cancer was 18.33 billion in the UK in 2008 and it is estimated that these costs will increase to 24.72 billion by 2020⁴.

6.2 Despite the medical advances and the improvements in survival and mortality in recent times, cancer outcomes in England are poor compared with the best outcomes in Europe⁵. A significant gap remains in survival and mortality. Health inequalities continue to persist in Tower Hamlets. The gap in life expectancy between the richest and poorest neighbourhoods in England is 7 years⁶. The North East London sector, and Tower Hamlets in particular has amongst the lowest cancer survival rates in the country⁷. A local comparison (see Table 1) indicates that someone living in Tower Hamlets is twice as likely to die prematurely from cancer than someone living in Kensington and Chelsea. The need for improving prevention and diagnosis is vital because of this pressing health inequality.

Table 1 Cancer mortality - PCTs and London and England average



6.3 The focus on cancer is important because this borough has the highest mortality rate from cancer in London for people of all ages and for people aged under 75⁸ and is ranked at 322 of 326 Local Authorities. Accounting for more than 54% of all new cases and 35% of cancer death in England and Wales, the four most common cancers in Tower Hamlets are breast, lung, colorectal (bowel) and prostate cancer. These cancers accounted for more than 47% of cancer deaths in Tower Hamlets in 2006 to 2008. A significantly large proportion of these were deaths from lung cancer (28.5% of all cancer deaths). Because lung cancer has amongst the lowest survival and highest mortality rates of all cancers, a high incidence of lung cancer makes cancer outcomes in Tower Hamlets worse than those for both London and England.⁹

⁴ Reducing Cancer Mortality in Tower Hamlets: a strategy for improvement 2011 - 2015

⁵ Department of Health - Improving Outcomes: A Strategy for Cancer, January 2011

⁶ Public Health White Paper, Healthy Lives, Healthy People

⁷ Reducing Cancer Mortality in Tower Hamlets: a strategy for improvement 2011 - 2015

⁸ Deaths before the age of 75 years are defined as premature.

⁹ Reducing Cancer Mortality in Tower Hamlets: a strategy for improvement 2011 - 2015

The table below (Table 2) further illustrates cancer survival rates for the four most common cancers. Poor survival is likely to be closely linked to late diagnosis of cancer. To improve survival rates, there is therefore a need to focus on earlier diagnosis. Early diagnosis is affected by peoples' understanding of cancer and recognition of its symptoms, late presentation to the GP/primary care and/or access issues to health care services. Whilst all these issues need to be addressed, the national and local cancer strategies have focused not only on early diagnosis but also preventative measures.

Table 2 1 Year and 5 year survival from the commonest cancers in Tower Hamlets*

| Lung Cancer | Breast Cancer | Colorectal Cancer | Prostrate Cancer |
|--------------------|---------------------|---------------------|---------------------|
| 29% survive 1 year | 89% survive 1 year | 70% survive 1 year | 90% survive 1 year |
| 9% survive 5 years | 74% survive 5 years | 48% survive 5 years | 65% survive 5 years |

*This includes data for patients diagnosed between 2005-2007 for 1 year survival and data for patients diagnosed between 2001-2003 for 5 year survival

7 Awareness of cancer

- 7.1 Increasing age and certain genetic factors increase the risk of developing cancer. The main lifestyle risk factors for cancer are smoking and tobacco use, poor diet, lack of physical activity, obesity and alcohol consumption, all of which can be reduced by changes in the wider environment and in people's behaviour. Whilst there has been some good work to address these issues such as targeted smoking cessation and initiatives to increase healthy eating and physical activity and reduce obesity within the Healthy Borough Programme, it is clear that more work needs to be done to create awareness of behavioural risk factors and to support people to make healthy changes
- 7.2 Findings from a recent survey in North East London using the Cancer Awareness Measure (CAM), a study of 3,500 interviews with people in 7 north east London PCTs about their understanding on cancer, showed low public awareness of cancer symptoms and lifestyle risk factors, and identified barriers to seeking advice. Lack of awareness and/or understanding impacts on early diagnosis and is therefore likely to result in poorer survival. Only 42% of 420 Tower Hamlets residents recalled that a lump or swelling might be cancer compared to 68% nationally, and less than 30% recalled any other signs. People from Black and Ethnic Minority (BME) groups, older people and those in the most deprived areas, had very low recognition of symptoms and those relating to the most common cancers (lung, breast, bowel and bowel) were mentioned by less than 10% of people. When people were asked if they could recognise symptoms from a list, results were better, but Bangladeshi people had amongst the lowest awareness; they recognised only 56% of warning signs compared with 74% recognised by people of white ethnicity.
- 7.3 Most people said they would seek a GP appointment within 2 weeks of a potentially serious symptom, but there were some delays in older people and in women seeking help. Perceived barriers were being too busy, difficulty making an appointment and for those in more deprived areas, worry about what the doctor might find. Women were more likely to be embarrassed or scared. Although a high proportion of people recognised smoking as a risk factor for cancer, there was less certainty, particularly amongst BME groups about whether behaviour (diet, exercise, obesity and alcohol consumption) were risk factors. Overall, there was sizable underestimation of cancer

incidence - 40% of respondents perceived lifetime cancer risk as less than 1 in 20 (it is 1 in 3).

- 7.4 Whilst Members acknowledge the need to balance universal provision and targeted provision, they felt that given this background, there is a strong business case for undertaking targeted awareness around cancer symptoms and lifestyle risk factors. The discussion on this is further explored under 8.4 – Raising awareness.

8 Summary of key discussion points

The working group were presented with information on cancer issues particular to Tower Hamlets and this was followed up with group discussions. The recommendations put forward are from discussions which took place during the presentations and in the groups and issues raised with the Chair by individuals unable to attend. The Scrutiny Policy Officer also attended the Social Action for Health event exploring cancer and access to health care. The recommendations which emerged from the debate and discussions focused on early diagnosis and intervention, appointments, GP-patient relationship and communication, raising awareness and information and support for families and the patient.

8.1 Early diagnosis and intervention

In order to improve cancer survival by increasing awareness and early diagnosis, it is important to know the stage at which cancer is detected. Earlier detection allows for earlier assessment and treatment. Tower Hamlets is participating in the National Awareness and Early Diagnosis Initiative. Public Health provided funding and support for Barts and the London NHS Trust to report the stage of cancer at diagnosis, and the characteristics of people diagnosed, to enable analysis of the journey to being diagnosed and where intervention could have taken place. Working group Members welcomed this piece of work and stressed the importance of mapping out the primary care stage of a journey. The local GP is usually the first point of contact for patients and there needs to be robust adherence to the appropriate guidelines for referring patients so that cancer can be diagnosed and treated early. It would be interesting and helpful to identify possible delays in primary care, to see how many times some patients presented before their referral and diagnosis and this may confirm some users' views that their GP does not listen to them. The working group would welcome a report detailing the findings of this piece of work, in particular an audit of the primary care stage looking at what lessons can be learnt from cases of late diagnosis or where diagnosis opportunities at primary care stage were missed. It would also inform discussions on local access issues. This is further explored under 8.3 – GP-Patient relationship and communication.

Recommendation 1: That Barts and the London NHS Trust present to Health Scrutiny Panel a report on the findings of the staging data study, in particular the lessons learnt from late diagnosis at the primary care stage.

8.2 Appointments

Missed appointments, particularly in cancer patients often result in less effective timing of diagnosis and treatment which has its own human and financial costs associated with it. The working group identified 2 areas for improvement.

Users felt that the hospital appointment booking system was difficult to use and that the bookings can be out of synch with actual appointments patients were aware of. They spoke of problems around the availability and the ease of access to the appointment booking system. The main concern being that they were unable to cancel appointments or that the appointment was not cancelled despite having telephoned to cancel it. DID NOT ATTEND letters were sent out to patients who hadn't received letters for their appointments or had already called to cancel it. They are a cost for the NHS and also for the patient in terms of later diagnosis. Some work could be done to make patients aware of the consequences and costs to the NHS of missed appointments. Given the problems identified with the appointments booking system, Members felt that a challenge session looking at the appointments booking system should be undertaken with the aim of ensuring an efficient system is set in place.

Given the low cancer survival rates in Tower Hamlets, the Working Group felt that missed appointments should not be a reason why people are diagnosed late. Earlier diagnosis is beneficial for both patients and the NHS. There was general agreement in the groups that in cases where the appointment is for checks on potential cancer patients, GPs should chase up patient attendance to ensure that they are checked and a diagnosis is reached. This should be built into a robust set of guidelines for GPs when making referrals.

Recommendation 2: That the Health Scrutiny Panel undertakes a scrutiny challenge session looking at the Barts and the London NHS Trust's appointment booking system and how best it can be managed to ensure it is accessible and efficient.

Recommendation 3: That GPs take responsibility to ensure patients referred for checks where cancer might be a possibility chase up patient attendance and that this is agreed and built into guidelines for GPs.

8.3 **The GP – patient relationship and communication**

A large part of the discussion was centred on GP- patient relationship and communication. Whilst the working group agreed that GPs have a central role to play and are influential in terms of people's health decisions, GP appointments were timed and users often felt that there wasn't enough time to discuss all their symptoms and to receive good treatment. Some users raised the issue of family members feeling or even being asked not to come to the GP unnecessarily and often successively given paracetamol to treat their symptoms. The group however agreed that residents should be persistent with getting a diagnosis if they are worried about their health. This was particularly important if they felt they were not being listened to. Two issues were raised from these experiences. Firstly to acknowledge the difficulty on the GPs side of managing the necessary number of patients on the day that have agreed appointments - on time.

Secondly that there are some issues around terminology which can frustrate the lines of communication in the relationship between GP and patient. This is not necessarily about translation issues. It is further complicated in cases where the patient has existing health complications which is more likely to be the case for someone living in Tower Hamlets compared to someone living in Notting Hill. A patient who is able to clearly articulate the problem and state clearly what they would like is more likely to come out feeling like they have been taken care of. In cases where there are health complications and communication issues, the patient is more likely to be frustrated with the outcome. Given this, working group members felt that the consultation process can be better structured. There was some discussion that work could be

done with patients, advocates, translators and GPs to look at the GP-Patient consultation process to consider how it can be structured to be clearer and more effective. It was felt that this would reduce repeat presentation and patient feelings of not being listened to.

In one particular case a cancer patient had repeatedly presented to the GP but had been told her health complaints were because she had many children and that this was damaging her back. She had very late stage pancreatic cancer which had spread to her liver by the time a private doctor had diagnosed it. The family members felt that had the GP taken the time to listen and investigate the patients' symptoms rather than dismiss them with pain killers, the patient would have had a longer survival rate. In discussing these cases, the working group felt that there is no check and balance in place for the decisions made. There was some general discussion that because people in Tower Hamlets are less likely to be articulate and persistent and more likely to have a complicated health history, there is a greater risk of them not being diagnosed appropriately or misdiagnosed. This makes the need to improve the consultation process stronger. The GP Consortia need to ensure that GPs pay closer attention to concerns raised by patients and have a greater awareness of cancer symptoms when patients present themselves. The Staging Data study may be able to inform this issue if it could also look at late stage cases where there had been repeat presentation to identify where it could have been detected earlier and the lessons learnt from this.

Recommendation 4: That the GP Consortia look at the consultation process involving patients, advocates and translators to seek to better structure and strengthen the consultation process to ensure patients concerns are addressed and that there is improved awareness of cancer symptoms.

8.4 Raising awareness

The working group welcomed the work being done around cancer screening but felt that more could be done to target those likely to be at risk and use innovative approach to targeting. Awareness of cancer symptoms alongside the offer of screening tests are the issues to focus on. Suggestions for targeted awareness raising are set out below:

1. Use influence as the driver for change, influential change drivers is likely to be doctors, children, and partners to target men. The working group agreed that these influencers could easily be included in the prevention initiatives. Doctors could write directly to patients to encourage screening take-up for example. There was some discussion about a study which showed partners – wives and girlfriends influencing the men to attend screening tests etc does increase take-up by men. There was also discussion of a motion sensitive poster which made a coughing sound and encouraged a visit to the doctor if someone has a persistent cough. Members felt there needs to be an emphasis on raising awareness and screening take-up being every ones responsibility – residents, GPs and all community leaders.
2. Use key meeting places such as places of worship, social venues, pharmacies, service provider centres. The idea behind this was to create discourse amongst the community about cancer symptoms and lifestyle risk factors and use this as a tool to raise awareness. The venues would also be idea places to provide information on screening tests and services available.
3. Target groups that are more likely to be at risk, using '1:3 risk factor' and 'you can survive longer if caught early' messages. The Cancer Awareness Measure gave

Members some interesting insights into awareness and understanding of cancer symptoms and lifestyle risk factors. In light of this study illustrating very low awareness amongst the general population and in particular the BME and Bangladeshi community, there should be some targeted work to address this issue. The working group made a suggestion that local ethnic media should be used. The Bengali channels for example could reach out to a targeted audience and would be effective in raising awareness of cancer symptoms and lifestyle risk factors. It could also be effective for encouraging patients to be more active in seeking health care.

4. There was also some concern that there is focus on four key cancers – Lung, Colorectal, Breast and Prostrate cancer but very little about other cancers which affect local residents – 53% of deaths between 2006 and 2008 were from other cancers¹⁰. Given the diverse nature of the borough, the Working Group felt that other cancers which affect local residents should be analysed to identify any local trends allowing for a more comprehensive approach to targeted awareness raising and prevention. Further analysis and better understanding of the mortality and survival rates of 'other' cancers (which together accounted for nearly half of cancer deaths in Tower Hamlets) may help to identify where to target interventions which will help to improve survival and to reduce the overall cancer mortality rate.

Recommendation 5: That NHS Tower Hamlets undertake analysis of other types of cancers that affect local residents to identify trends and to inform the development of preventative services.

Recommendation 6: That NHS Tower Hamlets undertake targeted work to raise awareness of cancer symptoms and lifestyle risk factors amongst the general population.

Recommendation 7: That NHS Tower Hamlets undertake work to raise awareness of cancer symptoms and lifestyle risk factors amongst groups who find it harder to access services and experience greater inequality, including the Bangladeshi community and through ethnic media.

8.5 Information and support

Younger people whose parents are affected by cancer spoke about the lack of information and support that was available for the cancer patient and their family as a whole. The lack of information and support was felt more amongst people who did not read and write English. Tower Hamlets is a young borough which is characterised by young family units therefore this is more likely to be an issue here. Users felt there was a lack of support available for the family to put practical measures in place were the parent was affected by cancer (all 3 cases involving parents were late stage). In their experience social workers did get involved but it often meant waiting for many weeks before connections were made and anything can be done, by which stage the patient was too unwell to make decisions or comment on changes. Those most likely to be affected by this delay are disabled dependents or children for whom the patient would have been the main carer. The areas of support needed would be financial management including benefits entitlement, housing issues and care arrangements for those left behind. The Tower Hamlets Palliative Care Centre has been set up at Mile End Hospital to provide support for all patients and their families during the end of life period, including bereavement care, care at home and general information for patients and their families. There was a discussion about the need for a whole family assessment to identify support needs and to facilitate contact with the relevant

¹⁰ Reducing Cancer Mortality in Tower Hamlets: a strategy for improvement 2011 - 2015

support services. It was felt that the Tower Hamlets Palliative Care Centre might be best placed to undertake whole family needs assessment and to facilitate contact with relevant support services. The working group would welcome the opportunity to visit this service so that councillors as community leaders can promote it further.

Recommendation 8: That NHS Tower Hamlets considers developing and offering whole family needs assessment to identify the needs of vulnerable patients and/or their family members and facilitate contact with relevant support services as part of services offered by the Palliative Care Centre.

Recommendation 9: That the Health Scrutiny Panel organise an all Member visit to the Tower Hamlets Palliative Care Centre to raise awareness amongst community leaders of this service.

9. Conclusion

- 9.1 Cancer affects local residents and disproportionate numbers die sooner compared to other parts of the country and this inequality needs to be addressed because it has such deep human costs in addition to the social cost. The aim of the session was to consider how this inequality can be addressed through local level intervention and the working group welcomed the opportunity to address this issue.
- 9.2 Cancer is complex, and its journey to diagnosis through the NHS can be complex. The working group welcomed the focus on prevention and the current efforts to address the four most common cancers in Tower Hamlets. There was a gap however in identifying trends or otherwise with cancers other than the four most common ones and exploring this may further inform the local approach to prevention. Other areas the working group found to be of particular importance to residents and local service provision is the relationship between GP and patient. Other recommendations which focused on improving cancer survival included looking at the stage of diagnosis for cancer cases and identifying lessons for learning from late diagnosis; improving the hospital appointments system and undertaking targeted prevention work with the general population and groups who find it harder to access services and experience greater inequalities including the Bangladeshi community, which appears to have the least awareness of cancer symptoms and lifestyle risk factors. The working group were pleased to hear that the Tower Hamlets Palliative Care Centre has been set up to provide information and request that consideration be given to the idea of a whole family needs assessment to ensure that difficulties, particularly for vulnerable families are not further prolonged in cancer cases.
- 9.3 The working group is grateful for the patients, friends and families that contributed openly to the discussions and for sharing an important element of their life experiences. This has greatly contributed to the discussion and debate and has informed the recommendations put forward in this report.

10 Concurrent Report of the Assistant Chief Executive (Legal)

- 10.1 The report sets out 9 recommendations, some of which relate to the future business of the Panel and some of which are directed to NHS bodies.
- 10.2 The recommendations relate to the development of early diagnosis and preventative services for cancer in Tower Hamlets. The Council's Constitution makes provision for the Health Scrutiny Panel to have responsibility for scrutiny of the health service in Tower Hamlets, consistent with the requirements of section 21 of the Local Government Act 2000.

- 10.3 The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 provide that an overview and scrutiny committee may review and scrutinise any matter relating to the planning, provision and operation of health services in the area of its local authority. The committee may make reports and recommendations to local NHS bodies and to its local authority on any matter reviewed or scrutinised in this way. A local NHS body is a Strategic Health Authority, Primary Care Trust, NHS Trust or NHS foundation trust which provides or arranges the provision of services in Tower Hamlets. The committee may, if it chooses, give its recommendations to a local NHS body and request a response from that body. It will be a matter for the NHS body whether it accepts the recommendations or not.
- 10.2 As regards the recommendations made in relation to the future business of the Panel, it will be for the members of the Panel to decide whether they take the recommended course or not.

11. Comments of the Chief Financial Officer

- 11.1 This report updates the Overview and Scrutiny Committee on the outcome of the scrutiny challenge session on the development of early diagnosis and preventative cancer services in Tower Hamlets.
- 11.2 Recent government announcements about funding reductions to the Council in 2010-11 and for the next four years will affect any recommendations agreed and any additional costs that arise from the recommendations must be contained within directorate revenue budgets. Also, officers will be obliged to seek the appropriate financial approval before further financial commitments are made.

12. One Tower Hamlets Considerations

- 12.1 Members were pleased to have had a chance to consider this issue which is important in Tower Hamlets because cancer is the largest cause of premature death in comparison to other London boroughs. Through their role as community leaders they were able to bring together partners and local residents to form a number of recommendations to address this pressing health inequality.
- 12.2 A number of recommendations in this report have One Tower Hamlets implications as the intended outcome is to focus on reducing health inequalities that exist within the borough and narrowing the gap between Tower Hamlets and the healthiest parts of the country by supporting people to improve access to primary and secondary care. Recommendation 7 in particular suggests targeted work amongst groups who find it harder to access services and experience greater inequality, in particular the Bangladeshi community as a study shows they have the lowest awareness of cancer symptoms and risk factors.

13. Risk Management

- 13.1 There are no direct risk management actions arising from this report.

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Agenda Item 5.6

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| Committee Health Scrutiny Panel | Date 19th April 2011 | Classification Unrestricted | Report No. | Agenda Item No. |
| Report of: Service Head One Tower Hamlets, Originating Officer: Jebin Syeda, Scrutiny Policy Officer | Title: Health Scrutiny Panel response to the Healthy Lives Healthy People White paper Ward(s) affected: All | | | |

1. Summary

- 1.1 At the last Health Scrutiny Panel Members were presented with an outline of the White paper – Healthy Lives Healthy People. The Health Scrutiny Panel discussed the implications of the White paper for Health Scrutiny and made a number of comments which have been fed into the consultation response which Public Health colleagues have co-ordinated.
- 1.2 The attached is a letter to Andrew Lansley, Health Secretary outlining the issues raised by the Health Scrutiny Panel in their response to the White paper. The consultation closed on 31st March 2011 and this letter has been submitted from the Chair as a collective response from the Health Scrutiny Panel.

2. Recommendations

- 2.1 The Health Scrutiny Panel is asked to note the contents of the letter attached and to note that a response to the White paper Healthy Lives Healthy People has been submitted.

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Public Health Development Unit
Department of Health
Wellington House G 16
155 Waterloo Road
London SE1 8UG
March 29th 2011

Scrutiny & Equalities Team
Tower Hamlets Town Hall
Mulberry Place

5 Clove Crescent
London E14 2BG

Enquiries to:

Tel: 0207 364 0941

Email: Jebin.syeda@towerhamlets.gov.uk

Web: www.towerhamlets.gov.uk

Healthy Lives Healthy People white paper – Health Scrutiny Panel consultation response

Dear Mr Lansley,

I am writing in response to your public consultation exercise, which ends 31st March 2011 on behalf of the Health Scrutiny Panel at the London Borough of Tower Hamlets. We welcome the opportunity to respond to the proposals outlined in the above consultation document.

The Health Scrutiny Panel welcomes the shift to give local people more power and say over their health service. We are supportive of the move to place health improvement at the heart of the local authority and will respond positively to changes in the structure and delivery of healthcare in the aim to do this. We believe that moving healthcare to local authority will mean that we can be much more responsive to local need. Whilst we recognise and support the move to more localised control over health, we need to ensure that any new arrangements are robust and enable decision makers to be held to account. Scrutiny has developed a track record of drawing together cross cutting issues at local level in relation to health inequalities and we see the new approach as an opportunity to develop this.

Health Scrutiny has statutory powers to call to account partners who provide local services and this has been used well to address local health inequalities. Over time it has developed as an effective resource and been a motivation for our partners to engage with elected representatives and enable the development of transparent and effective scrutiny. Through these statutory powers health scrutiny has developed as a resource for health colleagues to engage the views of the local community in helping to address local health issues. It is not clear how health inequality responsibilities will operate between the Health and Wellbeing Boards, GP Commissioning Consortia and local authority. In any environment, scrutiny would need to continue to have statutory powers and strong guidelines to enable it to hold local providers and commissioners to account whilst maintaining the independent role it has established.

We believe that the Chair of the Health Scrutiny Panel should regularly be invited to attend the Health and Wellbeing Board as an independent Member. This will enable a better understanding of issues being discussed and to use this to develop and prioritise the work programme and identify scrutiny topics. It will also enable our recommendations to be fully considered and help to strengthen the partnership work. In setting up the Health and Wellbeing Board and the GP Commissioning Consortia, we would want to ensure that scrutiny is independent yet there are strong links with them so that they can be held to account for decision making and commissioning through independent and transparent scrutiny. The new structures must work in a way that they still continue to focus on local needs and local solutions and we believe that opening up the Health and Wellbeing Boards to the Chair of Health Scrutiny Panel will give local people confidence that this is the case.

Scrutiny is dependent on relationships and we have developed these well locally. Health Scrutiny already has in place co-opted Local Involvement Network members and relationships with Trusts and we believe that these can be built on in the new structure. Tower Hamlets Involvement Network (THINK) which will become HealthWatch, have worked closely with the Health Scrutiny Panel. They have been a valuable resource for the local community and for Health Scrutiny, bringing to the fore health issues in the borough. We write in support of developing a strong independent local voice through THINK. A strong local voice through THINK and local councillors are crucial to maintaining a strong and transparent health service, we would not want this to be lost through the new changes.

I hope these comments are useful and look forward to hearing on the consultation response.

Yours sincerely,

Councillor Tim Archer
Chair of the Health Scrutiny Panel
London Borough of Tower Hamlets