TOWER HAMLETS

HEALTH SCRUTINY PANEL

Tuesday, 11 March 2014 at 6.30 p.m.
Room MP701, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

This meeting is open to the public to attend.

Members:
Chair: Councillor Rachael Saunders
Vice-Chair: Councillor David Edgar

Councillor Dr. Emma Jones, Councillor M. A. Mukit MBE, Councillor Gulam Robbani, Councillor Lutfa Begum, Councillor Zenith Rahman, David Burbridge and Dr Amjad Rahi

Deputies:
Councillor Peter Golds, Councillor Anwar Khan, Councillor Bill Turner and Councillor Lesley Pavitt

Co-opted Members:

David Burbridge	(Healthwatch Tower Hamlets Representative)
Dr Amjad Rahi	(Healthwatch Tower Hamlets Representative)

The quorum for this body is 3 Members.

Contact for further enquiries:
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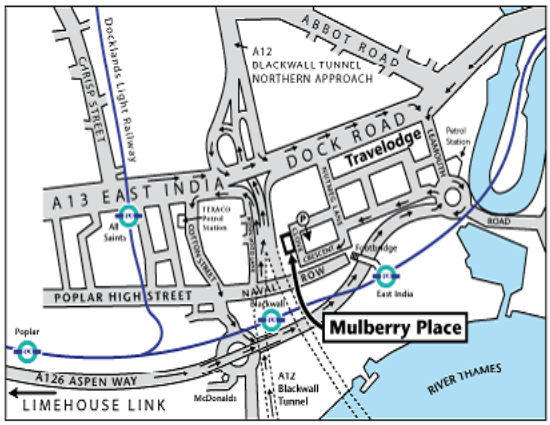

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APOLOGIES FOR ABSENCE

1. 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

2. MINUTES OF THE PREVIOUS MEETING(S)

To confirm as a correct record of the minutes of the meeting of Health Scrutiny Panel held on 28th January 2014. **3 - 12**

3. REPORTS FOR CONSIDERATION

3 .1 Education Social Care and Wellbeing (ESCW) - Update

To receive a verbal update on Majlish Home Care services.

3 .2 Life Course - Old Age

To consider the following verbal reports:

I. Public Health - Old Age
II. Like Age Plus
III. Silk Court
IV. Tower Hamlets Council - Older People Services

3 .3 Report of the Scrutiny Review of Accident and Emergency (A&E) Services in Tower Hamlets **13 - 36**

To agree the report of the Scrutiny Review on the Accident and Emergency (A&E) Services and to refer this report to Overview and Scrutiny Committee for consideration and then to Cabinet.

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

Next Meeting of the Panel (Provisional Date)
The next meeting of the Health Scrutiny Panel will be held on Tuesday, 15 July 2014 in Committee Room 1, 1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

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DECLARATIONS OF INTERESTS - NOTE FROM THE MONITORING OFFICER

This note is for guidance only. For further details please consult the Members' Code of Conduct at Part 5.1 of the Council's Constitution.

Please note that the question of whether a Member has an interest in any matter, and whether or not that interest is a Disclosable Pecuniary Interest, is for that Member to decide. Advice is available from officers as listed below but they cannot make the decision for the Member. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending a meeting.

Interests and Disclosable Pecuniary Interests (DPIs)

You have an interest in any business of the authority where that business relates to or is likely to affect any of the persons, bodies or matters listed in section 4.1 (a) of the Code of Conduct; and might reasonably be regarded as affecting the well-being or financial position of yourself, a member of your family or a person with whom you have a close association, to a greater extent than the majority of other council tax payers, ratepayers or inhabitants of the ward affected.

You must notify the Monitoring Officer in writing of any such interest, for inclusion in the Register of Members' Interests which is available for public inspection and on the Council's Website.

Once you have recorded an interest in the Register, you are not then required to declare that interest at each meeting where the business is discussed, unless the interest is a Disclosable Pecuniary Interest (DPI).

A DPI is defined in Regulations as a pecuniary interest of any of the descriptions listed at **Appendix A** overleaf. Please note that a Member's DPIs include his/her own relevant interests and also those of his/her spouse or civil partner; or a person with whom the Member is living as husband and wife; or a person with whom the Member is living as if they were civil partners; if the Member is aware that that other person has the interest.

Effect of a Disclosable Pecuniary Interest on participation at meetings

Where you have a DPI in any business of the Council you must, unless you have obtained a dispensation from the authority's Monitoring Officer following consideration by the Dispensations Sub-Committee of the Standards Advisory Committee:-

- not seek to improperly influence a decision about that business; and
- not exercise executive functions in relation to that business.

If you are present at a meeting where that business is discussed, you must:-

- Disclose to the meeting the existence and nature of the interest at the start of the meeting or when the interest becomes apparent, if later; and
- Leave the room (including any public viewing area) for the duration of consideration and decision on the item and not seek to influence the debate or decision

When declaring a DPI, Members should specify the nature of the interest and the agenda item to which the interest relates. This procedure is designed to assist the public's understanding of the meeting and to enable a full record to be made in the minutes of the meeting.

Where you have a DPI in any business of the authority which is not included in the Member's register of interests and you attend a meeting of the authority at which the business is considered, in addition to disclosing the interest to that meeting, you must also within 28 days notify the Monitoring Officer of the interest for inclusion in the Register.

Further advice

For further advice please contact:-

Meic Sullivan-Gould (Legal Services), 020 7364 4801; or
John Williams, Service Head, Democratic Services, 020 7364 4204

APPENDIX A: Definition of a Disclosable Pecuniary Interest

(Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012, Reg 2 and Schedule)

Subject	Prescribed description
Employment, office, trade, profession or vacation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	Any payment or provision of any other financial benefit (other than from the relevant authority) made or provided within the relevant period in respect of any expenses incurred by the Member in carrying out duties as a member, or towards the election expenses of the Member. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
Contracts	Any contract which is made between the relevant person (or a body in which the relevant person has a beneficial interest) and the relevant authority— (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land	Any beneficial interest in land which is within the area of the relevant authority.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the relevant authority for a month or longer.
Corporate tenancies	Any tenancy where (to the Member's knowledge)— (a) the landlord is the relevant authority; and (b) the tenant is a body in which the relevant person has a beneficial interest.
Securities	Any beneficial interest in securities of a body where— (a) that body (to the Member's knowledge) has a place of business or land in the area of the relevant authority; and (b) either— (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

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LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY PANEL

HELD AT 6.30 P.M. ON TUESDAY, 28 JANUARY 2014

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

Members Present:

Councillor Rachael Saunders (Chair)

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

Councillor Peter Golds (Substitute for Councillor Dr. Emma Jones)

Co-opted Members Present:

David Burbridge – (Healthwatch Tower Hamlets Representative)

Guests Present:
Dianne Barham – (Director of Healthwatch Tower Hamlets)

Officers Present:

Sarah Barr – (Senior Strategy Policy and Performance Officer, Corporate Strategy and Equality Service)
Deborah Cohen – (Service Head, Commissioning and Health, Education, Social Care and Wellbeing)
Paul Gresty – (Strategy, Policy and Performance Officer, Corporate Strategy and Equality Service)
Robert McCulloch-Graham – (Corporate Director, Education Social Care and Wellbeing)
Dorne Kanareck – (Education, Social Care and Well-being Representative)

Antonella Burgio – (Democratic Services)

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Dr Emma Jones and it was noted that Cllr Golds attended as substitute for Councillor Emma Jones and from Armjad Rahi, Co-opted Member(Healthwatch Tower Hamlets)

1. DECLARATIONS OF INTEREST

No declarations of discliosable pecuniary interests were declared.

2. MINUTES OF THE PREVIOUS MEETING(S)

The minutes of the Health Scrutiny Panel held on 3rd September 2013 and the notes of the informal Health Scrutiny Panel held on 19th November 2013 were approved as a correct record of proceedings.

3. REPORTS FOR CONSIDERATION

3.1 Education Social Care and Wellbeing (ESCW)

The Corporate Director, Education, Social Care and Well-being and the Education, Social Care and Well-being Representative gave a verbal update on issues relating to Majlish Home Care Services. The Corporate Director noted that the Authority had been monitoring the situation at the Home Care Services provider for some time and advised the Panel that there had been no effective response to the three warnings issued by the Care Quality Commission (CQC).

The following maters were noted by the Panel:

The Education, Social Care and Well-being Representative noted that there were no issues related to care provision or safeguarding but with organisational matters such as management structures, staff training and management level issues. However safeguarding remained the Council's priority and therefore CQC were kept fully informed.

The Panel was advised that:

- Some trustees of the care provider acknowledged the complaints made but they had been unable to implement the changes required.
- The Corporate Director had met with the new Chair of the trustees" and "the previous Chair and another trustee had resigned.
- CQC had inspected the service and were minded to withdraw its registration as a Dom Care provider. They did serve notice withdrawing the registered manager status. However the provider had a good history in terms of its service provision and therefore the Corporate Director had consulted with the Chief Inspector to ensure support was engaged. The Education, Social Care and Well-being Representative had been appointed as an external consultant and an interim manager was sourced to replace the de-registered manager.
- A support plan was agreed with the new Chair of trustees. It was noted however, that generally, the trustees were not supportive of the Council's efforts and while relations with direct staff management was good, the Council had received less welcome from senior staff.
- Presently LBTH were dealing with the issues but due to the sensitive nature of the matter could not comment further at this time.

In response to Members' questions the following information was provided:

Concerning assurance of safeguarding standards, the Panel was informed that, in its investigation, CQC applied their own investigative methodology. All recipients of services from this provider had been surveyed and the vast majority had responded positively. To investigate the quality of the provision and the Council had also approached the families of users and there had been some reports of wrong methodology training e.g. training in client lifting.

Staff training such as coaching on day-to-day practices such as hoist usage was an area of concern. It was noted that it was not alleged that staff were not trained however it had been found that a number of staff did not have the training that CQC expected. It was noted that there was a formal, standard curriculum package for this category of staff training and the Council expected that this should be met since other providers of such service used training packages of this nature. Additionally the Council had offered its own staff development facilities to the organisation but these had not been taken up.

The areas of concern identified by staff related to management culture, contracts and salaries rather than care provision. Additionally staff bullying was alleged. The Panel was advised that the Council had itself become concerned as 50 staff had whistleblown and all subsequently withdrew their representations. However there was concerted action to ensure that the whistleblowers were protected and could have confidence of the necessary changes in the organisational culture.

Members noted that there had been concerns around this provider for over one year and were concerned about the impacts of failing to act. The Corporate Director noted the comment and advised that there was work in progress to address the issues that had been identified. He advised that officers were working towards a resolution in the very near future. He acknowledged the importance of the provision of quality home care to residents of the borough and therefore the Council had taken steps to install support in order to turn around the concerns reported.

A Panel Member was concerned that there was only one Bangladeshi provider of this kind of home care and therefore there was little choice for residents. The Corporate Director advised that there are a number of providers in existence and the Directorate was working to enable service choice to be retained in the least disruptive way possible. Members were advised that these contracts related to users who must possess a personal budget but the core provision was arranged by the Council. Most of the business comprised spot purchases

The Council was presently monitoring how the service was responding to the implementation plan; however should the Council reach a view that a formal decision or action was necessary then it would act wholly through CQC. It was noted that CQC would undertake a further inspection (by 31st of March 2014) three months after the implementation of the intervention plan. This

would assess operations and provide evidence to determine whether issues had been resolved.

The Chair thanked officers for their verbal report and requested that the Panel be kept informed of ongoing developments both formally and informally

RESOLVED

That the update be noted

Action by:
Robert McCulloch-Graham (Corporate Director ESCW))

3.2 HealthWatch: Summary Feedback from Barts Health

The Director, HealthWatch Tower Hamlets, introduced the report advising that the data reported was based on comments collected from the following sources: online HealthWatch website, Rate Our Service workshops and telephone feedback interviews and also contained analyses of patient feedback from the following clinics; sexual health, renal unit, fracture clinics outpatients, and cancer clinic at Barts Hospital. She advised that the report would be analysed to identify key issues and develop monitoring tools with which to measure improvements from the Clinical Commissioning Group (CCG). These data would be shared with the Health Scrutiny Panel to support further mutually beneficial scrutiny.

The top 10 concerns identified in the period July – September 2013 were listed at page 34 of the agenda and these issues raised with CCG.
The following common complaints were also noted:

- Shortage of beds/staff – there were concerns regarding levels of care on specialist wards
- Accident and Emergency – there were concerns with popularity/mis-use of A & E services
- Food – there were complaints regarding quantity, temperature, special diets and help with eating.
- Hospital (building) mapping – users with disabilities were unable to easily navigate hospital buildings – better signage was needed
- Hospital Transport – there were complaints relating to excessive waiting times and a lack of communication between drivers and passengers
- Discharge – there were issues around timings of patients discharges
- Complaints – the complaints process was not clear nor was it clear how complaints would improve services

In discussion the Panel noted the following matters:

- A Panel Member observed that the report revealed the nature of day to day processes/activity in delivering services
- The HealthWatch Tower Hamlets representative made a verbal submission: He observed that there had been better patient

participation and input in the HealthWatch exercises. However he was concerned that Barts Patient Engagement Forum offered no mechanism where the public might speak with Barts management but, in his view, regarded HealthWatch as a substitute for patient engagement. He clarified that this in fact was not the role of HealthWatch.

  - Regarding complaints concerned with food, he noted the additional issue of how suitable food could be made available to stroke and dementia patients.
  - He also expressed a concern that, because of its recent establishment, CQC did not yet have sufficient expertise to properly assess how matters such as those mentioned were being delivered by Barts; these concerns did not relate to clinical care but to attitudes and compassion.
  - He further noted that Barts formerly had facilitated patient involvement in departmental forums. These forums were now discontinued and there was presently no mechanism in which to pursue clinical complaints.
  - The Barts Patient Engagement Sub-Group of TH Health and Well-being Board was not presently in operation.
  - He also observed that HealthWatch was responsible for inspection and overview of children's services and noted that these were already well inspected and therefore he would like to see HealthWatch included in commissioning overview arrangements.

- The dashboard format would be revised to better indicate period movements.
- The ratings scale ranged from levels 1-5 and was designed to track whether people's experience of care was improving or deteriorating.
- The response period for any recommendations or information requests to Barts was 20 days. The Director noted that Barts was not presently providing feedback or responding to HealthWatch recommendations and that HealthWatch planned in future to pursue these more effectively
- Feedback regarding “information sheets” indicated that these were too detailed and focussed on clinical accuracy but they did not give patients the facts that they needed to know.
- Hospital Transport – the Panel was informed that there were transport issues around lengthy waiting times but could be readily addressed by facilitating communication between the drivers and patients relating to collection times and any travel delays.
- Incontinence Service - The Service Head Commissioning and Strategy advised there would be a review of all of the provision in the Borough and all input would be welcomed. Comments should be made through the Deputy Chief Officer, Tower Hamlets Clinical Commissioning Group

The Chair advised that, in view of the comments regarding patient engagement, Barts should be invited to attend the March Health Scrutiny Panel to discuss this matter. Additionally the Panel's response should also be made at this meeting and therefore an item also added to the agenda.

RESOLVED

That the report to be noted.

Action by:
Tahir Alam / Sarah Barr (Strategy, Policy and Performance)

3.3 Integrated Care - Education Social Care and Wellbeing (ESCW) and Clinical Commissioning Group (CCG)

The Service Head Commissioning and Strategy tabled an update report which has been appended to the minutes. She reminded the Panel of the presentation made by the Associate Director Community Health Services, Barts Health NHS Trust and the Deputy Chief Officer, Tower Hamlets Clinical Commissioning Group at the meeting on 3 September 2013 about the redesign of health services in the borough over the next two years. The intended plan would be to relocate some services away from hospital setting to community settings, in GP surgeries, and in people's homes. She advised this work had evolved into the Integrated Care Programme and this had itself evolved and expanded to encompass neighbouring East London Boroughs of Newham and Waltham Forest to become a one of the 14 designated Department of Health Pioneer sites. The WELC Pioneer programme was about developing care pathways for older adults. The three local authorities were part of the programme of change and in this connection the following was to be noted:

- Transfer of some social care into these community-based services was proposed - although the timing of these changes had yet to be established.
- Local authorities would need to consider which services and staff would be most appropriately redeployed into the programme.
- It was felt that the single point of access and co-location of services was best method to deliver co-ordinated care. This would have implications for the workforce for example one consequence may be a requirement for home care workers to be up-skilled.
- Participation in the Pioneer programme did not attract additional funding but there was access to expertise. This advice has already been accessed to help resolve information governance issues
- There was ongoing work on financial modelling of the impact of the service redesign on activity flows, with the aim of ensuring that funding followed the activities.
- Funding for these developments would be in the Better Care Fund but this is not new money into the system but one fund into which several pre existing funding steams have been merged. Funding in 2014-15 was a centrally determined allocation. However for 2015-16 a proportion of the grant would only be paid if targets were met therefore the Partnership of the CCG and Council were considering which targets were most appropriate to measure.

The Panel was informed that:

- The first draft of the plan for the use of the Better Care fund had to be submitted by 14th February and therefore the Health and Well-being Board was required to consider this matter at its meeting on 6th February.
- There were risks around the programme for those involved and there were potential cost pressures. However the Council's focus should remain “better care for residents". Learning could be drawn from previous integrations which showed a need for significant input of formal programmes of organisational development
- The duration of the programme was expected to be three years and there would be regular progress updates made to Health Scrutiny Panel
- Carers Breaks funding would be located in the CCG base budget but would not automatically be passed to carers

In discussion the Panel noted the following information:

- A future scenario being thought about was that local authorities might not provide fieldwork social work but would be the commissioners of services whilst the NHS would act as the provider. This raised issues about differences in the ethos of service cultures between the social care model and the medical model.
- Additionally some governance issues were expected since the NHS was not a democratically accountable body.
- Concerning financial modelling for the changes, the Panel was advised that there was an expectation that monies in the Better Care Fund would be pooled from 2015-16 onwards.

The Chair noted that there would be challenges for local authorities and NHS bodies in terms of trust and transparency of issues. However the work previously been done by the NHS into collaborative working by GP networks would provide a useful reference. The Panel was informed that there were plans for a savings pool to be used as an incentive for providers to work together in an integrated way.

The Chair noted that it would be necessary to consider the impact of the reduction for Barts Health service provision therefore a review was necessary to examine which clinical services should be continued and which should not.

RESOLVED:

That the update to be noted

3.4 Health Scrutiny Review of A&E services

The Panel was informed that its draft report titled ‘Scrutiny Review of A & E Services had been circulated to all Panel members for comment. The following key issues were identified from the review findings:

- Recruitment of local people was generally at less skilled levels

- Issues concerned with the management of Winter Pressures
- A and E services were viewed by residents as a convenient form of service access

The Panel discussed the findings of the review and the following observations were noted:

- A & E services were popular because they were quick convenient and provided good tests to users of the service. In contrast GP services were less convenient for patients to access
- There was no patients groups' representation on the CCG Urgent Care Group
- The Health and Well-Being Board would hear from NHS England on the matter of hours for primary care provision

The Chair requested that the report should also address the following:

- To whom will review recommendations be made
- How much has changed since McKenzie in 2008:
- What is the agency that can influence GPs in the absence of the PCT:
- Are there any changes in the large numbers of young people choosing to attend A and E:
- Include a suggestion that a GP practice be cited within A and E
- Include a note on the general issues of accessibility to GP surgeries/services

It was agreed that the Panel's comments would be incorporated into the review following which the final draft would be circulated to Members for comment. The review report would then be presented to the Panel at its next meeting prior to submission to Overview and Scrutiny Committee in April 2014. Additionally it was agreed that any recommendations outside of the scope of the Council would be referred to Tower Hamlets Health and Well-being Board.

The Chair also requested that an item for funding for extra GP hours be added to the next HSP agenda

RESOLVED

That the discussion be noted

Action by:
Tahir Alam / Sarah Barr (Strategy, Policy and Performance)

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

- The Chair advised the Panel that Sarah Barr, Policy Performance and Scrutiny Officer would shortly be undertaking a secondment with a neighbouring authority. She thanked Sarah for her comprehensive

support to the Health Scrutiny Panel and wished her success in the progression of her career.

- The Panel was reminded of the meeting of INEL JHOSC that would be hosted by Tower Hamlets Council on 17 February 2014. At this meeting the joint committee would discuss:
    - The recent CQC inspection of Barts hospital (Barts and CQC would attend the meeting)
    - Receive a financial update
    - Consider a proposal to move Moorfield's Eye Hospital.

The meeting ended at 8.12 p.m.

Chair, Councillor Rachael Saunders
Health Scrutiny Panel

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Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	**11th March 2014**	**Unrestricted**		
Reports of: Corporate Strategy and Equalities: Louise Russell **Presenting Officer:** Tahir Alam, Strategy Policy and Performance Officer One Tower Hamlets Service, Department of Law, Probity and Governance		**Title:** Report of the Scrutiny Review of Accident and Emergency (A&E) Services in Tower Hamlets **Ward(s) affected:** All		

1. Summary

1.1 This report summarises the findings of the Scrutiny Review of Accident and Emergency (A&E) Services in Tower Hamlets for the Health Scrutiny Panel and highlights a number of recommendations to be put before the Overview and Scrutiny Committee for their consideration and referral on to Cabinet for agreement.

2. Recommendations

2.1 Agree the report of the Scrutiny Review on the Accident and Emergency (A&E) Services to be submitted to the Overview and Scrutiny Committee for consideration and referral to Cabinet.

LOCAL GOVERNMENT ACT, 1972 (AS AMENDED) SECTION 100D
LIST OF "BACKGROUND PAPERS" USED IN THE PREPARATION OF THIS REPORT

Background paper	Name and telephone number of and address where open to inspection
None	N/A

3. BACKGROUND

3.1 The coalition government has introduced radical changes to the National Health Service which took effect from April 2013. There has been a devolution of both financial resources, (in the range of £2 billion), and decision making powers for many health services to local GPs. Primary Care Trusts have been abolished and the Clinical Commissioning Groups (CCG's) and Commissioning Support Units created in their place. Other changes include the transfer of Public Health functions into local government, and the establishment of NHS England and Public Health England. These changes have put the health service, nationally and locally, under pressure, especially given the complex issues that many services already faced. One of the most prominent issues under public and media scrutiny is the performance of Accident & Emergency (A&E) services.

3.2 Locally, Barts Health, the largest NHS trust in the country, was formed by the merger of Barts Health and the London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust on 1 April 2012. It has been experiencing significant financial difficulties and had at one point been rated high risk by the organisations which inspect its performance such as the Care Quality Commission (CQC) and NHS England. In August 2013 Barts Health announced that they had voluntarily gone into 'financial turnaround', and in order to support this they had brought in extra expertise and support to work with clinicians and managers in order to ensure that they deliver on their turnaround programme. At the same time there was a flurry of reports on the failure of A&E services across the nation's hospitals including concerns about Barts Health.

3.3 Given the significant concerns being raised about A&E services and about Barts Health, it was decided to undertake a scrutiny review of local A&E services to better understand the issues faced and what is being done to address them. The focus is only on A&E services and does not look at the wider financial situation and the process of 'financial turnaround' at Barts Health.

3.4 The review however outlines the approaches that jointly health services are developing and implementing. Its recommendation suggests ways that the council can contribute to alleviating some of the current issues and impact on A&E services. The Council also offers recommendations on how different stakeholders can work together to improve health and wellbeing across the borough.

4. LEGAL COMMENTS

4.1 The Health and Social Care Act 2012 ('the 2012 Act') aims to strengthen and streamline health scrutiny and enable it to be conducted effectively as part of local government's wider responsibility in relation to health improvement and reducing health inequalities for their area and its inhabitants. It introduces a new role for local authorities in the co-ordination, commissioning and oversight of health and social care, public health and health improvement. Further, section 190 of the 2012 Act amends s244 of the National Health Act 2006, which sets out the Council's health scrutiny functions and enables the Secretary of State to make regulations which set out how the Council must exercise these functions.

4.2 Regulation 21 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 allows a local authority to review and scrutinise any matter relating to the planning, provision and operation of the health service in its

area, including provision of A&E services. The Council is required to invite any interested parties, including the NHS trust, to comment on these matters.

4.3 Regulation 22 empowers the Overview and Scrutiny Committee to delegate to the Health Scrutiny Panel its function to make reports and recommendations to the local authority, on any matter it has reviewed or scrutinised under Regulation 21. Regulation 22(6) requires that reports and recommendations made under this regulation must include—

(a) an explanation of the matter reviewed or scrutinised;

(b) a summary of the evidence considered;

(c) a list of the participants involved in the review or scrutiny; and

(d) an explanation of any recommendations on the matter reviewed or scrutinised.

The report of this scrutiny review fulfils those criteria.

5. COMMENTS OF THE CHIEF FINANCIAL OFFICER

5.1 In the short term the financial implications of the current set of recommendations can be contained within the existing financial resources of the authority. Barts Health's current resource commitment and response to the poor performance combined with joint working with authority in terms of social care support and raising awareness of A&E and public health would address the resourcing issues.

5.2 In the long term Integrated Care Programme and Better Care Funding include provisions and funding streams addressing the reduction of acute services via Out of Hospital Schemes which are developed such as the integrated care programme across primary and secondary health services and social care, and generally increased capacity in the community. As such any financial implications will materialize within the Better Care Fund performance.

ONE TOWER HAMLETS CONSIDERATIONS

6.1 As A&E services are used by the general population of the borough, the review and its recommendation takes into consideration the general health and wellbeing of the boroughs population, therefore positively impacting upon them.
The recommendations made will further enhance the partnership of the councils, Barts Health's and related health services, in order to continue and develop services and interventions that will work towards improving health inequalities across the borough. This will positively impact on reducing health inequalities which is a key part of building a robust approach to addressing disadvantage in the borough.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 There are no direct environmental implications arising from the report or recommendations.

8. RISK MANAGEMENT IMPLICATIONS

8.1 There are no direct risk management implications arising from the report or recommendations.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 There are no direct crime and disorder reduction implications arising from the report or recommendations.

Health Scrutiny Panel

Scrutiny Review of Accident and Emergency (A&E) Services in Tower Hamlets

TOWER HAMLETS

London Borough of Tower Hamlets
2014

Contents

1. Acknowledgements

The Review Group would like to express their deep gratitude and thanks to all the partners and officers that supported this review.
The views and perspectives of all that were involved have been fundamental in shaping the final recommendations of this report. We would like to thank all of those who gave their time and expertise during the review process.

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2. Chair's Foreword

At a time of huge change for the NHS we felt it to be important that we gain a real understanding of A&E services at the Royal London, to understand resident concerns and to be well placed to scrutinise any future proposed changes to services.

Since we started this review the CQC have reported on their inspection of Barts Health. Their account of a well led, effective A&E department is in line with what we saw on our visit to the department and in our conversations with stakeholders.

Where A&E faces challenges it is often in how it relates to the rest of the system. It is much easier for some to go to A&E than it is to wait for an appointment to see a GP, so unnecessary strain is put on emergency services.

There is more that Barts Health could do to make staffing more sustainable, in A&E and elsewhere, by training, developing and recruiting local people.

I recommend this review to you.

3. Recommendations

Recommendation 1:

That the council gives a greater profile to the promotion of flu vaccinations to staff and the community through its various services.

Recommendation 2:

That the council raises awareness of why and when A&E services should be used and promote other primary care services for minor ailments, to help reduce inappropriat*e* attendees at A&E.

Recommendation 3:

That the council sustain its programmes around smoking cessation, healthy eating and being active to acculturate a healthy lifestyle, reducing long term pressure on NHS and A&E services in the future.

Recommendation 4:

That the council accelerates its work with Barts Health NHS Trust to bring forward and implement plans for integrated care that reduce the pressure on A&E and other hospital services.

Recommendation 5:

That the council's public health service explores with Barts Health NHS Trust a joint research project to better understand reasons for inappropriate use of A&E by local residents, and what the drivers might be for changing behaviours.

Recommendation 6:

That the council and Barts Health work together on recruiting from the local community, and working with Higher Education institutions to train doctors and other medical practitioners from a diverse range of backgrounds and with roots in the local area.

4. Background

4.1 **National and local changes and pressures**

The coalition government has introduced radical changes to the National Health Service which took effect from April 2013. There has been a devolution of both financial resources, (in the range of £2 billion), and decision making powers for many health services to local GPs. Primary Care Trusts have been abolished and the Clinical Commissioning Groups (CCG's) and Commissioning Support Units created in their place. Other changes include the transfer of Public Health functions into local government, and the establishment of NHS England and Public Health England. These changes have put the health service, nationally and locally, under pressure, especially given the complex issues that many services already faced. One of the most prominent issues under public and media scrutiny is the performance of Accident & Emergency (A&E) services.

4.2 Locally, Barts Health, the largest NHS trust in the country, was formed by the merger of Barts Health and the London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust on 1 April 2012. It has been experiencing significant financial difficulties and had at one point been rated high risk by the organisations which inspect its performance such as the Care Quality Commission (CQC) and NHS England. In August 2013 Barts Health announced that they had voluntarily gone into 'financial turnaround', and in order to support this they had brought in extra expertise and support to work with clinicians and managers in order to ensure that they deliver on their turnaround programme. At the same time there was a flurry of reports on the failure of A&E services across the nation's hospitals including concerns about Barts Health.

4.3 Given the significant concerns being raised about A&E services and about Barts Health, it was decided to undertake a scrutiny review of local A&E services to better understand the issues faced and what is being done to address them. The focus is only on A&E services and does not look at the wider financial situation and the process of 'financial turnaround' at Barts Health.

4.4 **Accident and Emergency Services**

(A&E) is a medical treatment facility that assesses and treats patients with serious injuries or illnesses, specialising in acute care of patients who present without prior appointment, either by their own means or by ambulance. Due to the unplanned nature of patient attendance, the department must provide initial treatment for a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention. The emergency departments of most hospitals operate 24 hours a day, although staffing levels may be varied in an attempt to mirror patient volume.

4.5 (A&E) care service fall broadly into three types;

- Type 1: A consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of serious injury accident and emergency patients. This includes patients brought in through ambulance services.
- Type 2: A consultant led single specialty A&E service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients.
- Type 3: A&E Other type of A&E/Minor Injury Units (MIUs)/Walk-in Centres, primarily designed for the receiving of accident and emergency patients. A type 3 department may be doctor led or nurse led. It may be co-located with a major A&E or sited in the

community. A defining characteristic of a service qualifying as a type 3 department is that it treats at least minor injuries and illnesses (sprains for example) and can be routinely accessed without appointment[1].

4.6 Just over 3.6 million people used London's Accident and Emergency departments in 2012, 10 per cent more than in 2010, making the capital's A&E departments busier than ever[2].

5. Outline and methodology

5.1 In considering A&E services the Review Group began by looking at the broader national context, setting out the pressures on A&E services. It then focused on the local picture and what plans are being put in place by local services to address these issues. To inform the Group's work a range of evidence gathering activities were undertaken.

5.2 To gauge national concerns around A&E services two key documents have been referenced: the House of Commons Health Committee's report on *Urgent and Emergency Services*[3], and the King's Fund written submission to the Health Select Committee inquiry on *Emergency services and emergency care*[4]. A meeting organised by the London Assembly's Health Committee on A&E services, (where some of the foremost experts and those responsible for managing the London A&E services were present), was also attended. Various news articles were also referred to, to understand the national concerns that were raised though media reporting.

5.3 The Review Group also examined how local NHS organisations and health services have been working to address the pressure on A&E services, as well as preparation for increased pressures in winter. They visited the Royal London Hospital and met with staff from the A&E department. They received presentations from the Clinical Commissioning Group and representatives of the Urgent Care Boards which have been set up by local Clinical Commissioning Groups to create and implement emergency care improvement plans in local areas for winter pressures on hospital A&E services. The Urgent Care Board spoke about the main areas of concerns, and identified areas of service development and commissioning for A&E services and also preparation for the impact of winter pressures.

5.4 Information was received from Public Health in relation to projected population figures and trends of people likely to use A&E services, as well as public perceptions of A&E services and how A&E is used based on these perceptions. CQC hospital inspection reports were also reviewed. Information was also received from Tower Hamlets HealthWatch on the experiences of local people using A&E services.

[1] Emergency Departments: http://www.audit-scotland.gov.uk/docs/health/2010/nr_100812_emergency_departments.pdf
[2] http://www.london.gov.uk/media/assembly-press-releases/2013/09/are-london-s-hospitals-ready-for-a-e-pressures-this-winter
[3] http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news/13-07-23-urgemrepcs/
[4] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/submission-committee-inquiry-emergency-services-may13.pdf

6. The national picture

6.1 **Media focus**

There has been much media attention on recent data which shows A&E services are failing on key targets such as 'ambulance handover' and the 'four hour wait' commitment. Concerns have also been raised about the shortage of doctors working in A&E and the shortage of beds. These stories assume that there has been deterioration in A&E services. However, although these stories suggest the reasons for the 'crisis' are clear, the underlying issues behind the headlines are much more complex, furthermore, not all A&E departments have the same issues.

6.2 **National reviews of A&E**

In July 2013 the House of Commons Health Committee's report on *Urgent and Emergency Services*[5], and the King's Fund inquiry on *Emergency services and emergency care*[6], identified many of the more complex issues that have overburdened A&E services. Both reports highlighted the impact of a **rise in the population** over a period of years has caused. For example;

- London has seen a notable rise in A&E attendances. In 2012/13 just over 3.5 million people attended A&E departments across London, around 212,000 more than in 2011/12, and 347,000 more than in 2010/11.
- Demands on the London Ambulance Service have increased each year over the past 10 years[7], increasing by 2% in 2012 and by 3% in 2013.
- Emergency 999 calls rose by six per cent last year (April 2012 to March 2013), and a similar increase is anticipated this year[8].

- The most significant growth in those accessing A&E services has been in the 20 – 39 age group. This is mainly through 'type 1' services where ambulances have been called through the 999 number. Another population pressure on A&E services is the growing elderly population. They tend to take up bed spaces for long periods of time, therefore reducing hospital bed availability.

6.3 The Health Select Committee's review also found that **staffing levels** are not sufficient to meet demand. Only 17% of emergency departments nationally are managing to provide consultant cover for the required 16 hours per day during the working week. And most struggle to meet recommended best practice at the weekends.

6.4 Dr Anne Rainsberry, Director for NHS England-London, identified a problem recruiting doctors into A&E departments. Doctors are increasingly going into sub-specialisms in specific clinical areas. There are then not enough practitioners who are able to diagnose a range of general symptoms and illnesses as required in A&E. Furthermore, A&E departments are one of the busiest hospital departments with long hours of work and unsociable hours, putting many off from going into emergency care.

[5] http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news/13-07-23-urgemrepcs/
[6] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/submission-committee-inquiry-emergency-services-may13.pdf
[7] London Ambulance Service: http://www.londonambulance.nhs.uk/news/news_releases_and_statements/ambulance_staff_numbers.aspx
[8] Ibid

6.5 Recently there have been attempts to divert patients from A&E services by providing alternative services, such as walk-in centres. However, the Health Select Committee found that patients are **confused or do not understand how and when A&E services should be accessed**. Dr Rainsberry suggested that cultural understanding of A&E services varies and the demography of an area therefore influences the way A&E services are used. Also, the more deprived an area is, the higher the pressure on local services are.

6.6 Dr Clare Gerada, past Chair of the Royal College of General Practitioners, stated that another reason why people are accessing A&E is because A&E services are generally **quicker to access**. Patients will get seen on the day and A&E tend to carry out diagnostic tests more than GPs, which gives people a sense of reassurance.

6.7 There is concern about the implications for A&E following **the introduction of the 111 NHS helpline**. Patients who are put off using the 111 service because of reported problems with getting through or poor advice could put additional pressure on A&E services by making unnecessary visits. The 111 service has worked well in some areas but issues have arisen in others.

6.8 **Maintaining adequate A&E service provision: Winter and Beyond**
Significantly more pressure is placed on A&E during winter. The government response to the A&E crisis includes contingency funding to cope with winter pressures. They have allocated an additional £500 million for A&E services nationally, (£250 million for 13/14 and £250 million for 14/15) to alleviate winter pressures. £55 million out of the £250 million will come to London, to be allocated to priority hospitals. Investment of this funding will be influenced by local needs assessments and set out in a plan by the local Urgent Care Board. But most hospitals will be using majority of the money to invest in Community Health Services and additional doctors to staff A&E departments across the winter period.

6.9 NHS England has called for **Urgent Care Boards** to be set up by local Clinical Commissioning Groups to create and implement emergency care improvement plans in local areas, in consultation with local A&E departments and other relevant partners. This plan is to be reviewed, agreed and signed off by the Chief Executive of the relevant hospital.

6.10 Dr Anne Rainsberry has stated that the current A&E model is not sustainable due to structural problems in the health care system. In the future hospitals will have to develop inter-agency partnerships, working more with community health services and developing a robust system of integrated care.
There will need to be a different offer of urgent care for the growing younger population of 20 – 39 years who are increasingly accessing A&E services. A whole system approach to the health care system is required.

7. Tower Hamlets and the local context

7.1 **Tower Hamlets: Reasons for enquiry**

In light of all of the above and due to the significant health inequalities already in Tower Hamlets, it was felt necessary by the Health Scrutiny Panel to carry out a review of local A&E services. The Panel were keen to understand the extent to which national issues affecting A&E were being experienced locally, and how services are responding.

7.2 Core questions for the review:

- How is the A&E department at the Royal London Hospital coping and what impact is it having on waiting times?
- Do we have a local Urgent Care Board set up and has a local recovery and improvement plan been developed for winter? What are the key actions and how will additional resources be allocated?
- Does the A&E department have the necessary resources, particularly in terms of staff to meet local demands and changing needs?
- What are services doing to manage demand for A&E locally?
- Is the national increase in A&E use by young adults reflected locally? If so are there any plans to mitigate this?
- What do we know about appropriate use of A&E? What is being done to promote effective use and how well is this working?

7.3 **The Royal London Hospital A&E department**

The Royal London Hospital A&E department is open 24 hours a day, seven days a week. The department sees about 155,000 patients (adults and children) each year. The department consists of an Urgent Care Centre, a resuscitation area, an emergency assessment area, cubicles, a clinical decision unit and a separate children's A&E.

7.4 The department also works closely with the London Air Ambulance service and has developed joint administrative pathways for patients to ensure that those who arrive in the air ambulance are seen appropriately.

7.5 Of the £250 million of winter pressure funding made available by central government nationally, Barts Health NHS Trust will receive £12.8 million. Around three quarters (£9.1m) is being invested across the Whipps Cross, Newham and the Royal London hospital sites, and one quarter (£3.7m) is being invested in community schemes.

7.6 **Quality of services**

A national indicator of quality of service in A&E departments is the 95% benchmark. A well-functioning and properly staffed A&E department, supported by prompt access to diagnostics and a well-managed flow into inpatient beds will have 95% of their patients seen, treated and then either discharged or admitted within four hours. The Royal London was achieving 93.9% at the time of the review (November 2013).

7.7 **Urgent Care Board and the emergency care improvement plan and Barts Health affirmative action response**

As required by NHS England, Tower Hamlets CCG has set up an Urgent Care Board to develop and implement an emergency care improvement plan. The Board has identified key causal

factors for underperformance of the Royal London A&E, which will need to be improved in order to raise standards. During the Review Group's visit to the Royal London Hospital, they heard from senior managers of how Barts Health and the Royal London have responded by incorporating these into their winter strategy, putting plans in place through the development of various workstreams and extra investments on ongoing work.
The Urgent Care Board's emergency care improvement plan makes a number of recommendations (below), and Barts Health have responded accordingly by implementing what is highlighted after each recommendation:

- Contingency bed capacity is identified on all sites which can open in response to significant and sustained surges in activity. Also sufficient beds in nursing homes and elsewhere are to be available in the community to ensure that patients who do not need acute care are not occupying acute beds.

Barts Health plan to have 141 additional beds in place in total across the hospitals, with the Royal London having 60 beds. 18 additional community beds have also been identified.

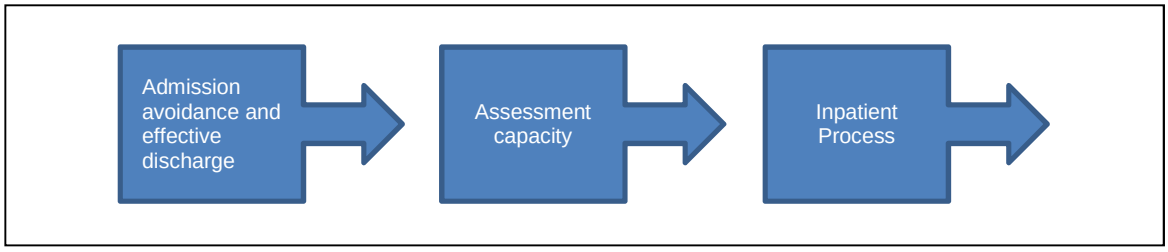
- Sufficient community and social care liaison staff to be available to permit discharge and/or follow on continuity of care where patients no longer require acute care, and that there are sufficient community services available to support admissions avoidance schemes, caring for patients effectively in their own homes.

Barts Health and the wider health and social care community have invested a significant proportion of the funding to be directed across the hospitals and communities to support patients at home and reduce avoidable readmissions, with investment in psychiatric services, extra social worker capacity and seven day working.

- Appropriate processes and policies to be in place to support timely discharge and ensure effective streaming within the emergency department.

Barts Health will be investing £1.5m on improving the flow of patients from A&E through improved clinically-led processes. Barts Health have also prioritised implementing and working to a more seamless patient flow process, working towards three key workstreams which will cover all aspects of emergency patient pathway from start to finish (Diagram 1, below.)

Diagram 1.



- That there are plans to ensure sufficient staff with the necessary skills available at all times, anticipating that staff may be absent due to illness or adverse weather.

More than £2.4m is being invested to increase assessment capacity for patients, including more senior clinical cover in emergency departments seven days a week, and more evening cover for emergency departments, paediatric and diagnostic services.

- Out of Hospital Schemes are developed such as the integrated care programme across primary and secondary health services and social care, urgent care centre, psychiatric liaison, and generally increased capacity in the community.

Barts Health will work to reduce the need for admitting patients, by working with external partners, supporting a shorter length of stay and better care and treatment at home for patients, this will also help reduce hospital admission and help to meet expected demands and provide some additional contingency.

- Managing winter pressures by working more closely with the independent sector to support the elderly through winter and promote self-management programmes.

  Projects have been developed to help avoid admissions which include; an additional £300,000 on extra GP out-of-hours support; £99,000 to support patients with mental health problems who regularly attend emergency departments. £1.85m invested across the three sites, in increased community support and access to expert opinion, especially for elderly patients.

- Management of flu in priority patient groups and staff in acute/primary/social care.

  Work is on-going with NHSE to ensure receipt of accurate data on primary care staff and patient flu vaccination uptake rates.

- London Ambulance Service – a policy for redirection of ambulance.

  New London Ambulance Service arrangements have been introduced to help better manage emergency patient flow.

- Patient communication and social marketing campaigns to ensure the most effective messages are going out to the public to prevent inappropriate A&E attendances and raise public awareness of why and when A&E services should be used, which is both a recommendation in the local Urgent Care Board plan and a broader national issue.

  Barts Health has launched a cross-borough marketing campaign, sending out messages on the importance of only using A&E in an emergency. The awareness campaign messages will run in the councils' East End Life newspaper and other local papers, on local radio stations, bus routes and social networking sites, in addition to being sent out to organisations and partners such as HealthWatch, GP surgeries, libraries, schools and residential care homes. Targeted marketing materials have also been produced such as posters, banners, fold up cards and leaflets to help people access appropriate care for their healthcare needs.

In addition to these improvement areas, Key Performance Indicators (KPI's) will be regularly monitored to make sure processes are organised and working well against meeting benchmarks. Core KPI's include:

- **Admission avoidance**
  Zero length of stay admissions: patients seen by admission avoidance team
- **Assessment Capacity**
  Breaches of four hour standard for non-admitted patients
- **Inpatient process**
  Discharge before 10am and 12pm; surgery cancellations; average length of stay: speciality repatriations
- **Effective Discharge**
  Medically fit patients with length of stay above five days; activity indicators for community provision, delayed transfer care

8 A&E: Public perceptions and demographic use

8.1 Public perceptions of A&E services is one of the major contributors to unnecessary admissions in A&E services, many patients are discharged with no investigation and no treatment. The Clinical Commissioning Group (CCG) term these patients as "inappropriately" using A&E. They are considered inappropriate as they may have been better managed in primary and community care settings. However, the Review Group heard that, from a patient perspective there may be many reasons why they presented at A&E and the patient may feel the attendance was entirely appropriate.

8.2 Tower Hamlets Public Health provided the Group with information from the (2012/13) demographic profile[9] of people presenting 'inappropriately' at A&E:

- The ethnic mix of these presentations is very broadly in keeping with the population mix of the borough (44% Bangladeshi, 20% White British and 9% Other White) (see Appendix: Table 1)
- Overall there are more males than females across all age groups except the 18-30 year olds (see Appendix: Table 2)
- By age group, the highest attendances are from 18 – 30 year olds (33% of total) followed by 31 – 44 year olds (25%), 45-64 years (15%) and 0-5 year olds (12%) (see Appendix: Chart 1)
- Time of day of attendances is split 46% out of office hours to 54% between 10am and 6pm. The 6-9pm time is the single most popular with 24% of all attendances (see Appendix: Chart 2). The 12-5am timeslot shows the clearest (upward) trend through the days of the week (see Appendix: Chart 3)
- Focusing on the three largest ethnic groups, and the 6-9pm presentations, we see:
  a. Declines towards the weekend for White British and White Other; and
  b. Constant levels of attendances throughout the week for Bangladeshi (see Appendix: Table 3)

8.3 In relation to public perceptions of A&E services, the results from the social marketing research conducted by Mckinsey, (commissioned by NHS Tower Hamlets,) provide explanations on some of the reasons why people attend the Royal London Hospital's Emergency Department, people were:

- confused about how to access healthcare in Tower Hamlets. These patients tended to have basic or poor English.

[9] provided by the Clinical Support Unit (CSU)

- they were seemingly confused about how to access care, but actually they were dissatisfied with their GP.
- they believed that the care provided by A&E services clinicians is superior to that provided by their GP.
- going to A&E was more convenient than trying to see their GP.[10]

8.4 The above attitudes are also reflected in the feedback Tower Hamlets HealthWatch received from local resident who used A&E services. Local residents felt:

"It's quicker to go to A&E and you seem to get a proper assessment and tests there and then."

"A&E does stand for accident and emergency but a lot of time when I go there it's not an emergency situation but the only reason I would go there is because I get treated better there."

"One of the reasons its overused is because in our Bengali ethnic what people like parents do is if they see their son or daughter with just like minor bruise or minor hurt they get so worried they say go to A&E instead of the GP and that could be another reason it's being overused."

"Doctors these days dismiss you too easily and the fact that they dismiss you – you don't want to go there a second time say with the same problem. So you obviously go to the immediate alternative – A&E. We have more trust and more faith in them and that they will maybe check you out. They will examine you to an advance level".

"In your local GP for example you've got 30 patients and only 2 GPs running it. That's going to make you a bit more frustrated the fact that it's your local GP and they're not prioritising it as much and it cause you to be less patient and go awol a bit. And then when you got to A&E it's more waiting time but it's a more better service and it's more advanced and more better treatment.

8.5 The response from Tower Hamlets HealthWatch workshops with patients has been that patients are generally quite positive about A&E services at the Royal London. People felt that services were easy to access, did not require prior appointments, and you were never turned away. A&E normally carries out some sort of physical assessment. This gives people a sense of reassurance that their problem has been looked into. Patients also felt that doctors listened to their problems and took them seriously. Some of the feedback on perceptions also concluded that patients do not associate A&E as being for an 'accident' or an 'emergency'; they just prefer it as a point of treatment. Some also saw it as the place you go for an injury as opposed to an illness.

8.6 The overall feedback from HealthWatch on the tendencies of usage also mirror Tower Hamlets Public Health data trends, in that the take up of a A&E services are mostly by the black and minority ethnic population and that there is a large proportions of the population who attend due to the lack of information of other services, and or incorrect assumptions of A&E service use, leading to 'inappropriate' attendances.

[10] There is more detailed breakdown of 'Usage by perception' provided by Tower Hamlets public health in the Appendix, under Diagram 2, 3, 4 and 5

8.7 Tower Hamlets has a large middle aged population, and demographic feature demonstrate variation of an ethnic mix across its age group. Population growth trends predict, that this will continue to grow with notable increases in the proportion of the middle aged and older aged population, especially those who are Bangladeshi.

8.8 The Review Group felt that the analysis of local data could be developed further through joint work with the local Clinical Commissioning Group (CCG), Barts Health and the Commissioning Support Unit (CSU). The analysis of future trends in population growth and demographic features could be measured to anticipate future implications, and utilise diminishing resources where they are needed best.
Further in-depth qualitative work could also be developed to understand the current reasons for 'inappropriate' attendances and what the drivers might be for changing behaviours.

9. Conclusion and recommendations

9.1 The Review Group welcomed Barts Health's response to the poor performance and pressures at the Royal London A&E department, and were encouraged by the partnership working with the Urgent Care Board and the development of its improvement plan. In considering the many issues that have been raised as concerns nationally, not only by the national media but also by experts and specialists in the field (for example, around patient flow through A&E services, the number of beds, understaffing, public perceptions of A&E services) the group felt assured that those are being addressed by the Urgent Care Board's improvement plan and being implemented at the Royal London through the various workstreams.

9.2 The Review Group would however recommend that Barts Health and its partners also consider long-term implications and consider longer term plans for A&E services. Although the Urgent Care Board has been set up to oversee this difficult period and the tough periods of winter planning, tougher periods may still lie ahead. In considering this, the group felt, Barts Health should think about more sustainable approaches in regards to winter planning and resources, with reduced reliance on the additional financial winter resources that may not always be available. This is additionally important given Dr Anne Rainsberry's warning that the current A&E model is not sustainable due to the changes in the overall health care system.

9.3 The Review Group would also like to make a recommendation around staffing. Staffing has been recognised by Barts Health as an internal issue which goes beyond just winter planning, and moving away from expensive and temporary agency staff is a key area for improvement, to permanent staff. Barts Health have planned to have a recruitment drive in the following months leading up to March/April 2014 to fill these vacancies with permanent positions. The Review Group would like to make recommendation that Barts Health works with the Council in recruiting local people to take up these employment opportunities, and not just in jobs as receptionists and health assistants, but also offer and invest in training and development opportunities so that local people can take up positions as doctors, nurses and managers. This can also have long term implications in strengthening relationships between the community and health services.

9.4 Barts Health is still a relatively new organisation, facing challenges that are very different adapting to the changes in the arrangement of the new national health care system, the current economic climate and due to its size being the largest trust in the UK. However in the

recent CQC deep dive inspection[11], the Royal London A&E department fared well. The CQC felt that A&E department at the Royal London was a good service: staff were polite, caring and supportive. The department had protocols and pathways that ensured most patients received safe and effective care and were responsive to the needs of most patients. Staff felt that the department was well-led and a good place to work. Inspectors saw examples of learning from incidents, and changes being made to prevent similar incidents happening in the future. This included evidence of new protocols being introduced. The department was beginning to work with the trust's other emergency departments to ensure that good practice and learning was shared, overall a good example of standard and quality.

9.5 The Review Group, despite having some concerns about the CQC's verdict more broadly, is encouraged by its assessment of the A&E department. The group makes the following recommendations, which focus on how the council can support local health partners in the short to medium term, but also in continuing to improve the health of the whole population, which will ultimately reduce the pressure on local health services, particularly A&E.

Recommendation 1:

That the council gives a greater profile to the promotion of flu vaccinations to staff and the community through its various services.

Recommendation 2:

That the council raises awareness of why and when A&E services should be used and promote other primary care services for minor ailments, to help reduce inappropriat*e* attendees at A&E.

Recommendation 3:

That the council sustain its programmes around smoking cessation, healthy eating and being active to acculturate a healthy lifestyle, reducing long term pressure on NHS and A&E services in the future.

Recommendation 4:

That the council accelerates its work with Barts Health NHS Trust to bring forward and implement plans for integrated care that reduce the pressure on A&E and other hospital services.

Recommendation 5:

That the council's public health service explores with Barts Health NHS Trust a joint research project to better understand reasons for inappropriate use of A&E by local residents, and what the drivers might be for changing behaviours.

Recommendation 6:

That the council and Barts Health work together on recruiting from the local community, and working with Higher Education institutions to train doctors and other medical practitioners from a diverse range of backgrounds and with roots in the local area.

[11] http://www.cqc.org.uk/directory/r1h

Appendix

Table. 1: Attendances by ethnicity

Fiscal year	2012/13	
Row Labels	Sum of Attends Count	% of total
ASIAN: Bangladeshi or British Bangladeshi	8349	44
ASIAN: Indian or British Indian	296	2
ASIAN: Other Asian, British Asian, Asian Unspecified	645	3
ASIAN: Pakistani or British Pakistani	207	1
BLACK: African	945	5
BLACK: Any other Black background	331	2
BLACK: Caribbean	311	2
MIXED: Other Mixed, Mixed Unspecified	191	1
MIXED: White and Asian	67	0
MIXED: White and Black African	65	0
MIXED: White and Black Caribbean	134	1
NOT STATED	769	4
OTHER: Any other ethnic group	976	5
OTHER: Chinese	193	1
Unknown	49	0
WHITE: Any other White background	1643	9
WHITE: British (English, Scottish, Welsh)	3858	20
WHITE: Irish	132	1
Grand Total	19161	100

Table. 2: Attendances by gender

Ethnicity Desc	(All)					
Sum of Attends Count	Column Labels					
	2012/13			2012/13 Total	Grand Total	
Row Labels	Female	Male	Not Known			X Male: one females
0 to 5	1016	1254	1	2271	2271	1.234252
6 to 11	434	576		1010	1010	1.327189
12 to 17	440	504		944	944	1.145455
18 to 30	3287	3030		6317	6317	0.921813
31 to 44	2186	2554		4740	4740	1.168344
45 to 64	1338	1459		2797	2797	1.090433
65 to 84	427	538		965	965	1.259953
85+	46	71		117	117	1.543478
Grand Total	**9174**	**9986**	**1**	**19161**	**19161**	**1.088511**

Chart 1. Attendance by age group

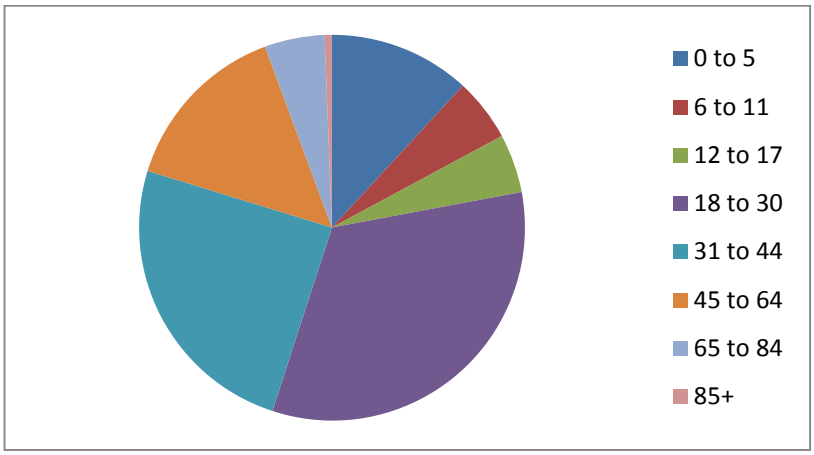


Chart 2: Attendances by time slot

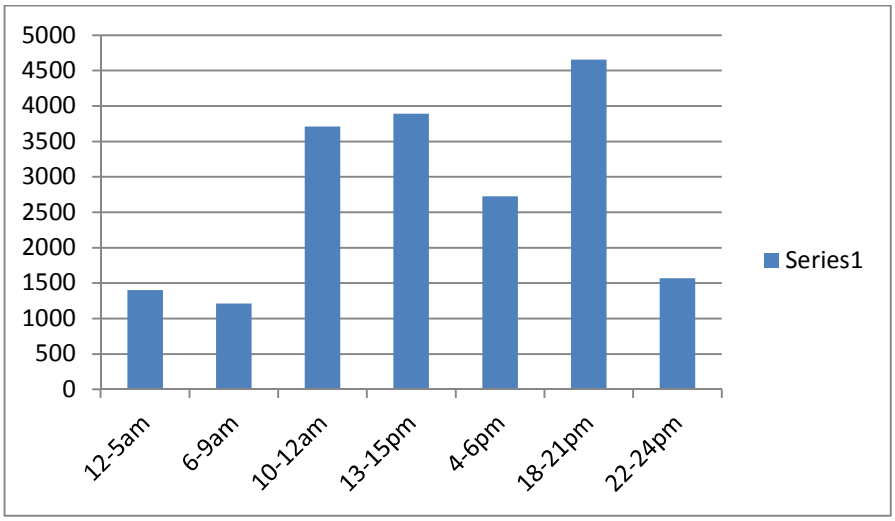


Chart 3: 18-44 year olds, presentations by timeslot and day of week

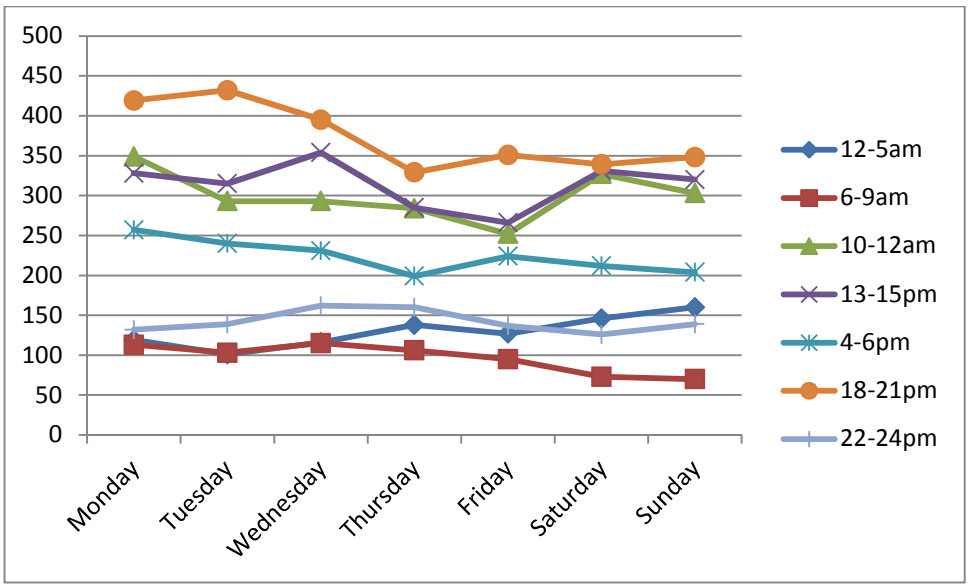


Diagram 2: Usage by perception

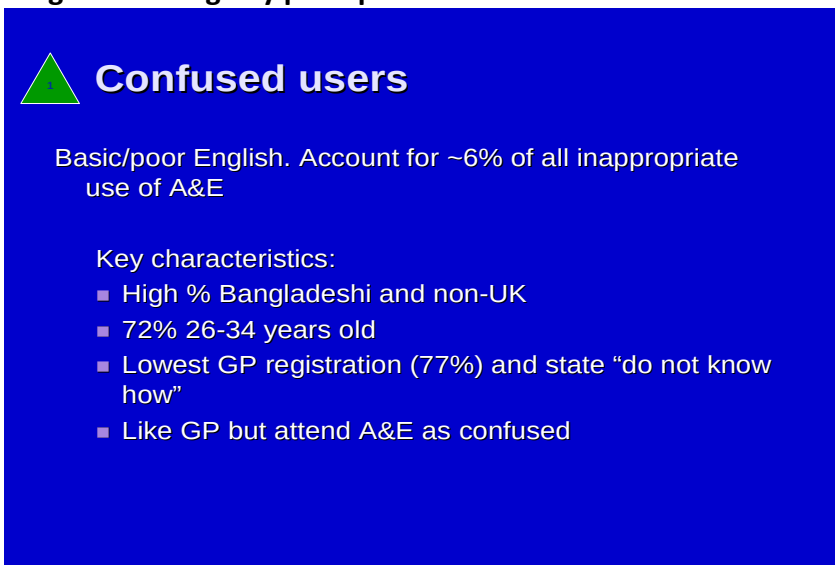


Diagram 3: Usage by perception

Diagram 4: Usage by perception

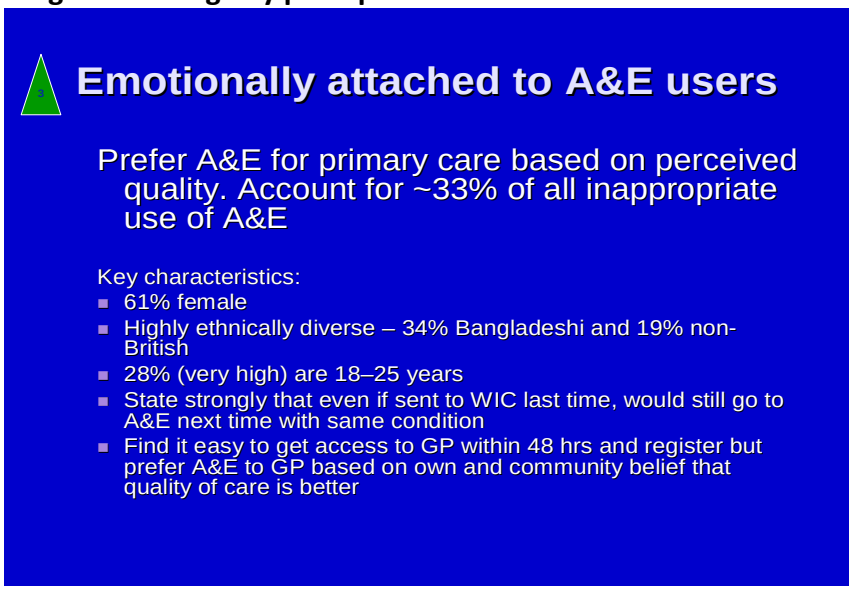


Diagram 5: Usage by perception