LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY PANEL

HELD AT 7.40 P.M. ON MONDAY, 2 MARCH 2015

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

Members Present:

Councillor Asma Begum (Chair)
Councillor David Edgar (Vice-Chair)
Councillor Danny Hassell
Councillor Craig Aston

Co-opted Members Present:

David Burbidge	–	(Healthwatch Tower Hamlets Representative)

Others Present:

Dr Somen Banerjee	–	(Interim Director of Public Health, LBTH)
Dianne Barham	–	(Director of Healthwatch Tower Hamlets)
Dr Malik Ramadhan	–	Deputy Group Director, ECAM and Clinical Director, Emergency Departments (Barts Health)
Deborah Madden	–	Deputy Director of Operations, ECAM and Acting Hospital Director, Royal London Hospital (Barts Health)
Andrew Attfield,	–	Associate Director of Public Health (Barts Health)
Nigel Woodcock	–	Community Health Services Procurement Programme Director (CCG)
Dr Osman Bhatti	–	Community Health Services Procurement Clinical Lead (CCG)
Dr Katie Cole	–	(Independent Clinical Advisor (CCG))

Officers Present:

Leo Nicholas	–	(Strategy, Policy and Performance Officer, Education, Social Care and Wellbeing)
Antonella Burgio	–	(Democratic Services)

Apologies:

Councillor Denise Jones
Dr Sharmin Shajahan (PhD)

INTRODUCTION

The Chair opened the meeting and welcomed Members guests from Bart's Health, Tower Hamlets CCG and Tower Hamlets Healthwatch.

1. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS

No declarations of disclosable pecuniary interest were made.

2. REPORTS FOR CONSIDERATION

2.1 Barts Health

The Deputy Group Director, ECAM and Clinical Director, Emergency Departments together with Deputy Director of Operations, ECAM and Acting Hospital Director, Royal London Hospital (Barts Health) and Associate Director of Public Health spoke to the Panel on the matter of Accident and Emergency (A&E) winter pressures. He informed the Panel that:

- Yearly, 300,00 patients were seen by Barts Health and of these, 155,000 per year were treated by Royal London Hospital (RLH) for a range of both minor and urgent conditions.
- The service was delivered through structured facilities designed to deal with a range of severity of conditions.
- Performance targets at Royal London Hospital (RLH) for A&E were set at 95% and performance was presently at 90% of targets.
- The following factors detrimentally affected access of local people to A&E services and were factors which each contributed to poor access to RLH beds
    - Bed-base issues – discharges
    - Trend towards elderly patients incurring prolonged length of stay
    - RLH was the specialist centre for gunshot wound events and received A&E referrals from other areas
    - Delayed return of referred patients to their home Health Trusts in each trust area

- Demographic changes indicating a trend towards an increased incidents of elderly trauma (e.g. hip fracture) than seen in previous years

He noted the following measures/initiatives to alleviate prolonged stay in acute beds:

- Statistics showed that, at any one time, 10% of the 700 beds provided at RLH were filled by occupants not actually recovering treatment. He suggested that a role of the CCG should be to try to facilitate movement to short-stay respite care in order to free beds for acute medicine.
- RLH worked with local GPs to deliver the Hot Clinics scheme

Dr Ramadhan noted that notwithstanding these schemes there were still pressures with patient influx into A&E and that other Trust Hospitals experienced the same pressures except that of tertiary care.

In response to the Panel's questions, the following information was provided:

The no impacts of the implementation of the Better Care Fund on the service had yet been observed. However the fund was announced by Government in 2013 and formed part of NHS two-year operational plans and five-year strategic plans. Therefore it would be more appropriate to monitor impacts in the forthcoming year.

One incident of Norovirus had been posted at RLH presently with no further spread.

The information campaign on buses and billboards promoting appropriate use of A&E and other forms of access to healthcare services had had no impact on public behaviour.

It was noted that outcomes of the last A&E review provided indications of the motivators for the patterns of A&E usage observed and, resulting from this, more investigations would be undertaken.

No data on the proportions that unnecessarily attended A&E was available at the meeting. However the Panel was advised that:

- There was no bar to access this service
- Usage was influenced by a number of factors such as opening times of GP surgeries, times of access to ancillary support services e.g. translators
- During the daytime a different stream structure was observed but at night times staffing levels were lower. Therefore during early morning hours there was competition between numbers attending and when these were able to access healthcare.

Concerning what factors would constitute desirable levels of access, the Panel was informed that the staffing model was able to cope with patient ingress but problems were experienced at patient discharge. Therefore it was

recommended that the campaign should also incorporate on appropriate departure from A&E and how quickly this can be undertaken appropriately.

Patient expectation and repatriation into local District General Hospitals (DGH) were issues that also needed to be considered. Some repatriations were complicated by the status of the patient (e.g. overseas tourist etc.) and therefore complex negotiations were often required.

Additionally, on a daily basis, 50 beds were occupied by patients who were fit to be moved on to other appropriate types of care. However but no suitable next stage care facilities were available. Faster onward discharges were also affected, in part, by a lack of suitable onward facilities that would have previously been available e.g. nursing homes: there were presently only two in Tower Hamlets. Additionally, in past years, hospitals provided a number of convalescent beds for those in need of nursing care. This form of hospital provision no longer existed.

It was noted that communications with Tower Hamlets Council were good and there were a range of arrangements with the CCG relating to how the care was resourced. However conversations with other DGHs were not always constructive.

Mr Burbige noted that, in his view, residents of the borough incurred detriment because of RLH's, operational successes and because of its Tertiary Unit facilities. Dr Ramadhan advised that this detriment was offset by the immediacy of the major trauma facilities available to any local residents suffer such a mishap.

Concerning discharges delayed because a consultant authorisation was awaited, the Panel was informed that afternoon patient reviews were now undertaken in all wards and there were also nurse-led patient discharge criteria which addressed this kind of situation.

Concerning the timing of release of winter pressures funding and its effects on levels of resilience in the service, the Panel was informed that by advance planning of how the funding would be used, staffing levels could also be synchronised in advance to meet the need during the periods of high demand. However this model carried a financial risk as it required money to be committed before the funding was released by Government additionally it required management approval before recruitment could be undertaken.

Concerning recommendations arising from the A&E Review relating to employment of local people, into healthcare roles, the Panel was informed that RLH supported the employment of local people into healthcare clinical roles and their progress into professional nursing roles. Members were also informed that roles at Bands 1-3 were aimed at this kind of career progression and talent pools and apprenticeship were other forms of entry into health careers.

Dr Ramadhan invited Panel members to visit A&E at RHL to experience the environment in which acute emergency medicine was delivered.

The Chair thanked Barts Health representatives for their presentation and the invitation extended.

RESOLVED:

The presentation be noted

2.2 Tower Hamlets CCG - Update on the community health services procurement and engagement activities planned

The Community Health Services Procurement Programme Director (CCG) and Community Health Services Procurement Clinical Lead (CCG) made their presentation which provided an update on community health services procurement and engagement plans with the aim of delivering these services more effectively. The present contract has been held by Barts Health since 2011.

The Panel was informed that one year ago NHS Tower Hamlets CCG canvassed a range of stakeholders regarding the re-procurement of community health services. The competitive dialogue model of procurement has been chosen with the aim of having a care coordinated function to underpin the services and to coordinate local services using a single point of access model.

In response to the Panel's questions, the following information was provided:

Concerning the effectiveness of the approach chosen, the Panel was informed that work on cardiac care had been done by Bexley CCG, which had resulted in new ways of procurement which were not solely price-based but more focused on patient outcomes and quality for the benefit of local patients.

The responses received in regard to the TH community health services re-procurement were encouraging and the approach CCG had adopted was one that had not, to date, been used extensively throughout CCGs in England. The CCG’s aim was to ensure a more patient centred approach and provide more patient centred outcomes. Early indications were favourable.

Concerning organisation of the dialogue days, the Panel was informed that there would be separate days dedicated to specific areas such as service model, mobilisation, IT, governance etc.

Concerning whether the outcome-based approach would incur greater financial risk, the Panel was informed that a new approach had been implemented with the aim of securing better quality and better targeted services.

The CCG has identified a cost range of £30-33M for the procurement. Mechanisms to support the approach would have the risks assessed so that appropriate risk boundaries could be set. The chosen range was intended to:

- Enable providers to be more innovative in regard to IT and access to contemporaneous records and also in regard to standards of facilities.
- Give bidders flexibility to move funding and prioritise responses to deliver the appropriate care
- Enable bidders to make longer term plans as the initial contract would be for five years with the possibility of extension to seven years.

The Panel discussed the composition of the Programme Board and was informed that:

- As GP members have conflicts of interest, they are not members. The Board is chaired by the Governing Body nurse representative, supported by three independent clinical advisors and other non-conflicted members.
- Patients are being proactively involved in the evaluation process e.g. evaluation days and final tender presentations. Additionally, patients will have a continuing role in the ongoing scrutiny of the contract.
- CCG would seek to utilise the Social Value and Care Act to ensure that applicants demonstrate commitment to the local area.
- A Market Day event was held in November 2014 which potential bidders attended, including those from the local voluntary sector, and were encourage to become involved. The voluntary sector

Concerning engagement with schools, the Panel was informed that this would be explored to enable parents of children with special needs to be reached.

RESOLVED:

The presentation and update report be noted

2.3 Health watch progress update

Director, Healthwatch Tower Hamlets presented the update and progress report. The Panel was reminded of Healthwatch core functions and strategic aims. Following this Members were informed of the initiatives undertaken in 2014 to achieve/promote Healthwatch's aims in relation to the themes of governance, understanding and support, influencing those with power to change services and leading to ensure local insight can influence services.
In regard to the 'patients' journey' the most common issues were found to concern:

- Errors in patient appointment letters
- Delays in specialist appointments
- Repeated cancelled appointments and surgeries
- Errors at admission
- Referrals to other providers
- Patient transport
- Poor staff attitudes - especially receptionists
- Occurrence of repetitive issues

Healthwatch has worked to help mitigate these by:

- Hosting an event for all providers to engage and explore how Healthwatch might assist to resolve these issues through the development of a Healthwatch Care Programme
- Exploring ways in which the patient journey can be improved
- Promoting a new feedback system
- Promulgating examples of good practice to other areas
- Engage with the Youth Panel to reach young people and schools programmes

In response to the Panel's questions, the following information was provided:

Getting to the root of an issue might be complex, therefore it was suggested that 4 of the most common issues should be identified and a trace-back audit undertaken to identify cause and appropriate remedy.

Concerning delays in getting GP appointments, the Panel was informed that the call-back system of appointment making was the most effective method but those for whom English was the second language experienced difficulties in this circumstance. It was necessary therefore, that GP surgeries should offer more than one method of making appointments to avoid excluding sections of the community.

Statistics showed that use of walk-in centres was preferred by the same demographic as that which tended to use A&E.

Noting the difficulties that non-English speaking resident could encounter in booking a GP appointment, the Panel was informed that a survey of how the Somali population accessed GP services would be undertaken to explore how strategies for better access could be developed.

Concerning what progress was being made to address the structural issues in accessing A&E services via inter agency partnerships, the Panel was informed that pressures at RLH remained and CAGs were not effective. There was much data but this needed to be analysed to explore how things could be done differently.

Concerning how Barts Health utilised internal audits, the Panel was informed that Healthwatch had requested baseline data on complaints but this had not been made available.

RESOLVED:

The presentation and update report be noted

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

Dr Banerjee wished to make the Panel aware of the Transforming Services Together programme and encouraged Members to become involved. It was also noted the Inner North East London JHOSC was monitoring the matter.

The meeting ended at 9.30 p.m.

Chair, Councillor Asma Begum
Health Scrutiny Panel