TOWER HAMLETS

HEALTH SCRUTINY PANEL

Wednesday, 8 April 2015 at 7.00 p.m.

MP701 - Town Hall Mulberry Place, 5 Clove Crescent, London E14 2BG

This meeting is open to the public to attend.

Members:
Chair: Councillor Asma Begum
Vice-Chair**:** Councillor David Edgar

Councillor Danny Hassell, Councillor Suluk Ahmed, Councillor Denise Jones, Councillor Mahbub Alam and Councillor Craig Aston

Deputies:
Councillor Sirajul Islam, Councillor Abdul Mukit MBE, Councillor Rachael Saunders, Councillor Chris Chapman, Councillor Julia Dockerill, Councillor Peter Golds, Councillor Shah Alam, Councillor Gulam Kibria Choudhury and Councillor Md. Maium Miah

Co-opted Members:

David Burbidge	(Healthwatch Tower Hamlets Representative)
Dr Sharmin Shajahan (PhD)	(Healthwatch Tower Hamlets)

[The quorum for this body is 3 voting Members]

Contact for further enquiries:
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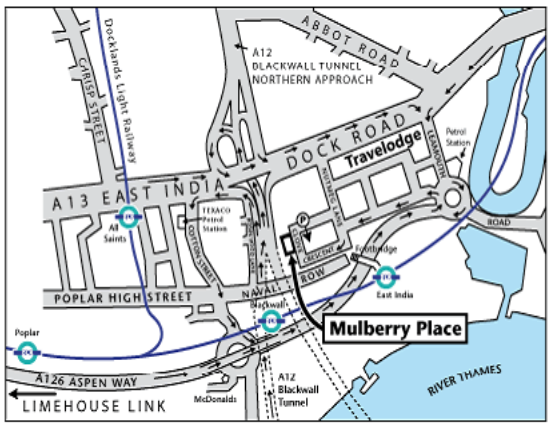

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PAGE NUMBER(S)

APOLOGIES FOR ABSENCE

1. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS — 1 - 4

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 Monitoring Officer.

2. MINUTES OF THE PREVIOUS MEETING(S) — 5 - 20

To confirm as a correct record the minutes of the meeting of the Health Scrutiny Panel held on 18th November 2014 and 2nd March 2015.

3. REPORTS FOR CONSIDERATION

3 .1 CCG - Self Management of Long Term Conditions — 21 - 28

To receive a presentation from Tower Hamlets CCG

3 .2 Update on Actions Arising from HSP Scrutiny Review of Accident and Emergency Services in Tower Hamlets — 29 - 40

To consider the update report arising from recommendations made by Health Scrutiny Panel in its review of A&E services in the borough.

3 .3 Barts Health — 41 - 44

To note matters arising from a recent CQC inspection.

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

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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, Interim Monitoring Officer, 020 7364 4800
- 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 7.00 P.M. ON TUESDAY, 18 NOVEMBER 2014

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

Co-opted Members Present:

Dr Sharmin Shajahan (PhD) – (Healthwatch Tower Hamlets)

Others Present:

Jackie Applebee – (Parent Governor Representative)
Paul James – (East London NHS Foundation Trust)
Simon Twite – (Strategist,Tower Hamlets Public Health)

Officers Present:

Dr Somen Banerjee – (Interim Director of Public Health, LBTH)
Sarah Finnegan – (Senior Strategy Policy and Performance Officer, Corporate Strategy and Equality Service, Chief Executive's)
Barbara Disney – (Service Manager, Strategic Commissioning, Adults Health & Wellbeing)
Antonella Burgio – (Democratic Services)

Apologies:

Councillor Denise Jones
David Burbridge, Healthwatch Tower Hamlets

1. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS

No declarations of disclosable pecuniary interests were made.

2. MINUTES OF THE PREVIOUS MEETING(S)

The minutes of the meeting held on 16 September 2014 were presented for approval. The Chair and Councillor Edgar noted that their attendance had been omitted from the record. It agreed that their attendance be added to the meeting and subject to this correction, the minutes approved.

RESOLVED

That the minutes of the meeting held on 16 September 2014 be approved subject to the following correction: that the attendance of Councillors Asma Begum and David Edgar be recorded.

3. REPORTS FOR CONSIDERATION

3.1 Transfer of Commissioning Responsibility for Early Years (0-5 years) Public Health Services from NHS England to the Local Authority

The Interim Director of Public Health presented the report which informed the Panel of proposals for the transfer of commissioning responsibility for Early Years Public Health Services from NHS England to the local authority and highlighted the following matters reported in the document:

- The transfer would take place on 1 October 2015.
- Early years services were important in terms of the long-term impact on lifelong health and well-being and therefore were critical for the future health and well-being of the community.
- The role of 0-5 years health visitors would increase. Tower Hamlets had a good allocation of health visiting already and it was anticipated that the health visiting role (which was about supporting families in a holistic way) would incorporate health services delivered in the home environment.
- In the past, because health visitors resources had been lower than they should be, health visitors had had focused on more urgent elements of their role but with the anticipated increasing provision that the transfer would provide, it would be possible to look to fulfil the health visitor role more fully.
- The approach would be to focus resources on the most vulnerable (teenage mothers etc) and in this way to help turn around infant health issues that exist in the borough through better assistance.
- A notional budget of £6.6 million excluding overheads and management costs had been set. However the Interim Director aimed to that an appropriate level of funding would be released before signing off the transfer.
- Staffing was presently 45 health visitors and the aim was to reach a level of 95 practitioners. The Interim Director noted that the market for recruitment of this role was competitive and therefore the package needed to be an attractive.

- There were national standards for delivery of health visitor services incorporating; antenatal visits, and health visits at: one month, 6 to 8 weeks, two months, and up to the two-year-old health check.
- The Interim Director noted that there were high levels of childhood obesity in Tower Hamlets and it was intended that the health visitor assessments would help to identify resources to address this situation.
- It was necessary to ensure that the health visitor service integrated with other nursing services in the borough. To do this, Public Health would engage with the local authority, GPs and other service providers. The options were to bring health visiting services in-house.
- Options for procurement of the health visiting services were being explored with the Director of Education, Social Care and Well-being taking into account that terms and conditions for a key issue around the transfer of services, recruitment and retention of staff.

Councillor Hassell requested that information on:

- Outcome indicators for early years
- Healthy child review

be circulated to members of the Panel.

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

- Funding would be received directly by the local authority therefore the Council would be able to decide how to procure these services either by direct employment or through contracts. Health visitor funding would be ring fenced within the public health grant however the duration of this grant was not certain.
- The matter of whether funding for the increased number of health visitors would be secured from Government, was being discussed with Barts Health and terms that overhead costs must be covered resolved to ensure that the mandate could be delivered.
- In relation to recruitment pool that could be accessed and facilitating recruitment, overhead costs had been included in the transfer terms of some boroughs. However the terms of those mentioned in the report excluded overheads. Reasons for this omission did not directly relate to issues or activities of these councils.
- Boroughs faced different issues concerning the pool for recruitment and its facilitation. The local recruitment strategy would be to bring students into the service so that by the time the transfer took place the recruits would have worked in the borough and have an option to remain. The market for recruitment was competitive therefore job satisfaction would be important.
- There was no requirement, per se, to transfer existing staff for capacity building but there were options to explore visiting-type roles which could become involved in health visiting and this may be a good option to explore to bring in skills. Paul James of East London NHS Foundation Trust (ELFT) advised that ELFT runs visiting services in Newham and similar recruiting issues were encountered. However there was a fast track commissioning available to train into these roles.
- Stakeholder engagement would be organised by the Associate Director of Public Health in three months time.

- The transfer of health visiting services to the local authority offered opportunities to better monitor health strategies for children.

RESOLVED

That the report be noted

Action by:
Tahir Alam, Senior, Strategy, Policy and Performance Officer (LGP)

3.2 Health and Wellbeing Strategy (Healthy lives, and Maternity and early years)

A summary paper was tabled at the meeting. The Panel was informed that:

- the strategy was informed by the joint strategic needs assessment (JSNA) and based on priorities listed at page 6 of the paper.
- the update concerned maternity and early years and healthy lives.
- at present the one year action plan was being addressed.

The following were also noted:

- the strategy had two approaches, prevention (public health role) and treatment
- aspirations centred around early years covering a 4-year term. These were also listed in the paper. The aspirational elements were:
    - healthy eating at home and at school. It was noted that this lever was not available to the local authority in respect of free schools and there were challenges around healthy eating outside schools in terms of fast food outlets
    - physical activity, aiming for sustained impact via enjoyable participation in physical activity
    - adolescence, aiming to promote strategies regarding safe around drugs, risky sexual behaviours, knowledge to become good parents
    - middle age, retaining healthier habits and better awareness of health risks such as diabetes and heart disease and improved awareness of signs and symptoms
    - end of life care, to be in control of end of life choices

  The above elements were undergoing a one-year refresh.

In response to Members questions the following information was provided

- The first draft of the revised strategy would be ready shortly and the revised action plans would be presented to the Health and Well-being Board in January 2015.
- High-level evidence of the importance of early years on health during later life was drawn from the findings of the Marmot review. Additionally evidence-based health checks were used to ensure that

people who had these could be referred appropriately. It was also noted that the strategy did not only rely on evidence-based data but incorporated innovative measures.

- There was concern that those in most need were not accessing services e.g. white middle-aged males, therefore the strategy aimed to address this.
- Opportunities for maximising section 106 benefits were secured via input into the Local Development Framework. However there also needed to be input from local people to improve the quality of green spaces. It was noted that this work was slow; however there were fenced off places that could be better used. The strategy could be used purposefully to explore the links between environment and health by setting out aspirations for the use of green spaces.

RESOLVED

That the report be noted

3.3 Carers

The Service Manager, Strategic Commissioning, Adults Health & Wellbeing gave a presentation set out at item 3.3 of the agenda and highlighted the following matters:

- The Care Act places a statutory duty on the Council to provide support for carers. The Council's JSNA summary (2014) highlighted that there was a need for people to take responsibility for their health. This would be achieved by preventative awareness programs delivered through partners such as LinkAge Plus as well as a broad range of "awareness" programmes to enable prevention and early diagnosis through public health and direct service provision. This joint approach meets the requirements of the Care Act
- The underpinning principles of the Council's Care Plan reflect the principles of the Care Act
- Arising from the impacts of the Care Act, the Council was presently reviewing its carers' service and rethinking services to ensure that it achieved an appropriate balance of specialist and community services.
- Support could be accessed across a range of Council services such as Ideas Stores etcetera.

In response to Members questions the following information was provided:

- Under the Act, transition from children's services to adult services would be smoother and transition services extended to 25 years old. Additionally the merger of Adult Social Care with Children's Services enabled better sharing of ideas to extend the carer work carried out by the council to children.
- It was accepted that, in general, carer levels were nationally underestimated. It was difficult to identify carers or those who perform

caring role as these persons did not necessarily reveal themselves or access services / agencies which would appropriately identify them.

- When the service was reviewed monitoring information would be analysed and finding used to assess the impacts of the Carer Act on services and inform how health services have benefited the community and how services are needed. It was noted that the Act would place greater emphasis supporting carers before they reach crisis point.
- Concerning the levels of advice and information currently available, a contract had been let to a consortium of local providers that give advice and information on a range of support available, including benefits. Awareness would increase once the Care Act was in force and the authority would also seek to raise awareness through outreach.

RESOLVED

That the presentation be noted

3.4 Update on GP Services and Funding Cuts

G.P Dr Jackie Applebee gave an update on the impacts of the Government's plans to implement MIPGL on General Practitioner (G.P.) services in the borough and East London.

The Government planned to roll out this program over seven years and, if effected, its implementation would destabilise 22 G.P. practices in East London. Tower Hamlets G.P.s have campaigned against this program and the Inner North-East London Joint Health Overview And Scrutiny Committee has sent a letter to the Head of Primary Care NHS England on this matter.

Issues with the programme concerned inaccurate and crude formulas used by NHS England, and accuracy issues, in calculating eligibility for additional funds. The East London GP action group was lobbying that the formula for primary care funding be based on life expectancy rather than absolute age as this better reflected when health issues in the borough would arise. Additionally the tool is used to rate GP practices was very crude and did not properly take into account the demographic of the population

It was noted that Simon Stephens will visit the CCG in December

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

- The formulation of poor eligibility criteria was not believed to be the result of due to incompetence but to under-resourcing which meant
    - there was no consultation at local level
    - criteria were not developed using local knowledge derived from information gained through familiarities that had been possible under the former PCT arrangement.
- The purpose of the meeting with CCG in December would be to pursue the issue of migration in the organisation, hygiene in the organisation

- Because of staffing shortfalls within NHS England its approach was mainly reactive rather than proactive.

RESOLVED

That the update to be noted

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

The Chair informed Panel that she had received a request from Mr Burbridge to consider the establishment of a standing committee between the Panel and Healthwatch Tower Hamlets. She advised that the matter would initially be explored informally and the proposal brought back to a future meeting

The meeting ended at 8.31 p.m.

Chair, Councillor Asma Begum
Health Scrutiny Panel

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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

Agenda Item 3.1

NHS
Tower Hamlets
Clinical Commissioning Group

Self-Management in Tower Hamlets

Health Scrutiny Panel, 8th April 2015

Julie Dublin, Zakia Khatun and George Lenon

NHS
Tower Hamlets
Clinical Commissioning Group

Who is Self-Management for?

- Around 15 million people in England have 1 or more long-term conditions.
- Levels of long term illness/disability in Tower Hamlets are 34% higher than the national average.
- People with long-term conditions are the most frequent users of health care services, accounting for 50 per cent of all GP appointments and 70 per cent of all inpatient bed days

NHS
Tower Hamlets
Clinical Commissioning Group

What is Self Management?

- For people with long-term conditions, self-management involves caring for their body and managing their illness, adapting everyday activities and roles to their condition, and dealing with the emotions that arise from having the condition. (*Health Foundation, 2015*)
- A self-management programme seeks to support people to manage their own condition through provision of tools, education and guidance on behaviours.

NHS
Tower Hamlets
Clinical Commissioning Group

Benefits of Self-Management

Return On Investment

Delivers on NHS Outcomes Framework

Patient choice

Cost effective

Flexibility

Proven positive clinical outcomes

self management uk

NHS Tower Hamlets Clinical Commissioning Group

What is happening to support Self-Management in Tower Hamlets?

- Patient education programmes
- Medicines support
- Diet and exercise advice and support
- Telehealth
- Psychological support
- Patient access to own GP records
- Training for clinicians in patient engagement
- Peer group support
- **Self-Management Pilots**

NHS Tower Hamlets Clinical Commissioning Group

5

Self-Management Pilots – Original Brief

Providers were asked to design pilots that:

- Fostered collaboration between statutory and voluntary sectors
- Demonstrated new ways of working
- Delivered demonstrable outcomes for patients who were in integrated-care cohorts and/or were living with one or more Long Term Conditions with poorly controlled symptoms.
- Addressed barriers to effective self-management

NHS Tower Hamlets Clinical Commissioning Group

Self-Management Pilots – Desired Outcomes

- Clinical outcomes - Has the intervention led to an improvement in clinical outcomes?
- Utilisation outcomes - Since accessing the pilot, has participants utilisation of emergency or primary care services changed?
- Wellbeing outcomes - Do participants feel that their quality of life has improved? Has it improved their perception of services they use? Have symptoms such as depression and anxiety reduced?
- Ability to effectively self-manage – Has the participants' **Patient Activation Measure** score improved?

NHS Tower Hamlets Clinical Commissioning Group

Self-Management Pilots – Providers

Green Candle – *Your Move*

- 12 week programme of exercise and dance
- Aimed at three cohorts of older people (55+):
  - Older men with one or more Long Term Conditions
  - People who have recently had a fall
  - People living with Dementia

NHS Tower Hamlets Clinical Commissioning Group

Self-Management Pilots – Providers

Community Options – *Esteem*

- Range of services which help people to consider the impacts of their mental wellbeing and behaviours on their physical wellbeing and vice versa.
- Services include: Weekly community choir; intensive one-to-one support for people living with hoarding; group education sessions for people with a mental health condition and diabetes

NHS Tower Hamlets Clinical Commissioning Group

Self-Management Pilots – Providers

Ability Bow – *Managing Your Health and Wellbeing*

- Support 75 people with Long Term Conditions to complete a tailored exercise programme
- The cohorts include people with long term physical conditions, severe mental illness and learning disability.
- Interventions aim to improve people's mobility, independence and confidence

NHS Tower Hamlets Clinical Commissioning Group

Self-Management Pilots – Providers

Social Action for Health & WHFS –*Self management and education for people with CVD, hypertension and diabetes*

- Redesigning services commissioned by the CCG for diabetes broadening the offer to people with CVD and hypertension
- Includes peer support, befriending and key message on diabetes
- Structured education for people with type 2 diabetes
- Patient Activation Measure used to determine which service individual will benefit from the most and how effective the intervention has been in improving activation level.

NHS Tower Hamlets Clinical Commissioning Group

Wider Context

- Strategic Drivers
- Patient Activation Measure
- Integrated Care
- Integrated Personal Commissioning

NHS Tower Hamlets Clinical Commissioning Group

PAM®
Patient Activation Measure®

Level 1 | Level 2 | Level 3 | Level 4

Insignia Health®

Measure. Engage. Activate.

Activation Starts with Measurement

The **Patient Activation Measure® (PAM)®** assesses the underlying knowledge, skills and confidence integral to managing one's own health and healthcare.

PAM segments consumers into one of four activation levels along an empirically derived continuum. Each level provides insight into an array of health-related characteristics, including attitudes, motivators, behaviors and outcomes.

This predictive guidance helps to identify realistic and achievable opportunities to change behaviors and treatment that can move an individual forward on a journey of increasing activation.

PAM in Action

More than 100 leading health organizations use the **Patient Activation Measure** and related Insignia products, including:

American Health Holdings
American Specialty Health
AtlantiCare
Boerhringer Ingelheim
DaVita
Fairview Medical System
Intercare Solutions
Johns Hopkins Healthcare
Kaiser Permanente
Marshfield Clinic
Medica
Moda Health
Monroe Plan for Medical Care
National Health Service (UK)
North Carolina Medicaid
Oregon's Health CO-OP
PeaceHealth
Providence Health Plan
Providence Health & Services
Regence BlueCross BlueShield
Roche
Sanford Health
Sanofi-Aventis
St. Luke's Health System
UnitedHealth Group
Washington State Medicaid
WellPoint

PAM is Backed by Extensive Research

The Patient Activation Measure is a unidimensional, interval level, Guttman-style 10- or 13-question scale developed by Dr. Judith Hibbard, Dr. Bill Mahoney and colleagues at the University of Oregon. PAM was created and tested using Rasch analysis and classical test theory psychometric methods.

To date, more than 150 independent studies worldwide have documented the importance of activation, the ability of this tool to measure activation and its ability to predict a broad range of health-related behaviors and outcomes.

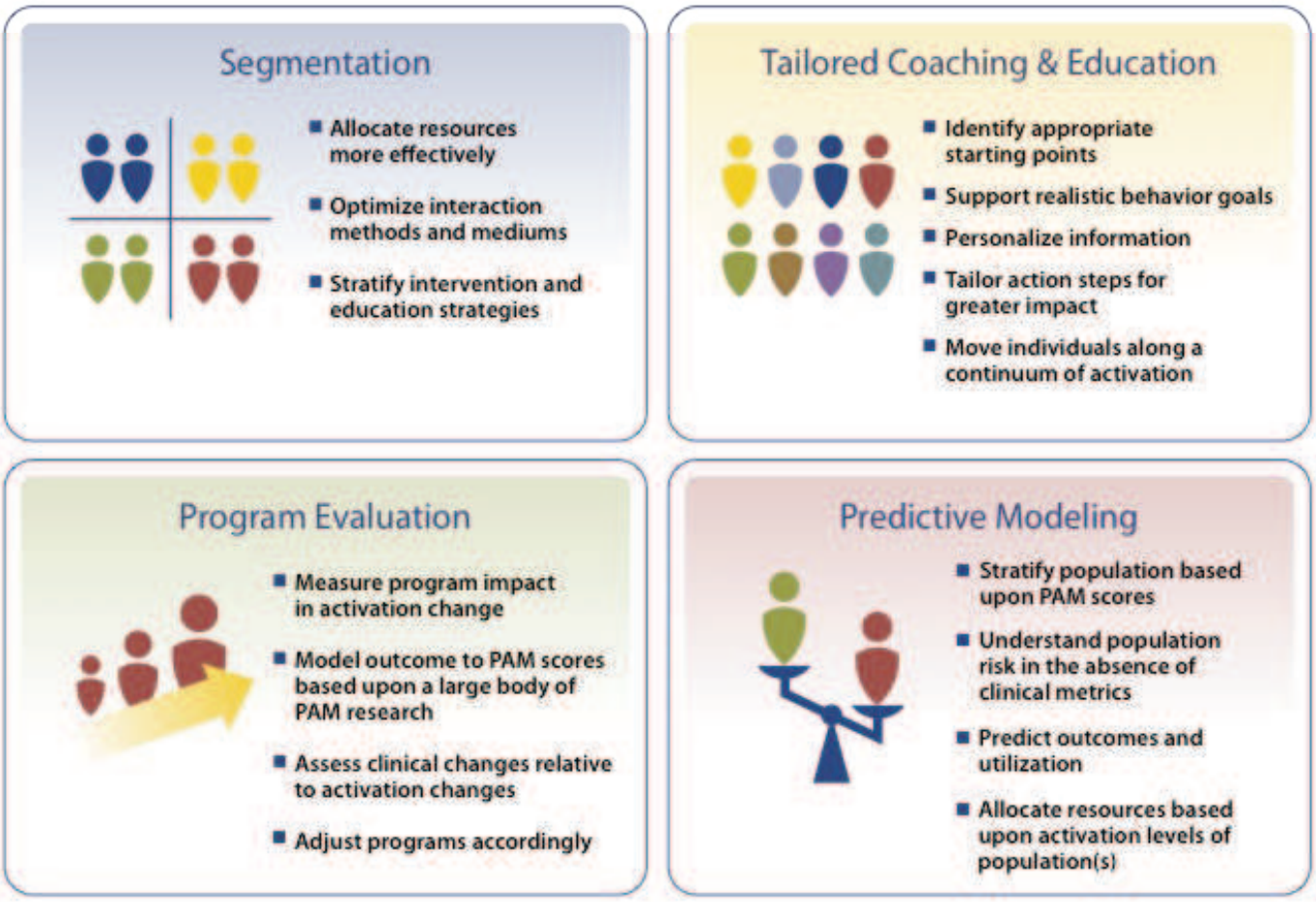
This research consistently demonstrates that individual self-management improves significantly with increasing levels of activation.

Rev.08122014

Self-Management Assessment and Applications

The Patient Activation Measure is reliable and valid for use with patients managing chronic conditions and with individuals engaged in disease prevention efforts. It is being used today in population health management programs, disease and case management systems, wellness programs, medical home projects, care transitions, such as hospital discharge protocols, and much more.

More than 200 health-related characteristics have been mapped to a PAM score and level of activation, offering a wealth of insight into an individual's self-management competencies. This empirically derived insight guides Insignia's coaching model (Coaching for Activation®) and consumer facing Web-based program (Flourish®).



About Insignia Health

Insignia Health specializes in helping health plans, hospitals, pharmaceutical firms and other health care organizations assess patient activation and develop strategies for helping individuals become more successful managers of their health and health care. Insignia Health applies its proprietary family of health activation assessments to measure each individual's self-management competencies. The Patient Activation Measure® and a decade of health activation research form the cornerstone of a complementary suite of Insignia solutions, which have proven to help clinicians, coaches and health care organizations improve outcomes and lower costs.

Insignia Health
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Info@insigniahealth.com

Patient Activation Measure (PAM) 13™

Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by circling your answer. Your answers should be what is true for you and not just what you think others want you to say.

If the statement does not apply to you, circle N/A.

1.	When all is said and done, I am the person who is responsible for taking care of my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
2.	Taking an active role in my own health care is the most important thing that affects my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
3.	I am confident I can help prevent or reduce problems associated with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
4.	I know what each of my prescribed medications do	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
5.	I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
6.	I am confident that I can tell a doctor concerns I have even when he or she does not ask	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
7.	I am confident that I can follow through on medical treatments I may need to do at home	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
8.	I understand my health problems and what causes them	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
9.	I know what treatments are available for my health problems	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
10.	I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
11.	I know how to prevent problems with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
12.	I am confident I can figure out solutions when new problems arise with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
13.	I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A

Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	**8 April 2015**	**Unrestricted**		
Reports of: Somen Banerjee: Director of Public Health **Presenting Officers:** Somen Banerjee: Director of Public Health Brian Turnbull: Service Manager First Response		**Title:** Action Plan Update 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 presents an update on the implementation of recommendations that were set out in the action plan in response to the Scrutiny Review of Accident and Emergency (A&E) Services in Tower Hamlets in 2014.

1.2. The scrutiny review made six recommendations. One of these recommendations was for Barts Health, four for the Director of Public Health, and one for the Service Head for Commissioning and Strategy in ESCW. Five of these recommendations were carried forward after the review period.

1.1 The Action Plan attached to this report (Appendix 1) sets out each recommendation with the corresponding responses from the relevant services, and the activities that have been and are being implemented to meet these.

2. Recommendation

2.1 The Health Scrutiny Panel is asked to consider the progress update provided.

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 recommendations under consideration came out of the scrutiny review of A&E services at the Royal London Hospital. The review was undertaken in response to the winter pressures A&E services were facing across the UK. Given the significant concerns being raised about A&E services it was decided to undertake a scrutiny review of local A&E services to better understand the issues faced, and what was being done to address them.

3.2. At the end of the review period, the working group made six recommendations. One of the recommendations had already been met by Public Health within the review development period, and therefore the other five were carried forward. These are all outlined in the corresponding Actions Plan.

3.3. The Action Plan attached to this report (Appendix 1) sets out each recommendation with the corresponding responses from the relevant services, and the activities that have been and are being implemented to meet them.

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.

This update report of this scrutiny review supports these criteria.

4.4 The Care Act 2014 was enacted in May 2014 and the majority of the legislation comes into effect from 1 April 2015. Section 1 of the Care Act 2014 places a general duty on the Council to promote an individual's well-being. Well-being is defined in the 2014 Act as including physical, mental and emotional wellbeing.

4.5 Furthermore, sections 2 and 3 of the Care Act 2014 place a general duty on the Council to prevent needs developing and to promote integration of care and support which includes preventative support. The strategy, and this update, evidences supporting these general duties.

4.6 Any strategy plan must be prepared in accordance with the public sector equalities duty to eliminate unlawful conduct under the Equalities Act 2010. The duty is set out at Section 149 of the Equality Act 2010. It requires the Council, when exercising its functions, to have 'due regard' to the need to eliminate discrimination (both direct and indirect discrimination), harassment and victimization and other conduct prohibited under the Act, and to advance equality of opportunity and foster good relations between those who share a 'protected characteristic' and those who do not share that protected characteristic.

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 materialise 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 took 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.

Appendix 1

<table>
<tr><th colspan="4">Scrutiny Review Action Plan – A&E Review</th></tr>
<tr><th></th><th>Recommendation and service response (27 May 2014)</th><th>Responsibility</th><th>Update (March 2015)</th></tr>
<tr><td>R1.</td><td>That the council gives a greater profile to the promotion of flu vaccinations to staff and the community through its various services.

Public Health is currently working with occupational health in the LBTH to promote flu vaccination with frontline provider staff focussing on those working with groups most likely to be at risk of admission.</td><td>Somen Banerjee (Director of Public Health)</td><td>Public Health has worked with occupational health to increase uptake of flu immunisation in frontline staff.

The first table is showing the numbers of staff and the staff groups who received the seasonal flu vaccination in Tower Hamlets for 2014/15

<table>
<tr><th>Staff Groups</th><th>Frontline staff</th><th>None Frontline Staff</th><th>Total</th></tr>
<tr><td>School staff (25 schools)</td><td>517</td><td>0</td><td>517</td></tr>
<tr><td>Home care staff</td><td>23</td><td>0</td><td>23</td></tr>
<tr><td>LA staff</td><td>408</td><td>251</td><td>659</td></tr>
<tr><td>Blank</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>TOTAL</td><td>948</td><td>251</td><td>1199</td></tr>
</table>

This table highlights that 80% of the staff who were vaccinated under the Staff Seasonal Flu Vaccination programme considered themselves to be front line worker ie working directly with the population in Tower Hamlets which is excellent and highlights that this vaccination programme was targeted well. The 2014 -15 staff vaccination programme has shown a considerable increase in uptake by 40% from last year’s vaccination of 726 staff members</td></tr>
</table>

Scrutiny Review Action Plan – A&E Review			
	Recommendation and service response (27 May 2014)	**Responsibility**	**Update (March 2015)**
			to 1199. The table below highlights the numbers of staff who attended from the various directorates in Tower Hamlets LA. The main disappointment of this campaign was engaging with the external home care providers and the care homes providers based in Tower Hamlets. If this exercise was to be repeated more time would be required to engage with the providers of home care / care homes to ensure their staff understand the importance of this immunisation programme and are given the time to obtain the vaccination.

LA Staff groups	**Nos Staff**
ESCW	273
CLC	122
Dev & Renewal	115
Law/Probity	35
Resources	113
Blank	1
TOTAL	**659**

Scrutiny Review Action Plan – A&E Review			
	Recommendation and service response (27 May 2014)	**Responsibility**	**Update (March 2015)**
R2.	***That the council helps in raising awareness of why and when A&E services should be used and promote other primary care services for minor ailments, to help reduce inappropriate attendees at A&E.*** One of the key interventions is GP registration. This requires understanding which groups in the community have higher levels of underegistration and targeting promotion of GP registration through a range of council services e.g. employment, housing. As part of the Health Lives Strategy, public health is developing a set of key messages for the community and these will include messages around use of health services. These will need to align with communications messages from the CCG, NHS England and Barts Health.	**Somen Banerjee (Director of Public Health)**	The Health Outreach Worker programme is to be implemented shortly. This involves 12 workers from the community based in Ideas stores and working at a neighbourhood level. They will provide the public with information and support around using health and social care services as well as living a healthy life. They will also be feeding back insights to commissioners across the LA and NHS on use of services (including A and E).
R3.	***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.*** In the medium to longer term, services promoting risk factors for health such as smoking cessation, healthy weight, sensible drinking and sexual health will reduce pressures on health services through impacts on prevalence of long term conditions such as heart disease, stroke, cancer, lung disease, musculoskeletial conditions and liver disease.	**Somen Banerjee (Director of Public Health)**	Public Health programmes around health trainers, tobacco, weight management and sexual health have been recommissioned. Substance misuse services are due to be recommissioned over 16/17. In addition, public health has been developing an Every Contact Counts programme which seeks to support frontline providers across health and social care to promote healthy lives in everyday interactions with patients/clients/public.

Scrutiny Review Action Plan – A&E Review			
	Recommendation and service response (27 May 2014)	**Responsibility**	**Update (March 2015)**
R4.	***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.*** The Education Social Care and Wellbeing directorate will work with Barts through its planned stages towards developing its integrated care services.	**Deborah Cohen & Bozena Allen (ESCW)**	In response to the recommendation from the A&E review ESCW already have 1 scheme in place to support this action, and have and are implementing a further 2 schemes to accelerate its work around integrated care with Barts Health, which will see a reduction in A&E users. The first scheme started in November 2013 and involved establishing an Out of Hours Scheme in order to work in A&E and two of its assessment wards. This scheme was originally funded by Winter Resilience Money (2013 - 14) and comprised 1 Senior Social Worker and one Social Worker. The scheme operates 9am - 8pm Mon - Fri and 10am - 8pm on Sat and Sun, and additionally operates on Bank Holiday (except Christmas Day) from 9am - 5pm. Staff in A&E and the two wards can bleep or call the staff if there is a patient who is medically fit to return home, but requires a care package or other assistance in order to be discharged without having to be admitted to an acute bed. At the end of the Winter Resilience period in April 14 the NHS evaluated the impact of the scheme and it was judged to have met and exceeded its aims. As a result of this the CCG agreed to fund the scheme from April 14 to the 31st March 15. During the first year of operation the scheme prevented 703 admissions to the Royal London Hospital. The second scheme is to extend the main Hospital Social Work Team from 5 day working (Monday to Friday 9am - 5pm) to a 7 day service covering Sat / Sun and Bank Holidays. This scheme

Scrutiny Review Action Plan – A&E Review			
	Recommendation and service response (27 May 2014)	**Responsibility**	**Update (March 2015)**
			is funded from the Winter Resilience Money 2014 - 15. As part of this scheme we were able to have a brokerage officer working with the Social Workers at weekends and extend access to the Reablement Team at weekends. In addition we commissioned 4 step down beds, comprising 2 residential dementia beds and 2 extra care flats. This scheme allows all the acute wards to refer medically fit patients at weekends, and allows us to speed up the process of discharge from the wards. The step down beds however have not proved to be popular with families as in many cases they have been reluctant to allow their relatives to move into them as this means they have to move twice. However, we have achieved approx. 50% occupancy throughout the schemes time (Oct 14 - end of March 15). This means that 2 acute beds have been available this winter that would have not been available without the step down beds. The two schemes above, excluding the step down beds and Brokerage, will now continue from April 15 and will be funded through the BCF scheme. Thus allowing us to improve patient flow through the Royal London Hospital 12 months a year. A third scheme has also been funded by the Department of Health with a grant of £75K. This money only became available in February 2015 however we were successful in the bid for this funding. This is being used to increase our Social Work capacity at Mile End Hospital, by employing a locum Social Worker to speed up discharges from non-acute beds at the hospital. This

Scrutiny Review Action Plan – A&E Review			
	Recommendation and service response (27 May 2014)	**Responsibility**	**Update (March 2015)**
			then allows staff at the Royal London Hospital to discharge suitable patients from acute beds and transfer them to Mile End Hospital for rehab. We have also employed a locum Social Worker at the Royal London Hospital to work with the Complex Discharge Team. This Social Worker (supported by a Sen SW) works with health colleagues on discharging Gold and Silver patients and liaising with other Local Authorities in order to speed up their patients. The scheme also covers the cost of additional care packages for the Gold and Silver patients and the purchase of OT equipment to support hospital discharges. This scheme will cease on the 31st March 15 when funding is ceased.
R5.	***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.*** Work in this area was conducted several years ago as part of the 'Local Heroes' campaign. It is unlikely that information alone will address this issue. Increasing GP registration and improving GP access will help. However, the design of A and E and the role of frontline staff in disincentivising repeat inappropriate usage is likely to be important. It is proposed that public health continue to work with the CCG in providing input on the implementation of the urgent care strategy rather than starting a new research project.	**Somen Banerjee (Public Health)**	Work in this area was conducted several years ago as part of the 'Local Heroes' campaign. It is unlikely that information alone will address this issue. Increasing GP registration and improving GP access will help. However, the design of A and E and the role of frontline staff in disincentivising repeat inappropriate usage is likely to be important. It is proposed that public health continue to work with the CCG in providing input on the implementation of the urgent care strategy rather than starting a new research project. No further action proposed.

Scrutiny Review Action Plan – A&E Review			
	Recommendation and service response (27 May 2014)	**Responsibility**	**Update (March 2015)**
R6.	***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.*** Barts in response have stated that they continue to engage in employing people from the local community through their established pathways for local recruitment. In addition Barts have increased the number of local offers for route to employment through apprenticeships in the Band 1 – 4 jobs and more roles are being created for Healthcare assistants and pharmacy technicians, which will also be available to local people. In order to increase take up of clinical roles from the local community, The Trust is working with Mulberry School in relation to its University Technical College provision and in June 2014, the first Barts Health Summer School will be taking place with a cohort of 20 students from Mulberry who wants to enter health careers. The Summer Schools will offer a unique experience to students in the form of work experience in Royal London Hospital combined with practical training such as a session in the Simulation Centre.	**Alistair Chesser & Attfield Andrew** **(Barts Health)**	An update on this was provided to the Health Scrutiny panel meeting on the 2nd March.

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Barts Health special measures following the CQC inspection report for Whipps Cross University Hospital

Following the Care Quality Commission (CQC) report published on the quality of services at Whipps Cross University Hospital after an inspection in November 2014, the Trust Development Authority (TDA) announced that Barts Health NHS Trust will be placed into special measures.

The Trust Development Authority (TDA) have taken this action as a result of the concerns in the report, the Trust's performance against the NHS Constitution standards and the financial challenges it faces.

CQC Report

The Whipps Cross report identified a number of failings and the hospital site has been rated as 'inadequate', the lowest of four CQC categories. The Trust has been served with four warning notices under the Health and Social Care Act relating to:

- care and welfare of people who use services;
- assessing and monitoring the quality of service providers;
- complaints; and
- staffing.

The key findings were as follows:

- There was a culture of bullying and harassment and there were concerns about whether enough is being done to encourage a change of culture to be open and transparent.
- Morale was low. Some staff were reluctant to speak with inspection teams, when staff did some did not want the inspection team to record the discussions in fear of repercussions.
- The decision in 2013 to remove 220 posts across the trust and down band several hundred more nursing staff has had a significant impact on morale and has stretched staffing levels in many areas. It was observed that reorganisation had a damaging impact on staff and the service provided.
- Staffing was a key challenge across all services and the environment was not conducive to recruitment and retention and the sustainability of services.
- The implementation of IT systems had impacted on patient safety and care. The trust recognised there had been issues and were attempting to resolve them. However patients were struggling to get appointments and be recognised as needing care and treatment.
- Patients, staff and stakeholders including Commissioners, MPs, Royal Colleges, Health Education England and local branches of Healthwatch continue to raise concerns about the quality of the service provided.

Safe:

- There were not enough nursing and medical staff to ensure safe care was provided.
- Handovers between medical staff were unstructured and did not ensure relevant staff were aware of specific patient information or the wider running of the hospital.
- There was limited learning from incidents. Staff did not have the time to report incidents, were not encouraged to report incidents and were not aware of any improvements as a result of learning from these incidents. Some senior staff were unaware of serious incidents and action plans that involved them leading the required change.

- There were low levels of compliance with mandatory training. It was not always evident that learning from the training was embedded.
- Medicines management required improvement in some areas including, but not limited to the storage and administration of medicines. There was an inconsistent use of opioids across wards.
- Patients nearing the end of their life were not identified, and their needs therefore were not always assessed and met.
- The application of early warning systems to assist staff in the early recognition of a deteriorating patient was varied. The use of an early warning system was embedded within the surgery, while in A&E and medical care areas, its use was inconsistent. The National Early Warnings System had not yet been implemented in the hospital.
- Theatre ventilation was not adequately monitored.

Effective:

- The use of national clinical guidelines was not evident throughout the majority of services. An end of life pathway to replace the existing Liverpool Care Pathway had not been introduced. National guidance for the care and treatment of critically ill patients was not always followed.
- The management of patients nutritional and hydration needs varied. In the National Care of the Dying Audit patient's' nutrition and hydration requirements being met was rated worse than the England average.
- Patient outcomes in national audits were similar to or below the performance of other hospitals.
- Records showed mental capacity was recorded and families were involved however it was found some staff lacked an understanding of the Mental Capacity Act and deprivation of liberty safeguards.
- The trust was working towards seven day working. Job planning for medical staff had started. Access to fundamental diagnostic and screening tests out of hours was limited. There was no critical care outreach team after 5pm or at weekends.

Caring:

- Improvements were required to ensure staff were always caring and compassionate and treated patients with dignity and respect at all times.
- In September 2014, 194 of 210 (92%) respondents to the friends and family test were 'extremely likely' or 'likely' to recommend the inpatient service.

Responsive:

- The average bed occupancy for from May to October 2014 was 91%. This impacted on the flow of patients throughout the hospital. Patients were cared for in recovery, or transferred out of critical care for non-clinical reasons.
- Patients well enough to leave hospital experienced significant delays in being discharged because of documentation needing to be completed. During inspection an estimated 30 patients were well enough to leave hospital but remained because their continuing health care assessments had not been completed. Staff that previously completed this paperwork were no longer in post because of the restructure.
- Operations were often cancelled due to a lack of available beds.
- The average length of stay (ALOS) was high, the trust recognised this issue was impacting on patient care and had taken some action to address it.
- The hospital was persistently failing to meet the national waiting time targets. Some patients were experiencing delays of more than 18 weeks from referral to treatment

(RTT). The trust had suspended reporting activity to the department of health and had started a recovery plan.
- Many patients experienced delays in their treatment as a result of lack of planning to introduce the electronic patient records system or when transport arrangements had changed. Patients complained that they were unable to get in touch with the hospital.
- Capacity issues within the hospital led to a high proportion of medical “outliers” (patients on wards that were not the correct specialty for their needs). The result of this was that patients were being moved from ward to ward on more than one occasion, this impacted on their treatment, delayed their stay in hospital and were on occasion transferred late at night.

Well-led:
- Staff reported that the executive team were not visible.
- Morale was low. The 2013 NHS Staff Survey for the trust as a whole had work related stress at 44%, the joint highest rate in the country for an acute trust. 32% recommend it as a place to work, which is third lowest in the country.
- Nursing staff who were previously supernumerary to the shift were no longer there to provide leadership and guidance.
- There were a number of vacant managerial posts and interim staff in post making it difficult for staff to be well-led.
- The application of clinical governance was varied, with some services lacking any formal, robust oversight. Risk registers were poorly applied in some clinical areas which led to some risks not being recorded and or escalated.
- The trust was £13.3 million off its financial plan at the end of September 2014, the year end forecast outturn was revised from £44.8 million to a deficit of £64.1 million. £2 million additional costs were specifically associated with the deployment of IT systems at Whipps Cross University Hospital as the deployment had been unsuccessful and it had been necessary to invest significant resources to address problems in outpatients booking and scheduling.

The hospital must ensure:
- Safety and effectiveness are a priority in all core services
- Services are to be well-led.
- Adequate steps are taken to meet the fundamental needs of patients.
- There are appropriate levels and skills mix of staffing to meet the needs of all patients.
- Bank and agency staff are fully inducted to ensure they can access policies, be aware of practices and provide care and treatment in the areas they are required to work in.
- Complaints are investigated in a timely manner and patients are involved and action taken.
- Robust assessment and monitoring of the quality of the service.
- Patients leave hospital when they are well enough. Average length of stay was higher than medically necessary.
- Procedures for documenting the involvement of patients, relatives and the multi-disciplinary team ‘Do Not Attempt Cardiopulmonary Resuscitation’ (DNA CPR) forms are followed at all times.
- Accurate records are available for the majority of patients attending outpatient appointments.
- Safeguarding procedures are improved and followed.
- All staff understand the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

- Equipment is ready for use and appropriately maintained.
- The environment is adequately maintained to protect patients.
- Medications are stored safely

Newham and Royal London Hospitals CQC Reports
The Whipps Cross is the first report that the CQC has published following their inspection of Barts Health NHS Trust. We expect that reports on Newham General and the Royal London will be issued later this year following their site inspections in January 2015.

CCG response
Waltham Forest, Newham and Tower Hamlets CCGs are in the process of working more closely in partnership with Barts Health, patients, local councils, Healthwatch and key stakeholders to fix the underlying causes of the issues identified in the report. They are currently developing a clinical strategy for east London that will transform the way care for patients is provided; preventing ill health, supporting people to live healthier lives and tackling inefficiencies, therefore investing in coordinated, high-quality sustainable services.

Whilst the CCGs will support managers and staff at Barts Health to make the improvements outlined by the CQC, they will also hold them to account if they do not see improvements and the change that is needed.

Health Scrutiny
Tower Hamlets Health Scrutiny have requested for Barts Health to come and discuss the current issues, however due to the communication manager at Barts Health being away and the short notice in rearranging of the Heath Scrutiny Panel meeting there hasn't been adequate time and notification to arrange this. However, this will be addressed through the Inner North East London Joint Health Overview Scrutiny Committee (INEL JHOSC) meeting in early May. We will also follow this up again with Barts Health after the Royal London CQC inspection report has been released.