TOWER HAMLETS

HEALTH SCRUTINY SUB-COMMITTEE

Thursday, 15 September 2016 at 6.30 p.m.

C1, 1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

This meeting is open to the public to attend.

Members:
Chair: Councillor Clare Harrisson
Vice-Chair**:** Councillor Sabina Akhtar

Councillor Dave Chesterton, Councillor Abdul Asad, Councillor Peter Golds, Councillor Abdul Mukit MBE and Councillor Muhammad Ansar Mustaquim

Substitues:
Councillor Danny Hassell, Councillor Amina Ali, Councillor Rajib Ahmed, Councillor Chris Chapman, Councillor Mahbub Alam and Councillor Aminur Khan

Co-opted Members:

David Burbidge	(Healthwatch Tower Hamlets Representative)
Tim Oliver	Healthwatch Tower Hamlets

[The quorum for this body is 3 voting Members]

Contact for further enquiries:
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Web: http://www.towerhamlets.gov.uk/committee

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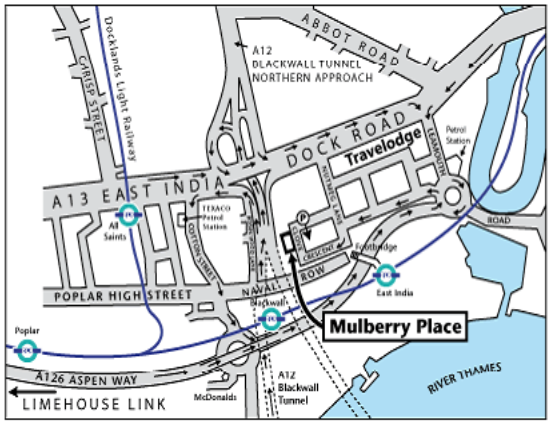

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		PAGE NUMBER(S)
	APOLOGIES FOR ABSENCE	
1.	**DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS**	**1 - 4**
	To note any declarations of interest made by Members, including those restricting Members from voting on the questions detailed in Section 106 of the Local Government Finance Act, 1992. See attached note from the Monitoring Officer.	
2.	**MINUTES OF THE PREVIOUS MEETING(S)**	**5 - 10**
	To confirm as a correct record the minutes of the meeting of the Health Scrutiny Panel held on Tuesday, 28th June, 2016.	
3.	**REPORTS FOR CONSIDERATION**	
3 .1	**Health Scrutiny Work Programme**	**11 - 22**
4.	**SETTING THE SCENE: FEEDBACK ON ACCESS TO HEALTH AND SOCIAL CARE**	
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5.	**COMMUNITY PHARMACY - BRIEFING ON CURRENT ISSUES**	**45 - 58**
6.	**ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT**	

Next Meeting of the Panel
The next meeting of the Health Scrutiny Panel will be held on Wednesday, 2 November 2016 at 6.30 p.m. in MP702, 1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

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DECLARATIONS OF INTERESTS - NOTE FROM THE MONITORING OFFICER

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

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

Interests and Disclosable Pecuniary Interests (DPIs)

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

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

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

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

Effect of a Disclosable Pecuniary Interest on participation at meetings

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

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

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

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

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

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

Further advice

For further advice please contact:

Melanie Clay, Corporate Director of Law, Probity & Governance & Monitoring Officer, Telephone Number: 020 7364 4800

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 SUB-COMMITTEE

HELD AT 6.30 P.M. ON TUESDAY, 28 JUNE 2016

MP701, 7TH FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG.

Members Present:

Councillor Clare Harrisson (Chair)
Councillor Sabina Akhtar
Councillor Dave Chesterton
Councillor Abdul Asad
Councillor Abdul Mukit MBE
Councillor Muhammad Ansar Mustaquim

Co-opted Members Present:

David Burbidge – (Healthwatch Tower Hamlets Representative)

Other Councillors Present:

Councillor Amina Ali
Councillor Amy Whitelock Gibbs

Apologies:

Others Present:

Dr Sam Everington – (Chair, Tower Hamlets Clinical Commissioning Group)
Caroline Alexander – (Director of Quality Development, NHS Tower Hamlets)
Jane Milligan – (Chief Officer, Tower Hamlets Clinical Commissioning Group)
Sandra Reading – Director of Maternity Services
Jackie Sullivan – Managing Director of Hospitals, Bart's Health Trust
Alwen Williams – Interim Chief Executive, Bart's Health Trust
Susan Biddle – Regional Advocate for London
Ceri Durham – National Childbirth Trust
Alison Herron – Bart's Health Trust
Matthew Hogg – Bart's Health Trust
Councillor Alison Kelly – Chair of Health and Social Care Scrutiny Committee
Jamie Whitburn – Bart's Health Trust

Officers Present:

Daniel Kerr – Strategy, Policy & Performance

	Officer
Afazul Hoque	– Interim Service Manager, Strategy, Policy & Performance
Dr Somen Banerjee	– (Director of Public Health)
Debbie Jones	– (Corporate Director, Children's Services)
Joseph Lacey-Holland	– Senior Strategy, Policy &Performance Officer
Denise Radley	– (Director of Adults' Services)
Sarah Vallelly	– Strategy, Policy & Performance Officer
Farhana Zia	– Committee Services Officer

1. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS

The Chair, Councillor Clare Harrisson welcomed everybody to the Health Scrutiny Sub-Committee meeting. She stated the meeting would cover some administrative actions, followed by a report on Maternity Services in Tower Hamlets.

Thereafter the Sub-Committee would receive a presentation from the Centre for Public Scrutiny, introducing Health Scrutiny to new Members of the committee.

She requested everyone to introduce themselves and commenced the meeting.

There were no apologies for absence and no declarations on interest declared.

2. APPOINTMENTS

Appointment of Vice- Chair

Councillor Abdul Mukit nominated Councillor Akhtar and Councillor Dave Chesterton seconded the nomination. Councillor Sabina Akhtar was elected as Vice-Chair of the Health Scrutiny Sub-Committee.

Appointment to the Inner North East London Joint Health Overview and Scrutiny Committee (INEL JOSC)

The Chair explained that she was seeking two nominations, two from the Labour Group (to include the Chair) and one from the Independent Group.

Councillor Clare Harrisson and Councillor Sabina Akhtar were nominated by the Labour Group and Councillor Muhammad Ansar Mustaquim was nominated by the Independent Group.

Co-optee Appointments for the Health Scrutiny Sub-Committee

The sub-committee agreed to appoint David Burbidge and Tim Oliver representing Healthwatch Tower Hamlets as co-optee's to the sub-committee.

3. MINUTES OF THE PREVIOUS MEETING(S)

The Chair referred members of the Sub-Committee to the minutes of the previous meeting held on the 20th April 2016. She asked members to approve these as an accurate record of the meeting.

The Members agreed the minutes to be an accurate record of the meeting.

4. REPORTS FOR CONSIDERATION

4.1 Terms of Reference - Health Scrutiny Sub-Committee

The Chair referred members to pages13-21 of the agenda pack and explained that the Committee is required to review the terms of reference on an annual basis. She asked if there were any points arising:

Councillor Abdul Asad referred to point 1.3 of appendix 1, and stated that the proportionality should state: 4 Majority Group Members (Labour), 2 Minority Group Members (Independent Group) and 1 Minority Group Member (Conservative)

He also stated that the appendix referred to the Independent group by their former title and that this should be amended.

Councillor Asad informed the sub-committee that the Independent Group also proposed to put forward Councillors Aminur Khan and Mahbub Alam as substitute members for this committee.

The Committee Officer informed Councillor Asad that the Independent Group would need to make a formal request to Full Council in order to have the nominations ratified.

The Sub-Committee **RESOVLED** to:

AGREE the terms of reference, Quorum, Membership, dates of future meeting for the Health Scrutiny Sub-Committee.

4.2 Review of Maternity Services at the Royal London Hospital

The Chair informed Members this report was outstanding from the last municipal year and was a review undertaken to examine Maternity Services in Tower Hamlets.

She invited Councillor Amina Ali to introduce the report and explain the conclusions reached by the Review Group.

Councillor Amina Ali informed the Sub-Committee that she had decided to focus on maternity services as the Royal London Hospital (RLH) specifically to look at patient experience; as feedback from patient organisations had

highlighted instances of poor experience in terms of compassion and continuity of care.

She stated the review examined four key themes of:

- Compassionate care
- Workforce to reflect the Community
- Consistency and continuity of care; and
- Capturing patient experience and community intelligence

The Review Group has made 17 recommendations and early discussions with Bart's Health Trust noted they welcomed the report and are keen to work with the Council and other stakeholders in addressing the issues identified.

Councillor Amina Ali invited the sub-committee to view a short film, which forms a part of the review and aims to bring the work of the Review Group to life.

Following the film, Alwen Williams the Chief Executive of Bart's Health Trust stated she welcomed the report and her team had undertaken to examine the recommendations made. She informed Members the Trust had an improvement plan which specifically looked at safe and compassionate care and that it was working hard to improve the day to day delivery of care; which is underpinned by a diverse workforce, reflective of the community and which instils the cultural step-change required.

She said that the Trust had refreshed its Patient and Public Engagement Strategy and had a strand of work which looked at how it can improve patient experience. This is entitled 'I want great care'.

Sandra Reading, from Bart's Health Trust outlined how the recommendations made in the report fitted with work streams being developed at the Trust.

This was followed by questions from Members who made the following points:

- Members were highly appreciative of the review and praised the members and officers involved.
- Members enquired how the film would be used and it's dissemination to the wider public?
- The recruitment of Midwives – reflective of the community & making it an attractive career choice
- Perinatal care – access to Mental Health services
- Bart's Health Trust views on when to report back to the Sub-Committee

The Sub-committee **RESOLVED** to **AGREE**:

1. It would receive an update in six months' time reporting on the progress made against the recommendations; and that

2. It would visit the Midwife Lead Unit at the Royal London Hospital on the invitation of the Chief Executive, Alwen Williams Bart's Health Trust.

4.3 Health Scrutiny Induction

Susan Biddle, Regional Advocate for London, Centre for Public Scrutiny and Councillor Alison Kelly, Chair of Health and Adult Social Care Scrutiny Committee at London Borough of Camden were invited to provide an induction workshop to Members.

The aim of the workshop was to

- Provide a brief introduction to the role and principles of good health scrutiny and what Sub-Committee members needed to know;
- Provide an opportunity to begin thinking around the forward plan for 2016 and how this can be shaped and informed; and
- Give an opportunity to hear from a fellow 'health scrutineer'

Members were informed Residents needed to be at the centre of any investigation /review and that the key things for them to consider was:

- What does our community want?
- What are the political issues?
- Agenda planning and
- Key outcomes

Following discussion Sub-Committee members were asked to comment upon the suggested items for the forward work programme:

- Having a thematic approach for the work programme - focussing on Primary Care.
- Community Pharmacy
- Commissioning and Contracting & Patient involvement
- Early Years Provision (0-5 years)
- Re-enablement Service
- NHS –'Transforming Services Together' plan
- Quality Accounts
- Mental Health
- Homecare contract

The Sub-Committee **RESOVLED**

That the Chair of the sub-committee would consult further with absent Members and officers to formulate the forward work programme for the sub-committee, which it would review at its next meeting.

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

There was no other business discussed.

The meeting ended at 8.40 p.m.

Chair, Councillor Clare Harrisson
Health Scrutiny Sub-Committee

Non-Executive Report of the: **[Health Scrutiny Committee]** 15/09/2016	TOWER HAMLETS
Report of: [Melanie Clay, Corporate Director, Law Probity & Governance]	**Classification:** Unrestricted
Health Scrutiny Work Programme 2016/17	

Originating Officer(s)	Daniel Kerr, SPP Officer, LPG
Wards affected	[All wards]

Summary

This report proposes a work programme for the Health Scrutiny Committee (HSC) for 2016/17.

The report sets out the process used to develop the work programme and suggests a number of ways in which HSC may wish to approach the workload.

Appendix 1 sets out the schedule for items across the HSC meetings for 2016/2017, along with the topics for 'Scrutiny Review' and site visits to be undertaken.

Recommendations:

The Health Scrutiny Sub Committee is recommended to:

1. Consider and agree on the draft work programme items and schedule for HSC.

2. Agree options for managing the HSC work programme

1. REASONS FOR THE DECISIONS

1.1 The Health Scrutiny Committee needs to agree that the prepared work programme is the most effective way to scrutinise local health and social care issues or suggest amendments of how the committee could better scrutinise LBTH health and social care services.

2. ALTERNATIVE OPTIONS

2.1 There are no alternative options.

3. DETAILS OF REPORT

3.1 This report details the work programme for the Heath Scrutiny Committee for 2016/17. The Health Scrutiny Committee is taking a thematic approach to its work programme and focusing on the theme of access to health and social care. Additionally this report details the role of Health Scrutiny and its responsibility as part of a Joint Health Scrutiny Committee across North East London.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 There are no current financial implications to this draft work programme. Recommendations from future reviews will be reported separately and any financial implications arising will be considered in the context of the outcomes based 2017/18 to 2019/20 medium term financial strategy.

5. LEGAL COMMENTS

5.1 There are no current legal implications to this draft work programme.

5.2 Any recommendations from future reviews will be reported separately and any legal implications arising will be considered in those reports.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 This report forms part of the HSCs scrutiny of the theme of access to health and social care services. This theme was chosen in order to identify where there are areas of inequality and poorer health outcomes, and make recommendations to improve these gaps. It allows for scrutiny of all community groups to recognise what the key barriers are for accessing health and social care services in LBTH.

7. BEST VALUE (BV) IMPLICATIONS

7.1 There are no best value impactions for this report.

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 There are no sustainable actions for a greener environment in this report.

9. RISK MANAGEMENT IMPLICATIONS

9.1 There are no risk management implications for this report.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 There are no crime and disorder reduction implications for this report.

Linked Reports, Appendices and Background Documents

Linked Report

- NONE

Appendices

- State NONE if none [and state EXEMPT if necessary].

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report
List any background documents not already in the public domain including officer contact information.

- NONE

Officer contact details for documents:

- Daniel Kerr

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Health Scrutiny Work Programme 2016/17

1. Introduction

1.1 This report proposes a work programme for the Health Scrutiny Panel (HSP) for 2016/17.

1.2 The report sets out the process used to develop the work programme and suggests a number of ways in which HSP may wish to approach the workload.

1.3 Appendix 1 sets out the schedule for items across the HSP meetings for 2016/2017, along with the topics for 'Scrutiny Review' and site visits to be undertaken.

2. Recommendations

The Health Scrutiny Panel is asked to:

2.1 Consider and agree on the draft work programme items and schedule for HSP.

2.2 Agree options for managing the HSP work programme.

3. Background

3.1 The Health Scrutiny Panel is a fundamental part of the local democratic process, enabling elected councillors to hold local NHS bodies to account for the quality of the services they deliver. In Tower Hamlets, HSP is also responsible for scrutinising social care services for adults and older people.

3.2 According to the Centre for Public Scrutiny (CfPS) the main role of HSP is to act as a lever to improve health and wellbeing in its local area and ensure that:

- The needs of local people are an integral part of the commissioning, development and delivery of health services;
- All sections of the community have equal access to health and wellbeing services;
- All sections of the community have an equal chance of a successful outcome from the services they use;
- Proposals for substantive service changes are reasonable;
- Delivery partners work together to provide more joined up services.

3.3 HSP draws its statutory duty and powers from the 'Health and Social Care Act 2001', which requires Local Authorities with social service responsibilities to have an Overview and Scrutiny Committee (O&S) function that can respond

to consultation by NHS bodies on significant changes and developments in health services, and provide for broader oversight of health and wellbeing issues.

3.4 The 'Local Government and Public Involvement in Health Act 2007' strengthens these powers further, and provides for O&S Committees to review and scrutinise the performance of public service providers, as well as empowering councillors to raise issues through a 'call for action'.

3.5 In Tower Hamlets the HSP has been established as a sub-committee of the main O&S Committee, with a Terms of Reference to:

- Review and scrutinise matters relating to the health and social care within the borough and make reports and recommendations in accordance with any regulations made;
- Respond to consultation exercises undertaken by any NHS body;
- Question appropriate officers of local NHS bodies in relation to the policies adopted and the provision of the services.

3.4. During the induction process for councillors appointed to HSP for 2016/17, members met to discuss the strategic focus for the panel in the year ahead. It was agreed that HSP will take a thematic approach to its work programme, with at least one agenda item per meeting focussing on issues related to '*access to health and social care'.*

3.5 In addition to, HSP will continue to receive items as part of its regular, rolling work programme in order to support:

- Health promotion and prevention through work with health partners and other third sector organisations;
- Developing better integration and partnership to improve joint service provision;
- Improving access to services as a key way of tackling health inequalities.

4. Access to Health and Social Care

4.1. Due to increasing demand for services and static/reducing levels of resource in both the NHS and local authorities, access to health and social care services has become a pressing concern in recent years. This is likely to be exacerbated in coming years by a range of social, economic and political factors.

4.2. Demographically speaking, Tower Hamlets has seen the largest population growth of any area in the country over the last decade - increasing by 27%. This trend is projected to continue over the next 10 years, with the borough expected to grow by a quarter to 2024 – again, the largest in England. The scale of this growth alone will place a major burden on local health and social care providers as a larger number of residents seek to access their services.

4.3. Moreover, the diversity of the Tower Hamlets population and its high level of deprivation mean that in addition to this higher volumetric demand there will also be more acute need. Many residents suffer from chronic conditions linked to poverty, and certain cultural issues amongst our communities restrict local understanding about how to access appropriate provision.

4.4. The growing aggregate demand for services and the severity of local need is unlikely to be fully matched by increased resources. Challenging efficiency targets for the NHS and persistent reductions to local authority budgets will impact on the capacity of the health and social care system to respond – locally Barts Health has the largest deficit of any hospital trust in England, and Tower Hamlets Council has to make £63 million of savings though to 2018/19.

4.5. Only though innovation across prevention, early intervention and demand management will services be able to meet local needs and provide effective care. By reviewing 'access health and social care services' in Tower Hamlets, HSP has the opportunity to take a pro-active role in supporting the local health & social care system meet these challenges.

5. Inner North East London Joint Health Scrutiny Committee (INEL)

5.1. The Council has assumed responsibility for Chairing INEL in 2016/17. INEL is a Joint Health Overview & Scrutiny Committee (JHOSC) made up of councillors from the London Boroughs' of Hackney, Tower Hamlets, Newham, and the City of London Corporation.

5.2. INEL is a statutory body that the same formal scrutiny powers as an individual health overview and scrutiny committee (HOSC) including:

- Access to information when requested;
- Requiring members, officers or partners to attend and answer questions;
- Making reports or recommendations to any NHS body or unitary authority with social care responsibility.

5.3. Significantly, the NHS has a duty to consult with INEL when it is proposing a major 'Case for Change' of services at the sub-regional/regional level. For example, INEL is currently reviewing the Sustainability and Transformation Plan (STP) for the North East London NHS region and the Transforming Services Together (TST) programme that covers the London Boroughs' of Tower Hamlets, Newham, Redbridge and Waltham Forest (the latter two of which sit on the Outer North East London (ONEL) JHOSC).

5.4. INEL can co-operate with any other Health Overview and Scrutiny Committee (HOSC), JHOSC or committee established by two or more local authorities within the Greater London area.

5.5. Efforts will be made to avoid duplication of work, and the councils HSP will endeavour not to replicate any work undertaken by the INEL. All scrutiny statutory powers for that topic being reviewed will be transferred to the INEL.

Appendix 1: Health Scrutiny Work Programme 2016/17

Key

Access to health and social care	**Agenda item relates to the Health Scrutiny theme of Access to health and social care**

Work Programme

Meeting	Agenda	Outcomes	Lead Officer	Method
Thursday 15th September, 2016 Paper Deadline: Tuesday 6th September,2016	Setting the scene: Feedback on access to health & social care	• Collect community intelligence on the theme of access to health & social care. • Understand the key issues restricting service access to health and social care services are.	Healthwatch CCG LBTH Adults & Childrens	Report/Presentation
	Role of Community Pharmacies	• Explore the role of community pharmacies and where they fit in the health care system. • Develop an understanding of the proposed cuts to community pharmacy funding and the impact this will have on the community. • Develop an understanding of how the pending changes to prescribing and the impact this will have.	Somen Banerjee (**LBTH Public Health**)	Report/Presentation
Wednesday, 2nd November, 2016	Early years and access to care: • Early interventions	• Explore the issues impacting access to health and social care for 0-5 year olds. • Consider the over reliance on A&E for 0-5 year olds and think of innovative ways to reduce this.	Debbie Jones (**LBTH Children's Services**)	Report/Presentation

Paper Deadline: Monday, 24th October, 2016	improving outcomes for 0-5 year olds.	• Form recommendations to improve access to health and social care services for 0-5 year olds.		
	Refreshing Commissioning Prospectus	• Review Tower Hamlets CCG Commissioning Prospectus to develop an understanding of their key priorities and commissioning activities. • Consider how CCG commissioning fits in with Transforming Services Together and the North East London Sustainability and Transformation Plan.	Jane Milligan **(CCG)**	Report/Presentation
Tuesday, 17th January, 2017 Paper Deadline: Friday, 6th January, 2017	Planning and GP's/health infrastructure	• Understand how significant increases in the Population and number of new homes impact health services • Review the Local Plan to help form an understanding of the relationship between housing and health and social care.	**CCG** (Housing Scrutiny link in)	Report/Presentation
	Carers Strategy	• Review the implementation of the new Carers Strategy following health Scrutiny Review in 2015. • Measure how effectively the recommendations from the review have been implemented.	Karen Sugars (**LBTH Service Head Commissioning and Health**)	Report/Presentation
Tuesday, 14th March, 2017 Paper Deadline: Friday, 3rd March, 2017	Access to care for people with mental health problems	• Develop an understanding of the key barriers restricting access to mental health services • Consider how the ELFT community pathways redesign will impact on access for people with a mental health problem,	Denise Radley (LBTH Adults Services)	Report/Presentation

	Bart's Health & East London Foundation Trust Quality Account	• Review and provide feedback to the Barts Health Trust and ELFT Quality Accounts.	Barts Health Trust ELFT	Report/Presentation

	Scrutiny Review and/or Challenge Session	
Topic	**Scope**	**Date**
Access to effective re-ablement services	**<u>Description</u>** This is an area which is seen as critical to a sustainable adult social care as it helps people to get back on their feet and regain their independence following a period of hospitalisation. The LBTH service is currently provided in house and there is a good evidence base for re-ablement services nationally. Currently, Tower Hamlets benchmark poorly in terms of the number of people discharged from hospital who receives the service and also the effectiveness of our intervention (measured by the number of people who receive it and don't require further care). This review will have a significant focus on over 65s and access to short term evidence based interventions which help people to regain skills and independence **Outcomes**	*TBC*

	• Scrutinise the performance of the re-ablement provision and make recommendations to improve access to the service and its effectiveness. • Understand the reasons for the poor performance of the service in LBTH. • Analyse what has worked nationally and how this can be adapted in LBTH • Feed findings into the current review of the service being undertaken by Impower.	

Site Visits		
Location	**Outcome**	**Date**
New Maternity Co-Location Unit at Royal London Hospital	Visit the Midwife Lead Unit at the Royal London Hospital on the invitation of the Chief Executive, Alwen Williams Bart's Health Trust. Follow up on the recommendations of the scrutiny review focusing on maternity services at the Royal London Hospital.	December 2016 /January 2017

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Committee:	Date: 15/09/2016	Classification:	Report No.	Agenda Item No.
Health Scrutiny Panel		Unrestricted		
Report of: Health Scrutiny Panel **Originating Officer:** **Dianne Barham** **(Healthwatch Tower Hamlets)**		**Title: Access to Health Services and Social Care – Community Insight** **Wards:** All		

1. SUMMARY

1.1 In order to provide the context for the Health Scrutiny Panel's theme of access to health and social care this report captures the views and experiences of residents, detailing what they feel are the most significant barriers to access.

1.2 This report forms part of the 'setting the scene' agenda item. This agenda item aims to allow the Health Scrutiny Panel to collect community intelligence on access to health and social care, scrutinise the key issues restricting access to health and social care services, and develop and understanding of how the pending changes to the NHS will impact access services.

2. RECOMMENDATIONS

The Health Scrutiny subcommittee is asked to:

1. Collect community intelligence on the theme of access to health and social care.
2. Understand what the key issues restricting service access to health and social care services are

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Key issues to accessing health and social care services in Tower Hamlets

Contents

Evidence

The findings in this report are based on:

- 224 pieces of patient and user feedback relating to access to health and social care services collected from 1 April 2016 through a combination of:
    - direct Healthwatch Tower Hamlets outreach and engagement at our own events, Enter and View visits, at service providers premises, at community venues and over the phone (128).
    - NHS Choices feedback on GP Practices (73)
    - PALS and Complaints data from the Royal London Hospital (39)
- The review of 14,572 comments from 'I want great care' on the Royal London Hospital, St Bartholomew's and Community Services
- Community intelligence gathered by voluntary and community organisations as part of the Tower Hamlets Community Intelligence Report 2016
- Feedback from Healthwatch Tower Hamlets members, Advisory Group, Task Groups and Board.
- Copies of all of the feedback and reports are available from Healthwatch Tower Hamlets.

GP Access

Of the 224 comments collected since 1 April 2016 87 related to GP services, of those comments 10 were positive and 51 were negative. Positive comments tended to focus on the quality of doctors and reception staff with an appreciation for being listened to, receiving good information, explaining care

and feeling involved in decisions.

Negative feedback focused clearly on two key areas.

1. Surgery telephone systems that prevented people from accessing appointments (41 comments)
2. The unavailability or long waits for appointments, particularly non urgent appointments (46 comments)

Telephone systems

The inability to access a majority of local GP practices by phone to book an appointment is causing patients wide spread frustration. It is common for patients not to be able to get through to a practice at all.

> *I have received three letters to remind me to book an appointment but there is never anybody to pick up the phone in this surgery.*
>
> *I have been calling the health centre the whole day. A total of 25 calls I have in my mobile phone. No one has answered the phone in the whole day.*

Or for people to have to wait between 30 minutes to an hour to get through on the phone line often only to be told that there are no appointments available.

The phone system is totally broken. It is usually impossible to set up an appointment by phone. It will literally tell you that there are no appointments with any doctors ever. (NHS Choices)

It seems to be common knowledge amongst patients that you need to phone the surgery first thing in the morning in order to have any hope of getting an appointment. This leads to a heavy number of calls at that time which exacerbates the problem further. For people who work it can be extremely difficult to arrange an appointment as they need to be traveling to, or be at work, at that time. It can also be a problem for parents who need to get children to school.

Many practices suggest people come down to the surgery first thing in the morning in order to access an appointment if they can't get through on the phone. This can lead to long queues forming outside surgeries upwards to hour before they open with people standing in the cold when they may already have an existing health condition.

Trying to get an appointment with this surgery is like being involved in some horrible Kafkaesque nightmare.

1-hour queue for an appointment not practical - very difficult for people who work."

Many GP practices have put in systems to ensure emergency and 48 hour appointments which have received both positive and negative comments with those who are able to come into the practice more likely to be able to access.

In order to access these appointments some patients are now saying that all their concerns are urgent which continues to put more pressure on the system as a whole and make it more difficult for genuine urgent appointments.

The triage or Doctor First call back system seems to work well with some patients who appreciate being able to confirm their self-diagnosis or course of action and therefore avoid a trip to the GP Practice. It can also help you to access an urgent appointment more easily. However some find it difficult discussing issues or expressing themselves over the phone rather than face to face. Others find it difficult to wait for a call back, if the Practice number is withheld people don't recognise the call back, they're at work and can't discuss their health issues or they don't have someone to interpret.

"You don't want to go out in case they ring you and so you stay in the house all day."

There is some feeling that this should not be a 'one system fits all' approach and that some groups should be given priority access e.g. older people, children with a learning disability. Unavailability or long waits for appointments

Once people have been able to reach the surgery, either in person or by phone, they are finding it difficult to access appointments. Waits are frequently four to six weeks for non-urgent appointments and in some cases people are told that there are no appointments available and that they need to call back every day to see if any appointments have been

released. This can lead to significant delays in treatment and some patients have simply given up trying to get non urgent screening appointments.

Many people simply default to A&E and the Walk in Centres as they know that they'll be open and they'll be seen. Some also believe they'll receive a better quality service.

> *Just get yourself to the walk in centre or to A&E. Trust me it's better to wait a couple of hours in a queue than try to deal with this place when you're in a bad way.*

Online appointments

Some practices seem to be operating effective online booking systems.

> *The online booking system works a treat and can usually get an appointment within a week (although usually only during work hours) - not sure why people are using the telephone in this day in age, apart maybe for emergency appointments only.*

However these seem to favour those who know how they operate.

> *Do not try to get an appointment by phone - get an online login and login at exactly 08:00 to book an appointment*

> *I've been trying several times a day for four days now to book an appointment online but there have never been any available. I don't understand how the system works and if there are never any appointments online why did they encourage me to register.*

There is a specific issue around access for people with learning disabilities who need to be able to see the doctor of their choice as quickly as possible, at an appropriate time of day (e.g. early appointment before the waiting room fills up) and not to be kept waiting for long periods.

Access to prescriptions

There seems to be an issue with accessing prescriptions and medication urgently if the GP is not available and the chemist is closed they are left with no prescriptions

> *48 hours to wait for repeat prescriptions. There isn't any explanation for the wait. Sometimes you can't help but run short. If you can't get your prescription, you just have to miss your tablets. That's dangerous.*

For some patients who require regular medication they cannot gain access to it, due to the simple fact of chemists being closed on a weekend. If closed they are left with no prescriptions

> *No protocol in place for patients who have not been able to have their heart meds dispensed from Lloyds chemist because it is closed on*

weekends. Lloyds is being run as a commercial enterprise it should be open 24/7 hrs.

Referrals

There seems to be an issue with gaining referrals to other services from the GP's with a range of issues around administration systems and processes between GPs and secondary care.

He told me he will post a referral to my home to see an eye specialist. I waited for two months and no letter has come through the post from my GP. I went back to my GP and he said a letter has already been sent to me. I said I have not received it and I doubt if the surgery sent me anything. He promised to send me another letter and it has been a month and I have not received anything. I think my GP surgery is slow and not very reliable. I will go back to my doctors and ask for another copy of my referral letter to be given to me in person. This I hope will speed up my referral and hopefully treatment for my eye.

Access to services and information

With ever changing policies and strategies on how to move services away from hospitals and increase patient self-management patients are becoming increasingly more confused as to where they should access care. There default position is often to go to the GP and if they can't access their GP then to go to A&E. This is further exacerbated by the large percentage of the population who have English as a second language and who may also neither read nor write in their own language. As this process of change seems to be increasing in pace it is important to consider how information gets through to patients in order for them not only to keep pace with, but also to drive that change.

Many people access information on health services through GP practices, but many practices are overloaded with information and initiatives and are not geared up to deal effectively with information distribution. People need to see their local health centre as somewhere you can go when you have a minor urgent health care need. As one of our Healthwatch members said "when you're ill you always think it's urgent". You don't necessarily want to sit and wade through a leaflet on where you should go or who you should ring.

The *Community Intelligence Report* 2016 recommended that GP practices be a place people can go to access information about services that can help them to manage their health and wellbeing. For some people, however this does not happen as the GP is lacking in the knowledge.

Didn't feel that her GP had a very good awareness of epilepsy and keeps having to repeat the same information all the time or if it's a new GP she has to start from the beginning. She is more of an expert. She tried to start a group at the GP practice around info for patients but they seemed too reluctant to get it started.

Interpreters

The issue of Bengali and Somali speaking staff is still coming up as an issue but perhaps not as significantly as it has in the past. Concern is now more focused on older isolated people who may not have strong family networks around them where they wish to talk about issues of a very personal and private nature. There was a feeling that Bengali staff should also be able to interpret or speak in Bengali and a need for more Somali frontline staff.

It can take longer to access an appointment when and interpreter also needs to be booked and there seems to be a tendency for them to be cancelled more frequently. Again this can lead to long delays in treatment.

> *Bengali reception staff need to be Bengali interpreters. No family/personal feeling not there.*
>
> *Elderly patients find it difficult to explain what's wrong so more Bengali doctors are needed.*

There continues to be a desire for more Bengali and Somali clinicians and ensuring local young people are attracted into health and social care professions at all levels.

We are seeing a change in language needs of the local community with the need for a more diverse range of interpreters required with new communities moving from Europe.

Suggested improvements

Not surprisingly the most common suggestion for improving access to GP services is to increase the number of GPs and other practice staff. This would improve the number of available appointments together with the quality. There is a feeling that there is not enough time during the doctor consultations with patients required to book another appointment- having to go through the whole process again. There is also a suggestion of more training for people on phones.

> *Training of reception staff needs improving such that they have the knowledge to answer queries on the phone.*

Understanding that there are restraints on space in many practices, it would be beneficial to have a dedicated information area within practices. This could move the focus away from GP Practices as just providing curative medicine but more as Health and Wellbeing Centres where people can get health and social care advice similar to a Citizen's Advice Bureaus but for health. This might include a computer set up for people to easily access the joint directory website with the same information also available at Ideas Stores and across community centres and organisations.

Some further suggestions made by Healthwatch members are:

- Ensure that GP Surgeries and frontline staff know where to get the right treatment and provide quick clear information on how to access the right service including making online appointments.
- Provide visual information in community, health group sessions, tagged on to ESOL, luncheon clubs, in the Post Office queue etc.

- Produce more visual education on different illness and where to go, e.g. DVD, advert, on TV.
- More awareness on community channels (Bengali channel) or GP surgeries.
- Support community health guides and community health champions to get the right information into social networks where it can be circulated among families and friends.
- Develop a local NHS Direct number with Sylheti and Somali speakers be established and every household be provided with a fridge magnet with the phone number on. It could function a bit like NHS Direct but with the knowledge of local Health Centres, their opening times, where the walk in centres are, after hours services, third sector groups etc.

Feedback from deafPLUS

deafPLUS have particularly noted

- A lack of access to BSL interpreters. This can cause:
  - confusion
  - delay in diagnosis
  - lack of understanding of treatment plan and how to take medication.
  - unable to explain any allergies/previous medical history
- General lack of deaf awareness amongst medical staff
  - Looking at computer and talking.
  - Generally not being deaf aware = making appointment stressful for deaf patient and leaving patients unsure of their diagnosis.
- Unable to book appointments as many require telephone bookings
- Doctor's calling out patient names when time for appointment and they don't hear this thus have missed their appointment.
- Not making written format easy to understand (e.g. appointment letters, referral letter, treatment plans, etc.) Some deaf people need things such as above written in an easy clear format OR in BSL format.
- Lack of specialist health services for deaf people E.g. mental health services specifically trained in dealing with mental health issues in deaf people

The Deaf Community is facing constant difficulty with telephone appointment booking systems, verbal prompts when their doctor is ready to see them, and rarely have a clear understanding of their diagnosis and treatment.

Eastern European Community in Tower Hamlets

DASL's research into the health care needs of people from Eastern European communities found that 40% found the registration process for GP's was complex and lengthy, some waiting months before they were informed that they had been successfully registered. Some people interviewed felt that a lack of adequate identification (e.g. passports, birth certificates, NIN cards, etc.) was a barrier to accessing health care and registering with a GP practice. Concerns were raised by one professional agency that when a person is trafficked or endured forced labour, very often they flee without any documents or identity.

Most stated that language was the biggest barrier with 77% saying this caused problems when trying to access health care along with the second being homelessness with 45% saying they experienced problems.

Women who had been pregnant said they were unaware of any ante natal care or what they could access in the way of pregnancy support, ante natal classes, activities or follow up care during pregnancy. One woman stated that she felt alone and frightened and didn't know where to turn for help.

Recommendations

- Registration at health care practices is explained or accessible in written information in EEC languages, or alternative information about where people can go if they are not eligible to register with a particular practice.
- Information about health care services for people from the EEC be available in accessible formats (language, electronically via websites, literature in accessible venues), specifically Polish and Russian. Extend the hospital telephone translation into English, Bengali and Polish & Russian
- Translation be available for pregnant women at every stage of pregnancy – including written information about stages of care.
- Some organisations are already putting into practice ways to improve access to health care for their service users, lessons and good practice should be shared across the sectors.
- Training for health care professionals on the intricacies of the EU regulations and health care in the UK for EEC.

Social Services

Delays in getting a care package

Through our preliminary work around hospital discharge, feedback direct to Healthwatch and through the Older People's Reference Group we are picking up potential significant concerns regarding delays to care packages being put in place and to undertaking assessments. This is leaving patients and their family and carers very distressed and uncomfortable with no, or not enough, care.

> *My sister has been hospitalised for the past two months. She hasn't been bathed and is very uncomfortable. She is emotionally stressed and the nurses have said she is ready to go home. Her social worker hasn't organised a care package for her and is never available. The social worker is never available and there is a dispute over who will be paying for the services she receives. They say the equipment needed isn't suitable for her but I've told her mattress and bed has been delivered. I don't know what to do, I've taken two days off to sort this out and bring her home.*

Lack of communication

Another issue is the lack of communication between the different professionals involved in a patients care.

> *Currently has a care package in place. She had a call from a social worker to say that they wanted to make an appointment for a **short term** assessment of her care. A couple of weeks later another social worker called to make an appointment to undertake a long term*

assessment. Shortly after that she had a call from the Occupational Therapist who wanted to assess her physiotherapy needs. She felt that at the least they should be talking to each other and sharing information. Ideally they should all come around together along with other people involved in her support and that they should do the assessment together. She can talk to them about what she thinks she needs."

Poor communication with client. Social worker confused of the needs of the patient. Reception staff ask too many questions. Bouncing from one professional to another. From 2016 I am struggling with my son's care because the LDS did not complete the paper work on time, so I am able to access respite for my son. Some error with the payment not paid to the respite centre, so they blocked my access to book.

Older People

Over the past 12 months there have been various consultations with the Older Peoples Reference Group concerning social care services both with Council officers and Healthwatch Tower Hamlets. Some of the key issues that have come up through those consultations are:

- Not knowing how to get a social care assessment. People are not aware of the emergency service social worker team. There was an instance where neighbours were constantly monitoring and supporting an older person who was suffering frequent falls.
- Not knowing that you're entitled to social care support and not knowing the system. They understand how to access health but not social care. Unaware of after care and enablement and whether they are entitled to it.
- With the introduction of a charging system some people may be put off and assume that they're not entitled to anything.
- A sense that the information that is available is online and not accessible by a large proportion of the older population.
- There should be more information/leaflets available at GP practices and at the hospital. Put something in East End Life and post directly to older people. Integrated Care Programme should focus more on social care. Care Coordinators should have a greater focus on accessing social care services.

Carers

A number of the Community Intelligence reports touched on issues relating to carers

- Health service information should be targeted at women as they are the primary health and caring providers in families.
- Important health messages promotions should include partnerships with grassroots services that are able to engage with women from communities that are poorly served by current services including carers. Priority must be given to those from particularly disenfranchised communities such as those of Somali heritage who rely

on oral traditions of communication and have limited reading, digital and English language skills.

- Health messages should be promoted through TV channels and touch screens at GP services in appropriate community languages so as to reach disenfranchised women and families through a range of approaches.
- The CCG and Healthwatch should continue to work in partnership with small organisations to undertake further research into the changing needs of the borough's most vulnerable women and carers so as to support them in maintaining good health for themselves and their families and dependents.
- The views of parents of children with Special Education Needs and children themselves need to be listened to on how services could work better together to improve the quality of their care.

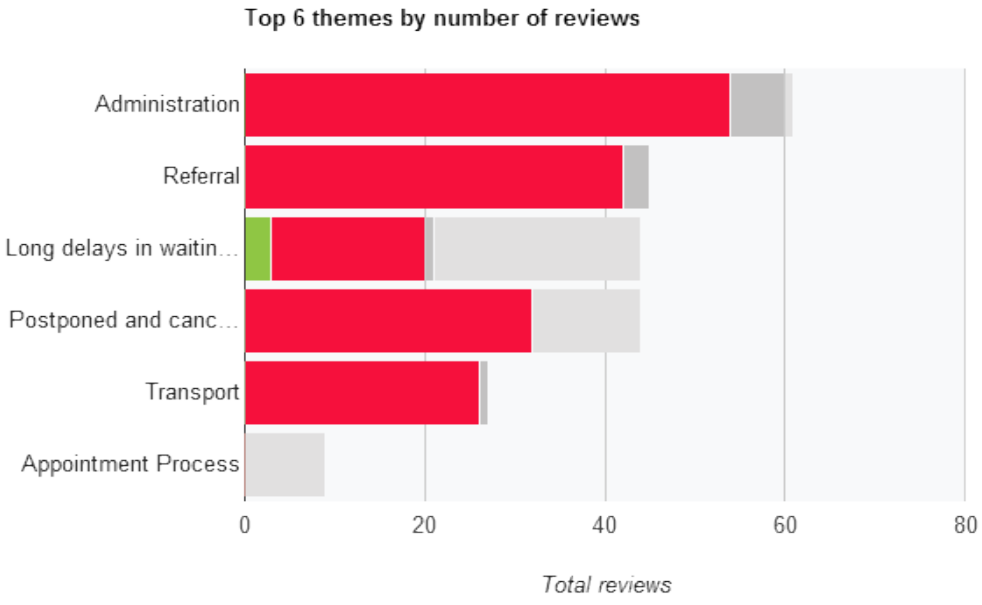
Women and children

Engagement undertaken by the Asian Women Lone Parent Association found that the biggest challenges faced in trying to help women and their children to be healthy and well were in relation to access and support services including getting their children into a good school, support to find a job/volunteering, knowledge and support to access local exercise services for themselves and their children.

Stress was a common challenge but over half did not know where to go to access mental health services. The recommendation was to look at a holistic programme that addresses all the needs of the women impacting on their mental and physical health. Stress is significant factor in their lives so looking at activities that will help alleviate this would be key.

Hospitals

In January 2016 Healthwatch reviewed 892 comments on services at the Royal London of which 219 related to access.



Reviewing the most recent comments the following arears still seem to be issues.

Appointment process

There seems to be an issue with gaining the hospital appointment once the GP has referred you.

> *Hospital appointments take too long to be booked. Especially when you are being referred via GP's.*
>
> *Hospital appointments are very late, especially when your appointments have been referred by GP.*
>
> *Booking hospital appointment after being referred by GP can be very difficult. It's really hard to get through to them, because lines are very busy. They take long to answer the calls. Sometime you have to call back the next day to book appointment. More staff should be employed at the central appointment line.*
>
> *The online booking system was not user friendly. I tried to change the time of my appointment and the outcome was an appointment was made at another hospital (Whipps) without my knowledge.*

We have had some difficulty trying to ascertain if the number of postponed and cancelled outpatient and surgery appointments is continuing to be a problems but it is still appearing in the patient comments.

> *My appointments were cancelled on several occasions and were never given an apology for that; also, I waited 45 mins before being seen.*

However there does seem to be some distinct improvements in some clinical areas that hopefully can be replicated in other areas of the hospital.

> *Very fast appointment after GP referral. Good "one visit clinic system." Appointments tend to be regular and organised.*

A general lack of communication seems to be felt

> *My son's scan results were supposed to have been sent from hometown. I called this morning and it was confirmed as done. When we arrived at the appointment there were no results available for consultant to view.*

Interpreters

It is clear that there is a definite issue with regards to the language barrier.

> *Bengali people are treated really poorly and badly. She recounted a story of a midwife and the mistreatment. Midwives do not listen and the baby was born on the ward. Patient couldn't speak English. The*

nurse said…you Bengali people have babies every year, why you crying?'"

Booking a translator before your appointment to see a GP or go to the hospital is very difficult because there aren't enough translators available and they are fully booked"

During our Enter and View visit to Ear, Nose, Throat (ENT) Outpatients they estimated around 40% of ENT patients are not seen as a result of them not having the necessary interpreting support, this is resulting in unequal access issues and having an impact on delaying patients in receiving treatment/medicine or necessary valuable medical advice.

Case study from deafPLUS

Client RD fell ill at deafPLUS during one of our bingo sessions. RD has asthma and is a diabetic. She also smokes and has poor general help. DeafPLUS staff called an ambulance and RD wanted our volunteer JN to accompany her as they are also friends.

Upon arriving at the hospital, the nurses started talking to JN expecting her to interpret for RD. JN is hard of hearing herself and explained that they needed to book a qualified interpreter and that she was only there as a friend.

The nurses refused to book an interpreter and kept talking to JN to relay the information over. At the end, JN texted deafPLUS and we immediately went over to the hospital and talked the procedure through with the nurses. An interpreter was booked for the next day and deafPLUS had no option but to stay to interpret in the meantime with no medical training or knowledge which put the client at significant risk and disadvantage.

Follow Up

There seems to be a mixed comments concerning follow up appointments

Good follow - up cure - friendly and attentive staff.

Operation was great. The services and care are not joined together. Follow appointments have been difficult to get and to chase. This patient was meant to get an appointment after 4 weeks and it has now been 6 weeks and he hasn't heard anything.

I was seen on time and attention was given and the follow up appointment was immediately issued to me at the reception.

This year I had an echo which was fine but the follow up appointment with a consultant was not there.

Finding services

Although this seems to be a rather superficial issue, there does seem to be a problem with regards to finding the actual service department leading to people missing appointments and finding it very challenging to get a new one.

The signs in the hospital are not clear as people/service users are not aware of the lifts and seem to be lost. The signs need to be more visible and clear. More information will also be good such as voice recognition as people with partial sight may find it hard.

The lift is very hard to use and some people say they don't know how to use them.

I did find it hard to find the clinic initially though - as my letter said to come to ultrasound on the first floor - but the hospital signs do not mention ultrasound at all.

Training of staff

There is a general view that the staff require more training

Training of reception staff needs improving such that they have the knowledge to answer queries on the phone.

Mental Health

The Healthwatch Tower Hamlets Mental Health Task Group has identified as one of its priority areas the need to improve access to work opportunities for people with mental health issues and is co-developing a project with users, ELFT and the Department of Work and Pensions.

Many people have said they could have avoided lower level mental health problems if they had had someone to talk to and there seems people would prefer not to access overly structured support. Employing more people with lived experience within services

Length of wait to see a Psychologist

I was referred by my GP to see the Psychologist. It took me eight weeks to get this appointment.

Access to out of hours' crisis support

The opening hours of the 'crisis' phone is not good, there is no one there in the evenings and weekends to answer the phone, sometimes I feel really awful in the weekends, but there is no one to talk to. (Deancross Personality Disorder E&V- 16th March 2016)

Not enough signposting of local support group services to service users

I would like to know more about activities that I can take part in, I get bored and need things to do…currently no one here is telling me where I can go to participate in other activities (Three Colts Lane CMHT- 29th June 2015)

Next steps for Healthwatch Tower Hamlets

As a result of the feedback that we have gathered above Healthwatch Tower Hamlets is in the process of developing a number of projects within in our work plan for 2016/17.

- A series of enter and view visits to eight to ten GP Practice's (2-3 in each Locality) in Tower Hamlets to review access to GP services. Working in partnership with the patients, CCG, CQC and the GP Care Group.
- Our Mental Health Task Group is developing peer researchers who will undertake outreach to discuss access issues regarding mental health users.
- To use Healthwatch England's Social Care Toolkit to help local us to find out to what extent delays in social care assessments, package arrangements and reviews are a concern for local people.
- Work with the Healthwatch Tower Hamlets Young Peoples Panel to identify the key issues impacting on access to health and social care services for young people. To agree project by end of September 2016.

Committee:	Date: 15/09/2016	Classification:	Report No.	Agenda Item No.
Health Scrutiny Panel		Unrestricted		
Report of: Health Scrutiny Panel		**Title: Access to Health Services (CCG)**		
Originating Officer: Jane Milligan (Chief Officer, CCG)		**Wards:** All		

1. SUMMARY

1.1 In order to provide the context for the Health Scrutiny Panel's theme of access to health and social care this report details the key issues around access to health care services and the actions Tower Hamlets Clinical Commissioning Group is undertaking in response to improve access.

1.2 This report provides a specific focus on primary care, urgent care, planned care, mental health, learning disabilities, and introduces the objectives of the Sustainability and Transformation plan

1.3 This report forms part of the 'setting the scene' agenda item. This agenda item aims to allow the Health Scrutiny Panel to collect community intelligence on access to health and social care, scrutinise the key issues restricting access to health and social care services, and develop and understanding of how the pending changes to the NHS will impact access services.

2. RECOMMENDATIONS

The Health Scrutiny subcommittee is asked to:

1. Collect community intelligence on the theme of access to health and social care.
2. Understand what the key issues restricting service access to health and social care services are.
3. Develop and understanding of the pending changes to the NHS and the likely impact this will have on the way residents access services.

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Non-Executive Report of the: **[Health Scrutiny Committee]** 15/09/2016	TOWER HAMLETS
Report of: Luke Adams, Service Head Adult Social Care Nasima Patel, Service Head Childrens Social Care	**Classification:** Unrestricted
Access to Social Care	

Originating Officer(s)	Joanne Starkie, Community Engagement Quality and Policy Manager
Wards affected	[All wards]

Summary

1.1 In order to provide the context for the Health Scrutiny Panel's theme of access to health and social care this report introduces the key issues around adults and children's social care services, detailing what the key challenges impacting residents access to social care services are and how the council is trying to improve access to these services for residents.

1.2 This report forms part of the 'setting the scene' agenda item. This agenda item aims to allow the Health Scrutiny Panel to collect community intelligence on access to health and social care, scrutinise the key issues restricting access to health and social care services, and develop and understanding of how the pending changes to the NHS will impact access services.

Recommendations:

The Health Scrutiny Sub Committee is recommended to:

1. Collect community intelligence on the theme of access to health and social care.
2. Understand what the key issues restricting service access to health and social care services are.
3. Develop and understanding of the pending changes to the NHS and the likely impact this will have on the way residents access services.

1. REASONS FOR THE DECISIONS

1.1 There is no decision to be made.

2. ALTERNATIVE OPTIONS

2.1 There are no alternative options.

3. DETAILS OF REPORT

3.1. This details the main barriers for residents accessing effective social care from the Local Authorities perspective. The report discusses how the Local Authority is responding to social, economic and political challenges to improve access to social care services for residents.

3.2. Moreover it discusses how the implementation of the Care Act has impacted on residents access to social care service and how the integration agenda has improved access to health and social care services

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 There are no current financial implications to this presentation. Recommendations from future reviews will be reported separately and any financial implications arising will be considered in the context of the outcomes based 2017/18 to 2019/20 medium term financial strategy

5. LEGAL COMMENTS

5.1 There are no current legal implications to this presentation.

5.2 Any recommendations from future reviews will be reported separately and any legal implications arising will be considered in those reports.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 This report forms part of the HSCs scrutiny of the theme of access to health and social care services. This theme was chosen in order to identify where there are areas of inequality and poorer health outcomes, and make recommendations to improve these gaps. It allows for scrutiny of all community groups to recognise what the key barriers are for accessing health and social care services in LBTH.

7. BEST VALUE (BV) IMPLICATIONS

7.1 There are no best value impactions for this report.

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 There are no sustainable actions for a greener environment in this report.

9. RISK MANAGEMENT IMPLICATIONS

9.1 There are no risk management implications for this report.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 There are no crime and disorder reduction implications for this report.

Linked Reports, Appendices and Background Documents

Linked Report

- NONE

Appendices

- State NONE if none [and state EXEMPT if necessary].

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report
List any background documents not already in the public domain including officer contact information.

- NONE

Officer contact details for documents:

- Daniel Kerr

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Non-Executive Report of the: **[Health Scrutiny Committee]** 15/09/2016	TOWER HAMLETS
Report of: Somen Banerjee, Director of Public Health	**Classification:** Unrestricted
Community Pharmacy – Briefing on Current Issues	

Originating Officer(s)	Somen Banerjee, Director of Public Health
Wards affected	[All wards]

Summary

In the context of proposed national reductions in funding to community pharmacy and their integral role in delivering on the aspirations of the National Five Year Forward View, the Tower Hamlets Health Scrutiny Panel has requested a briefing on the role of community pharmacies specifically focussing on the following questions:

- What is the role of community pharmacies and where do they fit in the healthcare system?
- What cuts to community pharmacy funding are proposed nationally and what might be the impacts be on the community and on resident's access to healthcare?
- What other changes to community pharmacies are planned and what impact will these have on residents access to healthcare?

Recommendations:

The Health Scrutiny Sub Committee is recommended to:

1. Explore the role of community pharmacies and where they fit in the healthcare system
2. Understand proposed reductions to community pharmacy funding and the impact this will have on the community.
3. Develop an understanding of the pending changes to prescribing and what the impact of this will be for residents.
4. Consider how the Panel should be involved in shaping community pharmacy in the future (particularly in the context of the current proposals being put on

hold whilst they are reconsidered nationally)

1. REASONS FOR THE DECISIONS

1.1 There is no decision to be made.

2. ALTERNATIVE OPTIONS

2.1 There are no alternative options.

3. DETAILS OF REPORT

3.1 This report considers the significant role of Community Pharmacies in supporting the health care needs of the population, and details it the implications of a reduction in funding. Community pharmacies are a key healthcare provider for residents and have a significant presence in the community. Pharmacies represent the most accessible primary care location, with 96 per cent of people able to get to a pharmacy within 20 minutes by walking or using public transport (99 per cent by car). Most community pharmacies have extended hours and weekend opening that GPs are unlikely to offer at scale any time soon. They are a key touch point for almost everyone in the community as they provide prescriptions, support people with a lifelong conditions, and help to advise on the best over the counter medication. The average person visits a pharmacy 14 times each year. All of this helps to relieve pressure on our hard-pressed GPs and A&E Departments, freeing them to make a difference to those patients who are truly in need of their help. In fact, as many as 20% of all GP appointments could be dealt with just as effectively, and far more rapidly, through community pharmacy.

3.2 The Department of Health announced that there will be a 6% reduction in funding to Community Pharmacies from 2016. At the same time, as part of new plans to transform the NHS, it is projected that 24% of attendances at GP surgeries can be catered for by patients being supported to self-care and being referred to pharmacies. This will have a significant impact on residents accessing health care services and place even more pressure on GP surgeries and A&E.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The national government funding for pharmacies has reduced by 6% from £2.8bn in 2015/16 to £2.63bn in 2016/17. Tower Hamlets currently has 48 pharmacies and the proportionate reduction in funding locally, equates to the loss of government funding to approximately 3 pharmacies in total, or a £12,000 loss to each. Strategies are being explored for the reprovision of services, revise payment structures and reduce costs without a loss of service to users.

4.2 For LBTH, there are currently, no financial implications arising from this briefing. Recommendations from future reviews will be reported separately and any financial implications arising will be considered in the context of the outcomes based 2017/18 to 2019/20 medium term financial strategy.

5. LEGAL COMMENTS

5.1 There are no current legal implications to this briefing.

5.2 Any recommendations from future reviews will be reported separately and any legal implications arising will be considered in those reports.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 This report forms part of the HSCs scrutiny of the theme of access to health and social care services. This theme was chosen in order to identify where there are areas of inequality and poorer health outcomes, and make recommendations to improve these gaps. It allows for scrutiny of all community groups to recognise what the key barriers are for accessing health and social care services in LBTH.

7. BEST VALUE (BV) IMPLICATIONS

7.1 There are no best value impactions for this report.

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 There are no sustainable actions for a greener environment in this report.

9. RISK MANAGEMENT IMPLICATIONS

9.1 There are no risk management implications for this report.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 There are no crime and disorder reduction implications for this report.

Linked Reports, Appendices and Background Documents

Linked Report

- NONE

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- Daniel Kerr

Community Pharmacy: Briefing on current issues

1. Background and context to paper

1.1 Community pharmacies are an integral component of the provision of healthcare in the UK. 1.2 million visits are made to community pharmacy for health related reasons each year. The strengths of community pharmacy are their accessibility in terms of location and long opening hours to services such as medicine supply, health promotion and signposting to health and social care services. In deprived population, people who may not be accessing conventional NHS service do access community pharmacies[1].

1.2 In December 2015, the Department of Health and NHS England set out proposals to change how Community Pharmacy is delivered in England and also announced a 6% reduction in funding to Community Pharmacies from 2016/17. The role of Community Pharmacy is also integral to the new models of care set out in the National NHS Five Year Forward View and, more locally, within Transforming Services Together plans to promote self-care and develop a more integrated primary care system across Tower Hamlets, Newham and Waltham Forest.

2. Purpose of paper

2.1 The Tower Hamlets Health Scrutiny Panel has requested a briefing on the role of community pharmacies specifically focussing on the following questions:

- What is the role of community pharmacies and where do they fit in the healthcare system?
- What cuts to community pharmacy funding are proposed nationally and what might be the impacts be on the community and on resident's access to healthcare?
- What other changes to community pharmacies are planned and what impact will these have on residents access to healthcare?

[1] https://www.england.nhs.uk/wp-content/uploads/2013/12/community-pharmacy-cta.pdf

3. What is the role of community pharmacies and where do they fit in the healthcare system?

National picture and policy[2]

3.1 The core roles of community pharmacies are:

- Dispensing medicines
- Advising on medicines use
- Promoting good health and supporting prevention
- Supporting people to look after themselves

3.2 The scale of delivery of community pharmacy services is substantial:

- There are 1.6 million visits a day of which 1.2 million are for health reasons
- Around 1 billion medicines are dispensed in community pharmacy every year
- £8 billion is spent every year in primary care on NHS medicines
- Prescriptions are growing at a yearly rate of 2.5%

3.3 The direction of travel is moving towards more integrated local models:

- Optimising medicines usage
- Supporting people with long term conditions
- Treating minor illness and injuries
- Taking referral from other care providers
- Preventing ill health
- Supporting good health

3.4 Specifically, the Department of Health has set out a vision for 'pharmacy at the heart of the NHS':

'The vision is for community pharmacy to be integrated with the wider health and social care system. This will help relieve pressure on GPs and Accident and Emergency Departments, ensure optimal use of medicines, will mean better value and patient outcomes. It will support the promotion of healthy lifestyles and ill health prevention, as well as contributing to delivering seven day health and care services'

3.5 This involves a range of developments in the roles of community pharmacists and pharmacies:

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[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/495774/Community_pharmacy_in_2016-17_and_beyond_A.pdf

- Pharmacists enabled to practice more clinically
- Clinical pharmacists in GP practices working alongside GPs
- Clinical pharmacists working in care homes working with residents and staff
- Clinical pharmacists helping patients with urgent problems, at the end of a phone
- Making it easier for patients to get prescriptions eg via internet
- Freeing pharmacists to support patients to make the most of their medicines and take care of their health

Local picture[3]

3.6 The Health and Social Care Act requires every council to produce a Pharmaceutical Needs Assessment (PNA). The Tower Hamets PNA was published in 2015 and assesses the provision of pharmacy services with respect to pharmacy services.

3.7 The key findings of the Tower Hamlets PNA were as follows

- Features of the current pharmacy network (as in 2015)
    - 48 pharmacies provide a wide range of services alongside 36 GP practices
    - 19 pharmacies per 100,000 population which is fewer than the rest of London (23) and England (22)
    - Pharmacies in Tower Hamlets tend to dispense a higher number of prescriptions each than elsewhere
    - 95% of prescriptions issued by GPs in Tower Hamlets are dispensed by pharmacists in the borough
    - Community pharmacies in Tower Hamlets provide a range of locally commissioned or additional services:
        - The Council provide a range of services through the Public Health Grant (smoking cessation, sexual health and substance misuse services) and also through Adult Social Care which delivers a prescription scheme through pharmacies for Community Equipment services (Transforming Community Equipment Services)
        - NHS England commission a targeted Medicine use review including medical use review

- Public perceptions (from focus groups)
    - Pharmacies are perceived to have friendly and helpful staff who build trust with customers

[3] http://www.towerhamlets.gov.uk/Documents/Public-Health/JSNA/Pharmaceutical_needs_assessment_report_2015.pdf

    - Pharmacies are considered to be convenient in terms of opening hours and accessibility for 'dropping in' for advice
    - There is appreciation of different languages spoken in pharmacies
    - Areas for improvement included information (eg services available, opening hours), confidentiality and staff training

- Demand
    - Evidence indicates that there is currently sufficient capacity across the borough for essential pharmacy service
    - Population growth in the borough will increase the need for future pharmacies to maintain current provision per head particularly in high growth areas

3.8 Overall, the impression is of a high quality network of community pharmacies across the borough providing a vital service and an accessible source of advice and support for residents.

4. What cuts to community pharmacy funding are proposed nationally and what might be the impacts be on the community and on resident's access to healthcare?

National Context - 'Bringing Pharmacy into the Heart of the NHS'[4]

4.1 In 15/16, the NHS committed £2.8bn on funding for community pharmacy (a median average of £220,000 a year per pharmacy)

4.2 The Department of Health have noted the following

- The numbers of pharmacies have grown by 20% since 2003 (from 9,748 to 11,674)
- There has been low uptake of digital channels providing pharmacy services
- 40% of pharmacies are in clusters of 3 or more and are within 10 minutes' walk of 2 or more other pharmacies
- Technology is being use for prescriptions at individual/cluster level or by large organisation but not uniformly

4.3 In the context of the Five Year forward view highlighting the £30 billion deficit if current patterns of provision and funding continue, community pharmacies are seen as an integral part of the new model of care relieving pressure on other elements of the system (eg general practice, urgent care) through the developments outlined in 3.3

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[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/495774/Community_pharmacy_in_2016-17_and_beyond_A.pdf

4.4 At the same time, the Government has identified areas of efficiencies in community pharmacy that it considers would not compromise quality of services or access. It argues that:

- there are more pharmacies than are necessary to maintain good patient access
- NHS funded pharmacies qualify for a complex range of fees regardless of the quality of service and levels of efficiency of that provider
- more efficient dispensing arrangements remain largely unavailable to pharmacy providers.

4.5 Based on these considerations, it has announced that the total funding commitment for pharmacies under the community pharmacy contractual framework will be no higher than £2.63bn compared to £2.8bn in 2015/16.

4.6 Linked to this, it has proposed changes in community pharmacy aiming to:

- integrate community pharmacy and pharmacists more closely within the NHS
- modernise the system for patients and the public to make the process of ordering prescriptions and collecting dispensed medicines more convenient and offering choice in how they receive their prescription
- ensure the system is efficient and delivers value for money
- maintain good public access to pharmacies and pharmacists

4.7 Specific proposals are to:

- Introduce a Pharmacy Integration Fund (PhIF) as the primary means of driving transformation of the pharmacy sector to embed medicines optimisation and the practice of clinical pharmacy in primary care focussing initially on deployment of clnical pharmacists in a range primary care settings.

- Ensure that the regulatory framework and payment system makes online, delivery to door and 'click and collect' pharmacy easier including introducing a new 'terms of service' for distance selling pharmacies

- Make efficiencies by

    - phasing out the 'establishment payment' (£25,000 paid to all pharmacies dispensing 2,500 or more prescriptions a month - arguing that this level is low and easy to meet and does not act as an incentive for improvement)

- introducing 'hub and spoke' dispensing models to capture efficiencies from large scale automated dispensing, reduced stock holding locally that would reduce operating costs of local pharmacies
- Encouraging longer prescription durations where clinically approriate eg 90 days for stable long term condition management (rather than the current norm of 28 days)

- Introduce a Pharmacy Access Scheme in which areas where pharmacies are particularly important for patient access will be required to make smaller efficiencies based on criteria around deprivation, age, disability, health need, birth rates, ethnicity and social housing level.

Pharmaceutical Services Negotiating Committee response[5]

4.8 These changes were set out by the Department of Health in December 2015 to the Pharmaceutical Services Negotiating Committee (PSNC) which is the official body responsible for representing the interests of all the NHS community pharmacies in England.

4.9 The PSNC responded to the Department of Health and NHS England in May 2016 in a letter that, whilst recognising the case for reshaping the community pharmacy service, highlighted significant concerns with the proposals.

4.10 The key issues the PSNC highlighted were as follows:

- Lack of clarity from the Government on the scale of closures of community pharmacies it wishes to achieve

- Many services such as extended hours of opening, home delivery services and supply of medicines in 'compliance aids' (ways to ensure they are taken properly) are provided voluntarily and free of charge and that discontinuation of these service would add to the burden on other services

- Clustering of pharmacies is not necessarily indicative of overfunding of the service as when a pharmacy closes the services for its patients transfers to other pharmacies and the costs do not disappear and there is also a reduction in choice for patients

- Having pharmacists working in general practice will not provide the support and care provided by community pharmacy and underplays the ability of community pharmacy to offer more to communities eg pharmacies working with acute trusts on newly discharged patients

[5] http://psnc.org.uk/wp-content/uploads/2016/05/PSNC-response-to-the-letter-Community-pharmacy-in-2016-17-and-beyond.pdf

- Simplification of remuneration of pharmacy fees to a Single Actvity Fee and removal of the Establishment Fee removes levers to incentivise desired behaviours (unlike remuneration arrangements for GPs)

- The proposals to drive remote, automated supply services and bypass the community pharmacy network are untested and there is a lack of evidence that this will result in cost savings

- Current experience of online, remote pharmacy service provision has not been encouraging as the impact of problems in supply change such as failure of the automated dispensing system have large scale impacts making the system vulnerable to unforeseen events such as extreme weather impacts on delivery

- It is not clear that the provision of 'remote pharmacy services' is in line with patient preference as their current market share is currently low and ' patients generally prefer to use a local pharmacy, where they can establish a relationship, sometimes quite a close one for patients with significant health needs, and they should not be pressured to accept a remote and impersonal service provider'

- It is possible for the NHS to improve care and make savings by developing services from pharmacies such as minor ailment, people living with long term conditions, promotion of healthy living and provision of urgent supplies of repeat medicines directly form community pharmacy

4.11 In conclusion, the PSNC considered that the proposal constitutes a 'major threat to the future availability to the public of an easily accessible source of informed health care, support and advice'.

4.12 In June 2016, the Government announced that it would engage further with the PSNC and other stakeholder before making any changes to the legislation on 'hub and spoke' dispensing and has delaying changes to beyond the previously planned date of October 2016.

Local Government Association response[6]

4.13 The Local Government Association (LGA) responded to the proposals and highlighted a concern that the focus on the integration of

[6] http://www.local.gov.uk/documents/10180/11493/LGA+response+to+the+consultation+-+putting+community+pharmacy+at+the+heart+of+the+NHS/5e2c3839-b1be-4fdc-bfbc-367ff121258f

community pharmacy with the NHS ignores the role pharmacy as an important social and economic asset.

4.14 It highlighted that community pharmacies are one of the core businesses which can 'make a difference between a viable high street and one that fails commercially'. This is particularly important at time in which traditional high streets find themselves under pressure from a wide range of powerful economic, technological and social trends.

4.15 The LGA also highlighted the importance of community pharmacies as a social asset. It pointed out that community pharmacies are often patients' and the public's first point of contact and, for some, their only contact with a healthcare professional. This may be particularly the case in areas of deprivation.

4.16 It noted also the common purpose between community pharmacy and local government around delivery of public health services, supporting independence, sustaining communities and as a hub for signposting people to services.,

5 What other changes to community pharmacies are planned and what impact this will have on residents access to healthcare?

Transforming Services Together and the role of community pharmacies[7]

5.1 The Transforming Services Together (TST) Programme sets out the strategy for transformation of the health and social care economy across Tower Hamlets, Newham and Waltham Forest. This sits under the umbrella of the North East London Sustainable Transformation Plan (STP) under development.

5.2 The role of community pharmacy is integral to its plans particularly within three of the high impact initiatives to shift care closer to home:

- Putting in place an integrated care model - community pharmacist are an integral part of an integrated NHS 111, pharmacy and primary care 'virtual hub' with increasing roles around minor ailments and independent prescribing

- Improving end of life care - community pharmacy provides 24/7 services as part of an integrated model of integrated end-of-life services

- Improving access, capacity and coordination in primary care - community pharmacies are routine settings for patients to get care

[7] http://www.transformingservices.org.uk/strategy-and-investment-case.htm

for minor ailments and are able to view and input into shared records with general practices

5.3 These changes are being piloted and implemented through the implementation of the TST programme.

The North-East London Local Pharmaceutical Committee - role and vision

5.4 The North-East London Local Pharmaceutical Committee (NELLPC) is formed under the NHS regulations to represent local pharmacy owners (and pharmacists) in North East London. The committee represents all pharmacies in the London boroughs of Barking and Dagenham, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest and its perspectives are important in shaping the future locally for community pharmacy.

5.5 In responding to the Government proposals, the NELLPC agreed that there is a need to reshape community pharmacy to support local and health care services highlighting issues such as non compliance with medications, prescribing errors, wastage and potential of community pharmacy to promote health through behaviour change.[8]

5.6 However, it has also set out a position that in some areas differs from that of national PSNC. Specifically, in setting out a vision for the future of community pharmacy that:

- prioritises the development of the clinical and public heatlh skills of pharmacists
- repositions community pharmacy as a clinical profession complementary to GP
- proactively offers support for community development and voluantary organisations
- strengthens hospital discharge schemes linking community pharmacy to primary and secondary care
- addresses the community pharmacy role in addressing mental health
- takes on repeat prescribing with robust governance and audit systems
- effectively supports patients with comorbidities (more than one condition)
- trains staff to support carers and patients around community equipment and daily living aids supporting independent living

5.7 It has set out this vision in a document entitled 'Self Care Pharmacy' and elements of this are being piloted across North East London. [9]

[8] http://nellpc.org.uk/?p=13312

[9] http://selfcarepharmacy.co.uk/ (and personal communicatin with Chair of LPC)

6 Discussion

6.1 Based on the issues outlined in this document, community pharmacy could be seen as being at a cross roads. As with all services that are funded significantly through the public sector, community pharmacies are facing the twin challenges of reduced resources and the opportunity to innovate and build on the strengths of the existing model.

6.2 The current proposals set out by the government remain under consideration but as they stand overall impact on access, choice, value for money and health outcomes is difficult to assess. For example, the reduced funding makes closure of some pharmacies inevitable. At the same time, the use of technology and the opening up on online services may extend choice and access.

6.3 Furthermore, if the aspirations for community pharmacy set out in Five Year Forward view and reflected in STPs are to be realised in terms of promoting self-care and reducing pressures on the system, this will require significant engagement of the NHS with community pharmacists collectively to work together on how to make this happen.