LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY PANEL

HELD AT 6.30 P.M. ON TUESDAY, 14 APRIL 2009

ROOM M72, 7TH FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Alexander Heslop
Councillor Ann Jackson (Vice-Chair)
Councillor Dr. Emma Jones
Councillor Abjol Miah

Other Councillors Present:
Nil

Co-opted Members Present:

Myra Garrett	–	(THINk Interim Steering Group Member)
Dr Amjad Rahi	–	(THINk Interim Steering Group Member)

Guests Present:

Caroline Alexander	–	(Director of Nursing, Tower Hamlets PCT)
Dr Ian Basnett	–	(Director of Public Health, Tower Hamlets PCT and LBTH)
Judith Bottriell	–	Associate Director Governance, Barts & The London Trust
Vivienne Cencora	–	Tower Hamlets Primary Care Trust
Rachel Grady	–	Tower Hamlets PCT
Dr Charles Gutteridge	–	Medical Director, Barts & the London NHS Trust
Vanessa Lodge	–	Tower Hamlets PCT
Peter Mills	–	Barts & the London NHS Trust
Peter Morris	–	Chief Executive, Barts & the London NHS Trust
Ben Vinter	–	Head of Corporate Affairs, Tower Hamlets PCT
Annelese Weichert	–	Tower Hamlets PCT
Susan White	–	Tower Hamlets PCT
Alwen Williams	–	Chief Executive, Tower Hamlets PCT

Officers Present:

Deborah Cohen	–	(Service Head, Disability and Health)
Afazul Hoque	–	(Acting Scrutiny Policy Manager)
Nojmul Hussain	–	(Scrutiny & Equalities Support Officer)
Alan Ingram	–	(Democratic Services)

Note: In the absence of Councillor Shirley Eaton, Chair of the Panel, the Vice-Chair, Councillor Ann Jackson, took the Chair for the meeting.

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Stephanie Eaton, Tim O'Flaherty and Bill Turner.

2. DECLARATIONS OF INTEREST

Nil.

3. UNRESTRICTED MINUTES

The minutes of the meeting held on 27 January 2009 were agreed as a correct record.

4. REPORTS FOR CONSIDERATION

4.1 Tower Hamlets PCT Declaration to the Healthcare Commission 2008/09

Caroline Alexander, Tower Hamlets Primary Care Trust, introduced a report detailing the PCT's preparations for the declarations it would have to make to comply with the Health Care Commission's requirements for performance assessments. The PCT would have to make two declarations in the current year, to reflect its functions as a healthcare provider (Tower Hamlets Community Health Services) and as a commissioner of healthcare services.

Alwen Williams, Chief Executive of Tower Hamlets PCT, added that PCTs were now to be subject to annual reviews of competency in commissioning and comply with the world class commissioning regime. She commented that the organisation was the highest performing PCT in London and was establishing links to work in association with Hackney and Newham PCTs.

Caroline Alexander then continued a comprehensive presentation on how monitoring was carried out to ensure robust processes for quality assurance of service providers; redesign of services where necessary; accessible and responsive care. She pointed out that access to GPs services in 24 hours had improved to 80% over the last year.

Susan White, Tower Hamlets PCT, explained measures by which Tower Hamlets Community Health Services addressed patient safety; clinical cost effectiveness; governance issues; access for wheelchair users; engagement of communities in service provision; care environment and public health.

The Chair invited questions on the report and PCT Officers responded to questions put by Members of the Panel relating to:

- Contracting out of failing GP services, with particular reference to the St Paul's Way surgery. It was acknowledged that the PCT would have

to involve local people earlier in such instances and lessons had bee learned in that respect. However, it was likely that any attempt to restrict bids for service provision to other local providers would be challenged through national commissioning rules unless particular specialisms were involved.

- Ensuring that pathways to more polyclinics were thought out with community involvement and measures should be undertaken to target BME communities to secure their inclusion in access to services to ensure early diagnosis of problems and the provision of linked services for full treatment. It was felt that great improvements to access had been made over the last 12 months and had been enhanced by a dedicated interpreting service through PRAXIS and a mobile dental service.
- Involvement of BME communities which had been undertaken with regard to an education programme concerning diabetes and also block breast screening sessions particularly targeting Somali and Bengali women. Very positive feedback had been received in these connections. In addition, information had been made available on staying healthy, regarding smoking and obesity. Meetings had been held in the community and at such locations at the East London Muslim Centre.
- Linking of dental services through schools and the mobile service was confirmed and dental decay rates had been halved over the past year.
- Encouraging BME communities to take up sight tests in local facilities was being progressed in liaison with colleagues in Barts and the London NHS Trust and was also being aimed at persons with learning disabilities.
- Smoking cessation and tobacco use had been identified as areas where more education was required and work would be progressed especially with the Somalian community to address the issue.
- Changing people's behaviour to improve their health was a major issue and health guides would be provided at all LAP meetings.
- Alwen Williams added that details of health training would also be provided to a future meeting of the Overview and Scrutiny Committee.

The Chair asked particularly that the matter of patient issues and complaints be reviewed for the next annual report and Caroline Alexander indicated that details of the relevant processes and community opinions would be provided. The Chair made the point that the views of THINk should also be included as an integral element.

The Panel noted the work being undertaken with regard to the required declarations and the Chair asked that any further comments to be made in this connection and also the report on End of Life Care be forwarded to Mr Afazul Hoque, Acting Scrutiny Policy Manager, as soon as possible.

4.2 Barts and the London NHS Trust Declaration to the Healthcare Commission 2008/09 (TO FOLLOW)

The Panel received a presentation from Dr Charles Gutteridge, Medical Director, Barts and the London NHS Trust concerning the Trust's declaration to the Health Care Commission. Dr Gutteridge introduced Mr Peter Morris, Chief Executive of the Trust, who had been in post for 10 days.

Dr Gutteridge provided a very detailed account of how the Trust had produced a self-assessment against the Health Care Commission's Core Standards in Domain 4 – Patient Focus; Domain 5 – Accessible and Responsive Care and Domain 7 – Public Health. He also described measures being taken to address current issues such as patient dignity/privacy on the old site, which would be improved when the new buildings were in use. There had been huge problems with the Trust's computer system over the past year and this had hindered meeting the national performance standards in booking and appointments processes, however, the Care Records Service was being developed to attain improvements.

Substantial improvements had been achieved in combating infection rates, which was a key priority, but more remained to be done. Development of the new site was proceeding on target and the first phase was due to open in March 2010. Dr Gutteridge added that the Trust was considered to comprise the leading emergency trauma treatment facility in London and achieved three times the survival rates of other hospitals. He then spoke at length Core Standards Document that had been circulated to the Panel, pointing out that there had been concerns at the surge of patient's complaints during the year as a result of computer problems affecting booking of appointments and access to services. This had resulted in failure to meet Core Standards C14c, relating to appropriate actions to make changes in service delivery and C18, relating to enabling all sectors of the community to access services and treatment equitably.

Following the presentation, the Chair invited questions and Dr Gutteridge responded to queries relating to:

- MRSA screening and infection prevention: monthly audits were now undertaken with cleaning service providers and most wards were now experiencing improvements.
- Agency/bank staffing: this represented about 15%-18% for the Trust's employees overall and management were keen to reduce this.
- The effect of trauma admissions on patients, particularly local people, awaiting treatment in Accident and Emergency: the Trust's patients were overwhelmingly local residents but emergency incidents did have an affect on waiting times. There was a need to invest in increased critical care services to provide additional beds and reduce waiting times. It was accepted that local residents should feel they could attend A and E without long waits but, in addition, people tended to go there as first port of call when other treatment centres could be more appropriate.
- Maternity care and confidence/trust of women had presented issues since before the last Overview and Scrutiny Committee service review: while concerns probably related to figures produced in 2006, personal performance assessments had been made for all staff by outside assessors. The programme had been very successful and individual

performances were being strongly monitored. 20 more midwives had been recruited and there was an ultimate target of ensuring 1 – 1 care in that area, with additional obstetricians on ward.

- C. difficile infections had been reduced from 484 per year, which was poor when compared to national standards, to 282, which was considered mid-range. The aim was to reduce this further to no more than 16 cases a month, which would be among the best levels nationally.
- There was no shop at the London Chest Hospital, Bethnal Green, to avoid patients from reintroducing further infections: the shop at Whitechapel was well-used but it was agreed that it was necessary to improve patients' knowledge of infection. This was further required in that 20,000 people a day passed through the hospital. A challenge programme was also in place to encourage patients to challenge staff and others who did not conform to hand-washing requirements.
- It was accepted that improvements were needed to the discharge process, particularly for older patients, so that GPs were informed and linked services could be provided.
- On staff accommodation, the Trust no longer provided or ran housing for staff except sleeping arrangements for on-call staff, although assistance was given with travel passes, etc.
- Junior doctor working hours: there had been a significant reduction from 100 hours a week average some years ago to none now exceeding 60 hours. The total would be eventually reduced to 48 to comply with European regulations and working practices would have to be redesigned accordingly.
- On a workforce reflecting the community: great attention was being given to selecting ethnic minority staff and recruiting from local schools. The selection of women doctors, who now made up 60% of that work area, now exceeded males. There was a wide representation of ethnic groups but Black Caribbeans were under-represented and pathways needed to be created for them. Nursing staff were recruited from East London but there was under-representation here especially of Bengali women and more were also needed as midwives, especially important for the Whitechapel area.
- Customer care issues, where there may be problems with contact between staff and patients, such as midwifery and phlebotomy, would be tackled when identified on a personal basis.

Peter Morris, Chief Executive of the Trust, then addressed the Panel on his vision for development of the Trust and service improvements.

The Panel noted the report and the Chair commented that the matter of parking problems for hospital patients (raised by Dr Amjad Rahi) would continue to be a problem to be addressed in future. She added that care at ward level, involving feeding and dignity was a major concern for older patients, along with discharge arrangements, and she considered that future Trust reports should specify how people were being helped. She also asked that patient comments and data relating to customer satisfaction be provided as soon as possible to Mr Afazul Hoque, Acting Scrutiny Policy Manager.

4.3 End of Life Care - Draft Report (TO FOLLOW)

The Panel considered and approved the draft report on End of Life Care and delegated final approval of the report to the Service Head, Scrutiny and Equalities after consultation with the Chair of the Health Scrutiny Panel.

It was noted that Councillor Heslop asked for his name to be removed from the list of contributors, in view of his late appointment.

4.4 Joint Strategic Needs Assessment - Draft Report of Scrutiny Challenge Session

The Panel noted and agreed the outcome of the Scrutiny Challenge Session on the Joint Strategic Needs Assessment Review and improving Adults' Health and Wellbeing.

The Chair asked that any further suggestions for inclusion be made available to Mr Afazul Hoque, Acting Scrutiny Manager, as soon as possible. She further indicated that steps were necessary to encourage people to be able to come forward and take up access to services and patient's choice. It was important that THINk were also involved to help develop an advocacy facility so that local people would be able to demand services.

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

NIL

The meeting ended at 8.35 p.m.

Chair, Councillor Stephanie Eaton
Health Scrutiny Panel