

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



**London Borough of Tower Hamlets  
2014**

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## **1. Acknowledgements**

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The Review Group would like to express their deep gratitude and thanks to all the partners and officers that supported this review.

The views and perspectives of all that were involved have been fundamental in shaping the final recommendations of this report. We would like to thank all of those who gave their time and expertise during the review process.

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## 2. Chair's Foreword

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

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

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

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

I recommend this review to you.

### 3. Recommendations

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Recommendation 1:

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

Recommendation 2:

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

Recommendation 3:

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

Recommendation 4:

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

Recommendation 5:

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

Recommendation 6:

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

## 4. Background

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### 4.1 National and local changes and pressures

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

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

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

### 4.4 Accident and Emergency Services

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

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

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

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

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

## 5. Outline and methodology

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- 5.1 In considering A&E services the Review Group began by looking at the broader national context, setting out the pressures on A&E services. It then focused on the local picture and what plans are being put in place by local services to address these issues. To inform the Group's work a range of evidence gathering activities were undertaken.
- 5.2 To gauge national concerns around A&E services two key documents have been referenced: the House of Commons Health Committee's report on *Urgent and Emergency Services*<sup>3</sup>, and the King's Fund written submission to the Health Select Committee inquiry on *Emergency services and emergency care*<sup>4</sup>. A meeting organised by the London Assembly's Health Committee on A&E services, (where some of the foremost experts and those responsible for managing the London A&E services were present), was also attended. Various news articles were also referred to, to understand the national concerns that were raised through media reporting.
- 5.3 The Review Group also examined how local NHS organisations and health services have been working to address the pressure on A&E services, as well as preparation for increased pressures in winter. They visited the Royal London Hospital and met with staff from the A&E department. They received presentations from the Clinical Commissioning Group and representatives of the Urgent Care Boards which have been set up by local Clinical Commissioning Groups to create and implement emergency care improvement plans in local areas for winter pressures on hospital A&E services. The Urgent Care Board spoke about the main areas of concerns, and identified areas of service development and commissioning for A&E services and also preparation for the impact of winter pressures.
- 5.4 Information was received from Public Health in relation to projected population figures and trends of people likely to use A&E services, as well as public perceptions of A&E services and how A&E is used based on these perceptions. CQC hospital inspection reports were also reviewed. Information was also received from Tower Hamlets HealthWatch on the experiences of local people using A&E services.

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<sup>1</sup> Emergency Departments: [http://www.audit-scotland.gov.uk/docs/health/2010/nr\\_100812\\_emergency\\_departments.pdf](http://www.audit-scotland.gov.uk/docs/health/2010/nr_100812_emergency_departments.pdf)

<sup>2</sup> <http://www.london.gov.uk/media/assembly-press-releases/2013/09/are-london-s-hospitals-ready-for-a-e-pressures-this-winter>

<sup>3</sup> <http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news/13-07-23-urgemrepcs/>

<sup>4</sup> [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/submission-committee-inquiry-emergency-services-may13.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/submission-committee-inquiry-emergency-services-may13.pdf)

## 6. The national picture

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### 6.1 Media focus

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

### 6.2 National reviews of A&E

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

- London has seen a notable rise in A&E attendances. In 2012/13 just over 3.5 million people attended A&E departments across London, around 212,000 more than in 2011/12, and 347,000 more than in 2010/11.
- Demands on the London Ambulance Service have increased each year over the past 10 years<sup>7</sup>, increasing by 2% in 2012 and by 3% in 2013.
- Emergency 999 calls rose by six per cent last year (April 2012 to March 2013), and a similar increase is anticipated this year<sup>8</sup>.
- The most significant growth in those accessing A&E services has been in the 20 – 39 age group. This is mainly through ‘type 1’ services where ambulances have been called through the 999 number. Another population pressure on A&E services is the growing elderly population. They tend to take up bed spaces for long periods of time, therefore reducing hospital bed availability.

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

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

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<sup>5</sup> <http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news/13-07-23-urgemrep/cs/>

<sup>6</sup> [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/submission-committee-inquiry-emergency-services-may13.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/submission-committee-inquiry-emergency-services-may13.pdf)

<sup>7</sup> London Ambulance Service: [http://www.londonambulance.nhs.uk/news/news\\_releases\\_and\\_statements/ambulance\\_staff\\_numbers.aspx](http://www.londonambulance.nhs.uk/news/news_releases_and_statements/ambulance_staff_numbers.aspx)

<sup>8</sup> Ibid



- 6.5 Recently there have been attempts to divert patients from A&E services by providing alternative services, such as walk-in centres. However, the Health Select Committee found that patients are **confused or do not understand how and when A&E services should be accessed**. Dr Rainsberry suggested that cultural understanding of A&E services varies and the demography of an area therefore influences the way A&E services are used. Also, the more deprived an area is, the higher the pressure on local services are.
- 6.6 Dr Clare Gerada, past Chair of the Royal College of General Practitioners, stated that another reason why people are accessing A&E is because A&E services are generally **quicker to access**. Patients will get seen on the day and A&E tend to carry out diagnostic tests more than GPs, which gives people a sense of reassurance.
- 6.7 There is concern about the implications for A&E following **the introduction of the 111 NHS helpline**. Patients who are put off using the 111 service because of reported problems with getting through or poor advice could put additional pressure on A&E services by making unnecessary visits. The 111 service has worked well in some areas but issues have arisen in others.
- 6.8 **Maintaining adequate A&E service provision: Winter and Beyond**  
Significantly more pressure is placed on A&E during winter. The government response to the A&E crisis includes contingency funding to cope with winter pressures. They have allocated an additional £500 million for A&E services nationally, (£250 million for 13/14 and £250 million for 14/15) to alleviate winter pressures. £55 million out of the £250 million will come to London, to be allocated to priority hospitals. Investment of this funding will be influenced by local needs assessments and set out in a plan by the local Urgent Care Board. But most hospitals will be using majority of the money to invest in Community Health Services and additional doctors to staff A&E departments across the winter period.
- 6.9 NHS England has called for **Urgent Care Boards** to be set up by local Clinical Commissioning Groups to create and implement emergency care improvement plans in local areas, in consultation with local A&E departments and other relevant partners. This plan is to be reviewed, agreed and signed off by the Chief Executive of the relevant hospital.
- 6.10 Dr Anne Rainsberry has stated that the current A&E model is not sustainable due to structural problems in the health care system. In the future hospitals will have to develop inter-agency partnerships, working more with community health services and developing a robust system of integrated care.  
There will need to be a different offer of urgent care for the growing younger population of 20 – 39 years who are increasingly accessing A&E services. A whole system approach to the health care system is required.

## **7. Tower Hamlets and the local context**

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### **7.1 Tower Hamlets: Reasons for enquiry**

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

### **7.2 Core questions for the review:**

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

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

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

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

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

### **7.6 Quality of services**

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

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

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

factors for underperformance of the Royal London A&E, which will need to be improved in order to raise standards. During the Review Group's visit to the Royal London Hospital, they heard from senior managers of how Barts Health and the Royal London have responded by incorporating these into their winter strategy, putting plans in place through the development of various workstreams and extra investments on ongoing work.

The Urgent Care Board's emergency care improvement plan makes a number of recommendations (below), and Barts Health have responded accordingly by implementing what is highlighted after each recommendation:

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

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

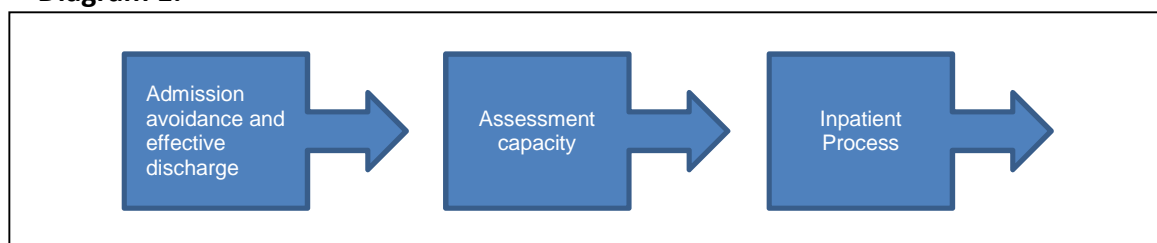
- Sufficient community and social care liaison staff to be available to permit discharge and/or follow on continuity of care where patients no longer require acute care, and that there are sufficient community services available to support admissions avoidance schemes, caring for patients effectively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

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

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

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

**Diagram 1.**



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

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

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

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

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

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

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

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

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

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

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

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

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

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

## 8 A&E: Public perceptions and demographic use

- 8.1 Public perceptions of A&E services is one of the major contributors to unnecessary admissions in A&E services, many patients are discharged with no investigation and no treatment. The Clinical Commissioning Group (CCG) term these patients as “inappropriately” using A&E. They are considered inappropriate as they may have been better managed in primary and community care settings. However, the Review Group heard that, from a patient perspective there may be many reasons why they presented at A&E and the patient may feel the attendance was entirely appropriate.
- 8.2 Tower Hamlets Public Health provided the Group with information from the (2012/13) demographic profile<sup>9</sup> of people presenting ‘inappropriately’ at A&E:
- The ethnic mix of these presentations is very broadly in keeping with the population mix of the borough (44% Bangladeshi, 20% White British and 9% Other White) (see Appendix: Table 1)
  - Overall there are more males than females across all age groups except the 18-30 year olds (see Appendix: Table 2)
  - By age group, the highest attendances are from 18 – 30 year olds (33% of total) followed by 31 – 44 year olds (25%), 45-64 years (15%) and 0-5 year olds (12%) (see Appendix: Chart 1)
  - Time of day of attendances is split 46% out of office hours to 54% between 10am and 6pm. The 6-9pm time is the single most popular with 24% of all attendances (see Appendix: Chart 2). The 12-5am timeslot shows the clearest (upward) trend through the days of the week (see Appendix: Chart 3)
  - Focusing on the three largest ethnic groups, and the 6-9pm presentations, we see:
    - a. Declines towards the weekend for White British and White Other; and
    - b. Constant levels of attendances throughout the week for Bangladeshi (see Appendix: Table 3)
- 8.3 In relation to public perceptions of A&E services, the results from the social marketing research conducted by Mckinsey, (commissioned by NHS Tower Hamlets,) provide explanations on some of the reasons why people attend the Royal London Hospital’s Emergency Department, people were:
- confused about how to access healthcare in Tower Hamlets. These patients tended to have basic or poor English.

<sup>9</sup> provided by the Clinical Support Unit (CSU)

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

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

*“It’s quicker to go to A&E and you seem to get a proper assessment and tests there and then.”*

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

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

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

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

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

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

<sup>10</sup> There is more detailed breakdown of ‘Usage by perception’ provided by Tower Hamlets public health in the Appendix, under Diagram 2, 3, 4 and 5

- 8.7 Tower Hamlets has a large middle aged population, and demographic feature demonstrate variation of an ethnic mix across its age group. Population growth trends predict, that this will continue to grow with notable increases in the proportion of the middle aged and older aged population, especially those who are Bangladeshi.
- 8.8 The Review Group felt that the analysis of local data could be developed further through joint work with the local Clinical Commissioning Group (CCG), Barts Health and the Commissioning Support Unit (CSU). The analysis of future trends in population growth and demographic features could be measured to anticipate future implications, and utilise diminishing resources where they are needed best.
- Further in-depth qualitative work could also be developed to understand the current reasons for 'inappropriate' attendances and what the drivers might be for changing behaviours.

## **9. Conclusion and recommendations**

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- 9.1 The Review Group welcomed Barts Health's response to the poor performance and pressures at the Royal London A&E department, and were encouraged by the partnership working with the Urgent Care Board and the development of its improvement plan. In considering the many issues that have been raised as concerns nationally, not only by the national media but also by experts and specialists in the field (for example, around patient flow through A&E services, the number of beds, understaffing, public perceptions of A&E services) the group felt assured that those are being addressed by the Urgent Care Board's improvement plan and being implemented at the Royal London through the various workstreams.
- 9.2 The Review Group would however recommend that Barts Health and its partners also consider long-term implications and consider longer term plans for A&E services. Although the Urgent Care Board has been set up to oversee this difficult period and the tough periods of winter planning, tougher periods may still lie ahead. In considering this, the group felt, Barts Health should think about more sustainable approaches in regards to winter planning and resources, with reduced reliance on the additional financial winter resources that may not always be available. This is additionally important given Dr Anne Rainsberry's warning that the current A&E model is not sustainable due to the changes in the overall health care system.
- 9.3 The Review Group would also like to make a recommendation around staffing. Staffing has been recognised by Barts Health as an internal issue which goes beyond just winter planning, and moving away from expensive and temporary agency staff is a key area for improvement, to permanent staff. Barts Health have planned to have a recruitment drive in the following months leading up to March/April 2014 to fill these vacancies with permanent positions. The Review Group would like to make recommendation that Barts Health works with the Council in recruiting local people to take up these employment opportunities, and not just in jobs as receptionists and health assistants, but also offer and invest in training and development opportunities so that local people can take up positions as doctors, nurses and managers. This can also have long term implications in strengthening relationships between the community and health services.
- 9.4 Barts Health is still a relatively new organisation, facing challenges that are very different adapting to the changes in the arrangement of the new national health care system, the current economic climate and due to its size being the largest trust in the UK. However in the

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

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

Recommendation 1:

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

Recommendation 2:

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

Recommendation 3:

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

Recommendation 4:

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

Recommendation 5:

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

Recommendation 6:

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

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<sup>11</sup> <http://www.cqc.org.uk/directory/r1h>



## Appendix

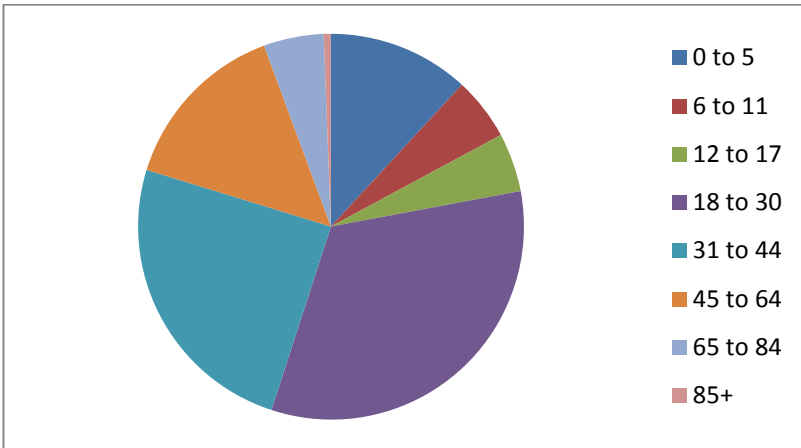
**Table. 1: Attendances by ethnicity**

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

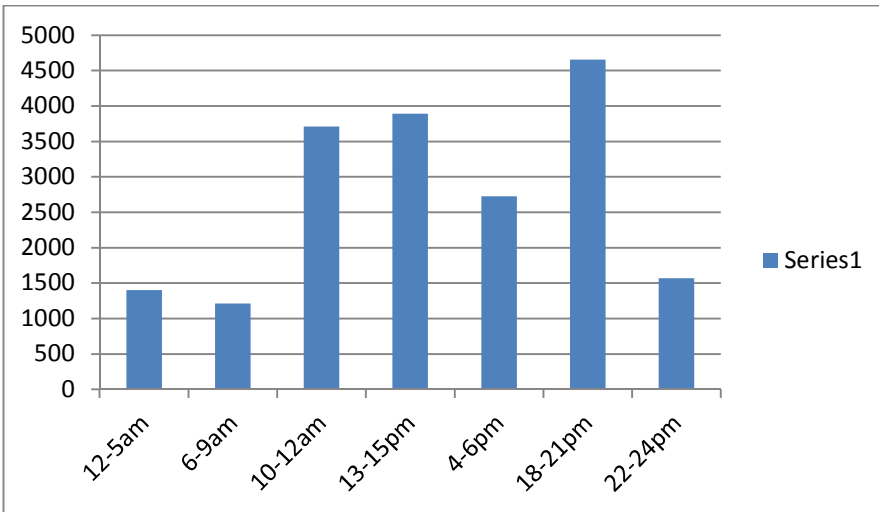
**Table. 2: Attendances by gender**

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

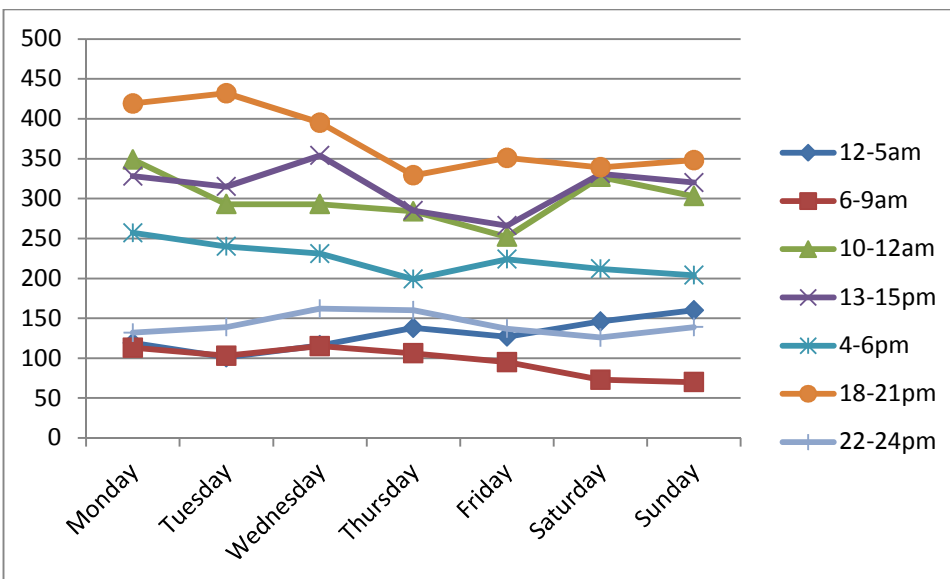
**Chart 1. Attendance by age group**



**Chart 2: Attendances by time slot**



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



## Diagram 2: Usage by perception

### Confused users

Basic/poor English. Account for ~6% of all inappropriate use of A&E

Key characteristics:

- High % Bangladeshi and non-UK
- 72% 26-34 years old
- Lowest GP registration (77%) and state “do not know how”
- Like GP but attend A&E as confused

## Diagram 3: Usage by perception

### Seemingly confused but dissatisfied

Have good English skills, disenfranchised and frustrated. Account for ~21% of all inappropriate use of A&E

Key characteristics:

- Attend both GP and A&E very frequently
- GP often advises to rest
- A&E often does tests
- Part-time, manual workers / unemployed seeking work
- All ethnic groups
- Believe OK for primary care to use A&E

## Diagram 4: Usage by perception

### Emotionally attached to A&E users

Prefer A&E for primary care based on perceived quality. Account for ~33% of all inappropriate use of A&E

Key characteristics:

- 61% female
- Highly ethnically diverse – 34% Bangladeshi and 19% non-British
- 28% (very high) are 18–25 years
- State strongly that even if sent to WIC last time, would still go to A&E next time with same condition
- Find it easy to get access to GP within 48 hrs and register but prefer A&E to GP based on own and community belief that quality of care is better

**Diagram 5: Usage by perception**



## **Convenience Users**

Prefer to go to A&E based mostly on the convenience of A&E. Account for ~39% of all inappropriate use of A&E.

### **Key characteristics:**

- 68% British white, 58% male, young: 68% below 35
- 21% (twice average) unemployed, not seeking work
- 34% on income support
- Unhappy with life in TH overall
- Prefer convenience of A&E:
  - Location is convenient
  - Tests are done quicker; all done in our place
  - Choose A&E because GP appointments are not at convenient times