LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH & ADULTS SCRUTINY SUB-COMMITTEE

HELD AT 6.34 P.M. ON MONDAY, 3 FEBRUARY 2025

COUNCIL CHAMBER - TOWN HALL, WHITECHAPEL

Members Present in Person:

Councillor Bellal Uddin (Chair)
Councillor Ahmodul Kabir
Councillor Marc Francis
Councillor Abdul Mannan
Councillor Sabina Khan

Members In Attendance Virtually:

Councillor Amy Lee

Other Councillors In Attendance Person:

Councillor Gulam Kibria Choudhury

Co-optees In Attendance Virtually:

Alia Begum

Officers Present in Person:

Georgia Chimbani	(Corporate Director, Health and Adults Social Care)
Filuck Miah	(Strategy and Policy Officer, Strategy, Improvement and Transformation Service)
Julie Dublin	(Senior Transformation Manager)
Justina Bridgeman	Democratic Services Officer (Committee)

1. DECLARATIONS OF INTERESTS

There were no declarations of disclosable pecuniary interest.

2. MINUTES OF THE PREVIOUS MEETING(S)

The minutes of the Sub-committee meeting held on 05 November 2024 were approved and signed by the Chair as a correct record of proceedings.

2.1 Action Log

Councillor Marc Francis reiterated his request made at the September meeting, for further details on the key performance measures that will be

included in the Strategic Plan. Members requested this be forwarded to the sub-committee for review, prior to the next meeting scheduled for 08 April 2025.

The Health and Adults Sub-Committee **RESOLVED**;

1. That further details on the key performance measures that will be included in the Strategic Plan, be circulated to the sub-committee for review prior to the next meeting scheduled for 08 April 2025.

2. That the Action Log be noted.

3. REPORTS FOR CONSIDERATION

3.1 Same Day Access Care

Jonathan Weaver, Senior Project Manager, Primary Care, provided the sub-committee with an overview of the programme, which will enable patients to access the same day urgent unplanned treatment and will improve the integrated service across primary and secondary care.

Members were informed that details of the programme have been submitted to the Tower Hamlets Together Board and is a joint effort between primary and secondary care. The Royal London Hospital, who deal with the Accident and Emergency department (A&E) and the GP Care Group, related to the Urgent Treatment Centre (UTC), have collaborated on designing the patient pathway to ensure early redirection from A&E to the primary care same day access service, to reduce the demand on the UTC.

Mr Weaver noted that the both the UTC and NHS 111 contracts are due to expire on the 31 March 2026. This means that any pathway changes that are introduced require completion over the next few months, to ensure the procurement and appointment process for new providers is ready.

It was noted that the current pathway is not suitable for patients and does not provide value for money. Patients could be redirected within the same day access care program and primary care is approximately a third of the cost. The service will have access to patients' medical records, to enable quicker access to care, make referrals, and ensure patients do not return with other health issues shortly after.

Members were informed that a review was undertaken on patients attending UTC and findings showed that a large number could have been seen earlier if same day access care was provided. A Healthwatch survey was conducted with patients at A&E and 66% were willing to be redirected to a primary care service, if feasible.

Mr Wever provided details of the patient's requirements for same day access care, the choice for patient's to decide if they want to be redirected and the locations in the borough where the service is available. The aim over the next 12 months is to redirect approximately 90 people to the programme a day, rather than the 30 people per day currently.

Details of the locations throughout the borough were given and the funding risks and business case outlined, to enable the programme to effectively transfer from acute care to primary community care.

Further to questions from the sub-committee, Jonathan Weaver;

- Confirmed that a walk-in service at St Andrews Hospital site was in operation, however the new programme is by appointment only and will enable more residents throughout the borough to benefit from same day access care, referable by a clinician, A&E or by NHS 111.

- Clarified that pilot sites for same day access care services will be available at Cable Street, the Barkentine Practice, Newbie Place, Spitalfields and Wellington Way. This will ensure more capacity of patients and will include monitoring the number of redirections from NHS 111. Each practice will also monitor the numbers to give a fuller understanding of the programme and patient feedback.

- Explained that the North East London Integrated Care Board (ICB) will allocate £1.5m to the same day access care. This will be used to support the Urgent Care pathway. A further £500,000.00 is required from a business case, which will be made from savings in the Urgent Treatment Centre (UTC) via A&E.

- Observed that discussions are ongoing with UTC staff regarding the best methods for initial assessment nurses to facilitate a redirection function in their role, to support the program.

- Confirmed that work is ongoing with stakeholders, which include GP's, the GP Care Group, the Royal London Hospital and Healthwatch.

- Acknowledged that the current capacity level is 30 patients per day. The same day access care levels aim is to redirect approximately 90 people to the programme daily. If patients' need to go to the UTC, they will be transferred. The programme will be monitored and if an increase in numbers is feasible, this will be implemented.

- Reiterated that the scheme will bring value for money and is beneficial to the patient. Residents who fit the criteria will be offered a redirection to the service and patients that have accepted it are satisfied. Satisfaction results can be shared to the sub-committee for review.

- Confirmed that discussions are ongoing with the Royal London Hospital on digital technology to assist patients who have met the criteria to book in appointments more swiftly. Technology will also be utilized to access patients records to facilitate improved consultations with the clinicians and with the NHS111 system.

The Health and Adults Sub-Committee **RESOLVED;**

1. That the presentation be noted.

3.2 Hospital Discharging Service

Julie Dublin, Senior Transformation Manager, gave an update on the hospital discharge process and outlined the Tower Hamlets Together Board's key priorities for municipal year 2024-25. Ms Dublin noted that hospital discharge varies depending on the individual's condition upon entering the hospital, how they are when departing the hospital and where they will be going.

Ms Dublin noted that the report only deals with adult discharges, then outlined the 4 discharge pathways a patient goes through when approaching their final day in hospital:

- **Pathway 0** refers to a patient discharged to home or a usual place and who does not have any a patient discharged to a home or a usual place who does have new or additional health or care needs.

- **Pathway 2** refers to a patient discharged to a community bed-based setting who has dedicated support for new or additional health or care needs, in the short term to aid in recovery and/or live independently. This also relates to someone who may require longer term care.

- **Pathway 3** refers to a patient discharged to a new residential or nursing home setting who may also require long term residential or nursing home care.

Members were informed that Pathways 2 and 3 require more complex care packages, equipment and support or may also require a residential bed. Details of the discharge framework were noted. This framework, compiled by stakeholders including Tower Hamlets Council, the Royal London NHS Trust, the East London Foundation Trust (ELFT) and the ICB, sets out six key priorities the discharge service adheres to:

1. Address risk- adverse decision-making and over provision of homecare in pathway 1.

2. Improve knowledge of discharge to assess (D2A) process for patient, families and carers.

3. Improve engagement with families/carers.

4. Address complex discharge issues earlier in the planning process.

5. Streamline and accelerate the process for reviewing high-cost packages of care.

6. Encourage better use of the reablement service, reducing inappropriate referrals, promote goal-focused therapeutic input in reablement.

Members were informed of the multidisciplinary team approach to discharging patients and collaboration required by brokerage staff, the acute hospital and community health services, alongside the reablement and rehabilitation services and the adult social care teams.

The ‘Transfer of Care Hub’, formerly known as the Integrated Discharge Hub, supports people about to be discharged from hospital to the most appropriate place, is not without challenges. Most notably the lack of suitable places within the borough. This has meant that some patients are housed outside Tower Hamlets, which can cause concern for family members. Members were informed that a lack of equipment has also caused challenges.

Accessible equipment available in more swiftly greatly has improved the discharging process. There have been instances where a patient refuses discharge due to housing issues and the choice policy has been implemented to facilitate a patient's discharge.

Ms Dublin then outlined the current activities being undertaken in line with the key priorities for a more streamlined service. This included the implementation of the optimal-handed care project at the Royal London Hospital and improving discharges through EHCC step-down beds.

Further work is required, including analysis of the priorities produced by the Integrated Discharge Hub and NHS England to ensure all requirements are met and all departments work together. A progress report will be provided to the sub-committee in six months’ time.

Following questions from the sub-committee, Julie Dublin, Councillor Gulam Kibria Choudhury and Georgia Chimbani, Director, Adult Social Care;

- Explained that homeless patients requiring discharge are usually placed with the Homeless Pathways team if they are not known to the borough, who will aim to identify their former place of resident and use the referral escalation process for them to be returned in that area for assistance by that local authority. Homeless patients who have ties to the borough are discharged and temporary accommodation is provided with assistance from the Housing team. Gloria House is also available for approximately 42 days for homeless patients to stay.

- Clarified that the Transfer of Care Hub is a multidisciplinary team, consisting of representatives from specialist care providers, ASC staff, community services and hospital departments. Discussions on the service are conducted weekly at escalation calls, and information sharing on the best methods of treatment for patient discharge are considered.

- Confirmed that the programs aim to ensure that the correct patient assessment and integrated care planning for discharge is continually implemented and the collaboration and trust between health and social care professionals, NHS staff and the patient remains.

- Explained that the discharge process involves a patient assessment to determines any ongoing needs. If a package of care is required, a review will be conducted and adjusted as necessary and may also include occupational therapists or adaptations.

- Acknowledged that housing adaptations can be complex due to some Landlords not willing to undertake modifications required, although there are means to escalate in these instances and many Landlords do comply.

- Clarified the various means of discharge depending on the patients requirements, including Re-ablement, step down beds when required and extra care sheltered. Consideration will be made to other ways of housing patients with varying levels of support.

- Noted that patients who require transportation when being discharged from hospital will have this arranged as part of their exit plan. One day delays can occur due to heavy traffic, or a requirement for a carer to accompany the driver. The majority of discharge date takes place on the day as planned. Consideration will be made to improving the delays.

- Explained that vulnerable individuals who require assistance but live alone are usually placed with a social worker, who works alongside the Transfer of Care Hub, to establish the level of support and package of care required. A home care provider will also be involved to ensure they work with the patient.

- Noted that the timeline for patients package of care is dependent on the patient's level of complexity. Advanced discharge planning can begin whilst in hospital and collaboration with a social worker. Some packages can be arranged within a day, if the patient is known and or minor changes are required.

- Clarified that methods to reverse delays in nursing and care home placements include giving care providers times scales to undertake assessments. Consideration is also be given to using a trusted

assessor model on behalf of multiple care homes, to ensure patients are received based on that assessment.

The Health and Adults Sub-Committee **RESOLVED;**

1. That a progress report on the Hospital Discharge Service to be provided to the sub-committee by July 2025.

2. That the presentation be noted.

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

The Chair informed Members that a second scrutiny review of the Maternity service and support for New Mothers, will take place on 10th February 2025 and will include representatives of Southwark Maternity Commission and Family Hub.

The Chair also updated Members on the final scrutiny session scheduled for 25th February 2025 on gestational diabetes, which has impacted Bangladeshi and Somali women. Members were urged to attend both sessions.

The meeting ended at 7.57 p.m.

Chair, Councillor Bellal Uddin

Health & Adults Scrutiny Sub-Committee