TOWER HAMLETS

Meeting of the

HEALTH SCRUTINY PANEL

Tuesday, 22 July 2008 at 6.30 p.m.

A G E N D A

VENUE
Room M72, 7th Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

Members:	**Deputies (if any):**
Chair: Councillor Stephanie Eaton **Vice-Chair:Councillor Motin Uz-Zaman**	
Councillor Ann Jackson **Councillor Abjol Miah** **Councillor Mohammed Abdus Salique** **Councillor Bill Turner** **Vacancy**	Councillor Denise Jones, (Designated Deputy representing Councillors Ann Jackson, Bill Turner, Md. Abdus Salique and Motin Uz-Zaman) Councillor Azizur Rahman Khan, (Designated Deputy representing Councillor Stephanie Eaton) Councillor Abdul Matin, (Designated Deputy representing Councillor Stephanie Eaton) Councillor Abdul Munim, (Designated Deputy representing Councillor Abjol Miah) Councillor Tim O'Flaherty, (Designated Deputy representing Councillor Stephanie Eaton) Councillor M. Mamun Rashid, (Designated Deputy representing Councillor Abjol Miah) Councillor Dulal Uddin, (Designated Deputy representing Councillor Abjol Miah)

[Note: The quorum for this body is 3 Members].

Co-opted Members:		
Mr Naruz Jaman	–	Tower Hamlets PCT Patient and Public Involvement Forum (Vice-Chair)
Mr John Lee	–	East London NHS Foundation Trust Patient and Public Involvement Forum (Vice-Chair)
Dr Amjad Rahi	–	Barts and The London Patient Public Involvement Forum (Chair)

If you require any further information relating to this meeting, would like to request a large print, Braille or audio version of this document, or would like to discuss access arrangements or any other special requirements, please contact: Amanda Thompson, Democratic Services, Tel: 020 7364 4651, E-mail: Amanda.Thompson@towerhamlets.gov.uk

LONDON BOROUGH OF TOWER HAMLETS

HEALTH SCRUTINY PANEL

Tuesday, 22 July 2008

6.30 p.m.

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF INTEREST

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 Chief Executive.

		PAGE NUMBER	WARD(S) AFFECTED
3.	**UNRESTRICTED MINUTES** To confirm as a correct record of the proceedings the unrestricted minutes of the ordinary meeting of Health Scrutiny Panel held on 26 June 2008.	**3 - 6**	
4.	**REPORTS FOR CONSIDERATION**		
4a	**Health Scrutiny Work Programme 2008/09 - 2009/10 (20 minutes)**	**7 - 18**	
4b	**Primary Care Trust Response to Draft Health Scrutiny Protocol (10 minutes)**	**19 - 24**	
4c	**North East London Stroke Services (15 minutes)** Update on current developments and the future direction of effective stroke provision in North East London.	**25 - 28**	
4d	**Complaints and Performance by NHS Trusts (45 minutes)** • Annual Complaints Report - Primary Care Trust • Annual Complaints Report – East London NHS Foundation Trust • Quarterly Complaints Report – Barts and the London NHS Trust •	**29 - 56**	

4e **St Paul's Way Medical Centre (15 minutes)** **57 - 64**

Update on monitoring arrangements and performance of services at the Centre following contract for provision being taken on by ATOS Healthcare.

4f **Local Involvement Network Update (15 minutes)**

Verbal update on the arrangements for procuring a host organisation to develop the Local Involvement Network.

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

DECLARATIONS OF INTERESTS - NOTE FROM THE CHIEF EXECUTIVE

This note is guidance only. Members should consult the Council's Code of Conduct for further details. Note: Only Members can decide if they have an interest therefore they must make their own decision. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending at a meeting.

Declaration of interests for Members

Where Members have a personal interest in any business of the authority as described in paragraph 4 of the Council's Code of Conduct (contained in part 5 of the Council's Constitution) then s/he must disclose this personal interest as in accordance with paragraph 5 of the Code. Members must disclose the existence and nature of the interest at the start of the meeting and certainly no later than the commencement of the item or where the interest becomes apparent.

You have a **personal interest** in any business of your authority where it relates to or is likely to affect:

(a) An interest that you must **register**

(b) An interest that is not on the register, but where the well-being or financial position of you, members of your family, or people with whom you have a close association, is likely to be affected by the business of your authority more than it would affect the majority of inhabitants of the ward affected by the decision.

Where a personal interest is declared a Member may stay and take part in the debate and decision on that item.

What constitutes a prejudicial interest? - Please refer to paragraph 6 of the adopted Code of Conduct.

Your personal interest will also be a prejudicial interest in a matter if (a), (b) and either (c) or (d) below apply:-

(a) A member of the public, who knows the relevant facts, would reasonably think that your personal interests are so significant that it is likely to prejudice your judgment of the public interests; AND
(b) The matter does not fall within one of the exempt categories of decision listed in paragraph 6.2 of the Code; AND EITHER
(c) The matter affects your financial position or the financial interest of a body with which you are associated; or
(d) The matter relates to the determination of a licensing or regulatory application

The key points to remember if you have a prejudicial interest in a matter being discussed at a meeting:-

i. You must declare that you have a prejudicial interest, and the nature of that interest, as soon as that interest becomes apparent to you; and

ii. You must leave the room for the duration of consideration and decision on the item and not seek to influence the debate or decision unless (iv) below applies; and

iii. You must not seek to improperly influence a decision in which you have a prejudicial interest.

iv. If Members of the public are allowed to speak or make representations at the meeting, give evidence or answer questions about the matter, by statutory right or otherwise (e.g. planning or licensing committees), you can declare your prejudicial interest but make representations. However, you must immediately leave the room once you have finished your representations and answered questions (if any). You cannot remain in the meeting or in the public gallery during the debate or decision on the matter.

LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY PANEL

HELD AT 6.30 P.M. ON THURSDAY, 26 JUNE 2008

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

Members Present:

Councillor Stephanie Eaton (Chair)

Councillor Ann Jackson
Councillor Abjol Miah
Councillor Bill Turner
Councillor Motin Uz-Zaman

Co-opted Members Present:

Mr John Lee	–	East London & City Mental Health Trust Patient and Public Involvement Forum (Vice-Chair)
Dr Amjad Rahi	–	Barts and The London Patient Public Involvement Forum (Chair)

Officers Present:

Deborah Cohen	–	(Service Head, Disability and Health Services, Adults Health and Wellbeing)
Afazul Hoque	–	(Acting Scrutiny Policy Manager, Scrutiny and Equalities, Chief Executive's)
Michael Keating	–	(Acting Assistant Chief Executive)
Shanara Matin	–	(Scrutiny Policy Officer)
Louise Fleming	–	(Democratic Services)

1. ELECTION OF VICE-CHAIR FOR THE MUNICIPAL YEAR 2008/2009 (5 MINS)

The Panel RESOLVED that Councillor Motin Uz-Zaman be elected Vice-Chair of the Health Scrutiny Panel for the 2008/09 municipal year.

2. APOLOGIES FOR ABSENCE

Apologies were received from Councillor Mohammed Abdus Salique and Susan Ritchie, who had been due to make a presentation on item 6.

3. DECLARATIONS OF INTEREST

No declarations of interest were made.

4. UNRESTRICTED MINUTES

The minutes of the meeting held on 18th March 2008 were agreed as a correct record.

4.1 MATTERS ARISING

Commissioning Intentions and Operating Plan – The Chair reported that underperforming PCTs would not be penalised in terms of funding.

Drug Treatment Figures were circulated to Members present.

The Chair advised that Barts and the London had commented on the Health Scrutiny Protocol and raised questions relating to the way in which the Trust would liaise with the Panel in respect of changes to service.

The Chair also advised that the Panel would provide comments in future to the Joint Overview and Scrutiny Committee.

5. REPORTS FOR CONSIDERATION

5.1 Health Scrutiny Panel Terms of Reference (5 Mins)

The Panel noted its Terms of Reference, membership and schedule of dates for the municipal year 2008/09. The Terms of Reference would be reviewed over the course of the year to ensure that it was appropriate and included all relevant health representatives.

6. HEALTH SCRUTINY INDUCTION (60 MINS)

Michael Keating, Acting Assistant Chief Executive, gave a detailed presentation on the role of the Health Scrutiny Panel in relation to Scrutiny and Equalities within the Council. He outlined the mission statement and highlighted the theme of “One Tower Hamlets”, which was the overarching focus of the Council’s new Community Plan. The main aim of the Panel would be to build on the previous health scrutiny carried out and to create and strengthen community leadership. It was noted that the feedback from the CPA Inspectors in relation to the Council’s scrutiny function had been positive.

Shanara Matin, Scrutiny Policy Officer, gave an induction presentation for new Members outlining the main reasons for scrutinising health and the future aims. She also briefed Members on the current powers of the health scrutiny function and the key areas of work.

It was noted that Susan Ritchie, Interim Head of Participation and Engagement, would make a presentation to the next meeting of the Panel on the role of LINks. It was also noted that 6 tenders had been received to become the host organisation of the Tower Hamlets LINk.

Deborah Cohen, Service Head Disability and Health, gave a presentation, highlighting the importance of the integration of health and social care organisations. It was noted that Barts and the London would be likely to apply for Foundation status. The Panel was advised that five actions were in place for improving partnership between the NHS and Adult Health. It was intended for the PCT to become the lead commissioner on Mental Health, with all other areas falling to the Council. Commissioners would be required to apply for licences to operate, with effect from Spring 2009. There would also be a review of all PCTs in London in order to strengthen commissioning capacity. Ms Cohen circulated articles relating to health care reform and the role of Councillors from the Democratic Health Network (DHN).

Members asked a number of questions relating to adult protection and the integration of the children and families policy, which it was felt needed to be examined. It was also felt that more detail was needed on mental health workers and delivery of service. Ms Cohen advised that a representative of Children's Services would be invited to a future meeting and further information on the "Think Family" initiative would be reported to the Panel. Members expressed concern over the PCT review and its potential effect on funding and differing targets. It was considered to be important for the Panel to be involved in the discussions. It was also stressed that the PCT understand the needs of the communities.

7. HEALTH SCRUTINY WORK PROGRAMME 2008/09 (30 MINS) - TO FOLLOW

The Panel considered a draft work programme for the 2008/09 municipal year. Members raised a number of areas to be reviewed. It was considered that work carried out needed to be relevant to the community.

The Panel RESOLVED that the 2008/09 work programme be agreed, with the addition of the following areas:

i) Joint working with the NHS in respect of end of life care, with particular focus on the cultural differences;
ii) Organ Donation;
iii) The use of Khat in the Somali communities, to be included as part of the Tobacco Review Update; and

iv) the postponement of the review on Heart Disease until 2009/10.

8. HEALTH SCRUTINY PROTOCOL (15 MINS) - TO FOLLOW

The Committee received the draft Health Scrutiny Protocol. It was requested that comments be passed to the Chair or officers by no later than 10th July, in order that a revised draft be reported to the Panel on 22nd July 2008.

9. TOBACCO CESSATION REVIEW (5 MINS)

The Chair advised that the Tobacco Cessation Review would be reported to Cabinet at the end of July. Labelling on Chewing Tobacco and general enforcement would be reviewed.

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

Members raised concerns over the type of cooking oil used in fast food outlets in the Borough and agreed that proprietors needed to inform customers of ingredients being used. The Chair advised that health care professionals would be able to become more involved and given more influence in commenting on planning applications for fast food establishments.

Members requested that e-mail updates on health scrutiny issues be provided in-between meetings.

The meeting ended at 8.10 p.m.

Chair, Councillor Stephanie Eaton
Health Scrutiny Panel

Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	22 July 2008	Unrestricted		4

Report of:	Title:
Michael Keating Acting Assistant Chief Executive Originating Officer(s): Shanara Matin Scrutiny Policy Officer	Health Scrutiny Panel Work Programme 2008/09 – 2009/10 Ward(s) affected: All

1. Summary

1.1 This report outlines the proposed two year work programme for the Health Scrutiny Panel (HSP) for municipal years 2008/09 and 2009/10.
1.2 The report sets out the process used to develop the Health Scrutiny Work Programme and suggests a number of ways in which the Panel may wish to approach the workload.
1.3 Appendix 1 sets out the long list of items for inclusion in the work programme.
1.4 Appendix 2 sets out the schedule for items across the Panel Meetings for 2008/09

2. Recommendations

The Health Scrutiny Panel is asked to:

2.1 Consider and comment on the proposed list of work programme items and schedule attached at Appendix 1 and Appendix 2
2.2 Agree options for managing the work programme in particular the way the work programme will be delivered this year at paras 5.3 – 5.10
2.3 Agree to review the rolling work programme every quarter

LOCAL GOVERNMENT ACT, 2000 (SECTION 97)
LIST OF "BACKGROUND PAPERS" USED IN THE PREPARATION OF THIS REPORT

Background paper	Name and telephone number of and address where open to inspection
N/A	Shanara Matin 020 7364 4548

3. Background

3.1 The statutory duty and powers given to local authorities for Health Scrutiny were established through the Health and Social Care Act 2001. Local authorities with Social Services responsibilities are required to have an Overview and Scrutiny function that can respond to consultation by NHS bodies on significant changes and developments in health services and take up the power of Overview and Scrutiny on broader health and wellbeing issues.

3.2 The primary aims of health scrutiny are to:

- identify whether health and health services reflect the views and aspirations of the local community
- ensure all sections of the community have equal access to services
- and have an equal chance of a successful outcome from services.

3.3 These specific powers and duties are themselves an articulation of the vision for health scrutiny in its work, underpinned by the aim of putting patients and the public at the centre of health services. The 2003 Department of Health guidance describes Health Scrutiny as,

> "A fundamental way by which democratically elected community leaders may voice the views of their constituents and require local NHS bodies to listen and respond."

3.4 In Tower Hamlets the Health Scrutiny Panel has been established as a sub-committee of the Overview and Scrutiny Committee. Its Terms of Reference are:

(a) To review and scrutinise matters relating to the health service within the Council's area and make reports and recommendations in accordance with any regulations made

(b) To respond to consultation exercises undertaken by an NHS body

(c) To question appropriate officers of local NHS bodies in relation to the policies adopted and the provision of the services.

3.5 As part of an induction process for the new administration in 2006, the Members set out the strategic focus for the Panel for the next four years and agreed that the overarching objective for Health Scrutiny in Tower Hamlets should be tackling health inequalities. Since then each year the Panel has developed a two year rolling programme of work putting forward detailed proposals for the year at hand as well as proposing plans for the following year. The rolling programme of work has helped to manage changes in the Panel's Membership which is agreed annually and to pick up individual areas of interest, skills and expertise of Members, as well as to provide a continuous thread for longer term issues.

3.6 This report provides an overview of work carried out in year 1 and 2 in response to that framework and sets out the work programme for 2008/09 – 2009/10.

4 The work of the Health Scrutiny Panel in 2006/07 & 2007/08

4.1 The broad cross-cutting themes of the rolling work programme were and remain:

- 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.

4.2 The priority areas for improvement and challenge were identified as smoking, heart disease and mental health. On the basis of this the Panel has delivered two in-depth reviews on Access to GP and Dentistry Services and Smoking and Tobacco Cessation. Both reviews have been well received by NHS partners and stakeholders. A summary of the reviews is outlined below.

4.3 **Access to GP and Dentistry Services**

Key Areas of Recommendation:

- Need for better information for residents about accessing primary care services
- Step change required in work being undertaken on patient education
- Long term sustainable funding for initiatives such as extended opening and mobile dental unit hours are key to tackling problems with access to primary care

Impact:

- In March 2008 the Access to GP and Dentistry Services Review action plan was evaluated through a Challenge Session and Members welcomed the progress against recommendations including higher numbers of people accessing for example the mobile dental unit.
- The review has directly contributed to the Tower Hamlets PCT Primary Care Access Strategy (Sept 2007).

4.4 **Smoking & Tobacco Cessation**

Key Areas of Recommendation

- Testing assumptions of how services and communications materials about smoking cessation are provided
- Tackling the gap in labelling and enforcement of imported tobacco products e.g. chewed tobacco or for use with 'paan'.
- Resourcing and Training needs to improve both enforcement and cessation services.

Impact:

- The review has just been recently completed and will be evaluated six months into the delivery of the action plan.
- The findings and recommendations have influenced the draft Tower Hamlets Tobacco Control Strategy.

4.5 Members have also responded to a number of NHS consultations including two applications for NHS trusts to become Foundation Trusts. The Panel has also responded to a number of service improvement reviews including Maternity Services and Long Term Conditions and Palliative Care.

4.6 In 2007/08 the Panel took forward a number of issues that were raised as community concerns over health services by Members. This included problems experienced by residents in getting appointments by telephone or in person at the Shah Jalal Medical Centre where the Panel requested that the PCT review procedures. This was followed up with an action plan and the progress reporting to the Panel has been able to

demonstrate improvements in the facilities at reception and the telephone systems supporting the practice. The practice has also recruited extra staff which has made many more appointments available. In another example a Panel Member requested NHS Trusts prepare a briefing on work to tackle the under representation of black and minority ethnic staff in Nursing. This has also led to work to improve recruitment from BME communities which the Member is taking forward individually with the Trusts.

4.7 Both the Chair of the Overview and Scrutiny Committee and Chair of the Health Scrutiny Panel were nominated as the Borough representatives to the Joint Overview and Scrutiny Committee (JOSC) reviewing Lord Ara Darzi's report for NHS London, "Healthcare for London". This unprecedented review took place over six months and included elected Councillors from 35 separate local authorities in London and the South East, 15 separate evidence sessions hearing from 27 high profile expert witnesses and received written submissions from another 28 professional, official and voluntary organisations. The proposals outlined in the document highlight a number of facilities in Tower Hamlets as best practice examples. Whilst these are opportunities for the Borough there are equal concerns over new models of if they were to result in losing the benefits of continuity of care from one GP and the implications on travel requirements for some patients. The JOSC also raised concerns over "Payment by Results" and what this might mean for funding for Trusts serving areas with higher levels of health inequalities.

4.8 Other areas of work undertaken by the Panel include:

- Service visits to the Barts and the London Hospitals redevelopment site, St Clements Hospital site ahead of its closure and the new Barkantine Centre that operates primary care services on a polyclinic model.
- Responding to PCT consultation on the outcomes of the Maternity Services Review and on the PCT Commissioning programme for 2008/09.
- The third year of annual health checks – including joint meetings with health scrutiny in Hackney and Newham relating to East London NHS FoundationTrust

5. Health Scrutiny Panel Work Programme 2008/09 – 2009/10

5.1 Health inequalities remain a key challenge for the borough and for regional and national government across the UK. The evidence review for the Mayor of London's Draft Health Inequalities Strategy highlights the widening gap in health inequalities over the last decade and the wide-ranging social, economic and environmental factors that impact on health. The review for example cites the increasing differences in income distribution that have widened the difference between mortality rates for rich and poor. Although this has not been because of a worsening of the rate amongst poorer groups, mortality rates continue to fall much faster for more affluent groups. This highlights some of the challenges to addressing health inequalities but also the broader scope of issues with which Health Scrutiny could potentially engage.

5.2 The Local Government and Public Involvement in Health Bill replaces Patient and Public Involvement Forums with Local Involvement Networks (LINks). The new model for patient engagement is much broader and has the remit to engage as many stakeholders, forums and organisations as possible and to channel those views to improve health services. Health Scrutiny will in effect become the "court of appeal" for difficult to resolve issues and there are significant capacity-building challenges to ensure the LINk delivers on the Government and local aspirations for it. The development of the LINk is likely to be a key area of work across 2008/09

5.3 The process for preparing a long list of items for the Health Scrutiny Work Programme has been to draw on a number of sources. The Health Scrutiny Panel has key business, policy and performance items that it must respond to for example PCT Commissioning Intentions, responding to the Next Stages Review of Healthcare for London and taking part in the Healthcare Commission's Annual Health Check process. Members of the Panel have been invited to comment on a draft list of items which includes the above and to suggest further issues. The three NHS Trusts were also requested to feedback on possible consultation exercises and where Health Scrutiny could add value to existing programmes of work. There are increasingly areas where NHS Trusts and Social Care Services are required to consult with Health Scrutiny according to their own performance and governance regimes for example the CSCI recommendation that the annual report on Adult Protection be referred to Health Scrutiny. Please see Appendix 1 for the full list of proposed work programme items for inclusion in 2008/09.

5.4 In developing the delivery methods for the work programme this year it has been a priority to rethink how the Panel can deliver effective Health Scrutiny given its widening agenda as well as how to retain the flexibility required to respond to issues as they arise for example NHS Consultations or local concerns with services. There are also a number of methods that work well for Overview and Scrutiny Committee as recognised within the Comprehensive Performance Assessment's highly positive comments on Scrutiny. These could be adapted for Health Scrutiny for example Challenge Sessions and Scrutiny Spotlight to help meet these challenges. The Panel is also keen to improve engagement with the Acute and Mental Health Trust and on to build on the existing levels of engagement with the Primary Care Trust on public health priorities. In order to facilitate this the following methods are proposed.

Thematic meetings – It is proposed that we pilot one of the Health Scrutiny Panel Meetings in 2008/09 to explore a significant borough-wide health priority by seeking contributions from all three Trusts and other stakeholders as appropriate. This year it may be appropriate to review the Healthcare for London – Next Stages Review in this way and to include Social Care, Housing and local community perspectives within the programme.

Challenge Sessions – This has been used as a tool within Health Scrutiny to evaluate review action plans and could increasingly be used for a structured approach to dealing with Member / community concerns over health services or public health challenges. This would help to root specific local issues in a strategic context and inform broader improvements in health.

Health Scrutiny Spotlight – Inviting the Lead Member for Health to present on the portfolio. This could help to avoid duplication and promote a joined up approach to health related work across the Council.

Member led fact finding sessions / visits– This year Members have identified many important health issues which will not be possible for the Panel to consider as a group particularly within the constraints of the four formal Panel meetings of the year. These are however issues that are important to the quality of life experiences for local people and it is proposed that individual Panel Members, supported by the Scrutiny Policy Team, will arrange meetings and interviews with stakeholders and report back to the Panel on their findings.

Public Health Briefings – This would tap into the Panel Members Community Leadership Role. Across the range of work the Panel engages with the need for

improved methods of communicating public health messages is often repeated. These cover issues such as how to improve take up of screening and testing services, championing public health messages for example for smoking cessation services or how to manage blood pressure. Members are uniquely placed to promote public health and to inform how messages might best be disseminated based on their knowledge of local communities.

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5.5 The Panel began developing the Health Scrutiny Protocol to help define the working arrangements between the local authority, NHS Trusts, LINk, Tower Hamlets Partnership and other stakeholders towards the end of 2007/08. It is proposed that the protocol is a live and evolving document and able to reflect the changing landscape of the local health economy. The draft version has been circulated to all Trusts and final comments are expected by 22 July 2008. It is anticipated that the Protocol will help to ensure that delivery methods work effectively to deliver the objectives of the work programme.

5.6 Through the induction programme for the Panel, Members considered both End of Life Care and Heart Disease as potential review topics. It was recognised that Heart Disease is a significant cause of premature death and a priority area of action for the borough. The response from the Primary Care and Acute Trusts has been that whilst Health Scrutiny has a significant role to play a review might not be able to focus on a manageable area of activities given the large scale and scope of Health Services work on this area. Members agreed the in-depth review topic for 2008/09 to be End of Life Care Services. This area of health services straddles NHS and Social Care provision. It has been the subject of review for service improvement already and there is an opportunity for Health Scrutiny to influence and inform the reshaping and simplification of services to meet diverse community needs. Mental health has also been identified as an area for review and will be considered for 2009/10.

5.7 Over the next two years there are a number of policy developments and issues that will have an impact on health scrutiny and its work programme:

- "Next Stages Review" - responding to the implementation plans following Lord Darzi's report on improving healthcare in London which proposes a radical change to the way health services will be delivered
- The Local Area Agreement with health outcomes around increased life expectancy and improved health and levels of physical activity for children and young people
- The ongoing developments in Commissioning for example Practice Based Commissioning and World Class Commissioning by the PCT
- The continuing work by the East London NHS Foundation Trust in working as a Foundation Trust and the Barts and the London NHS Trust potential application for Foundation Trust status, for example in supporting recruitment of Trust members
- The further development of the Local Involvement Network following the appointment of a ‘host’ organisation.
- Possible restructuring / mergers of Primary Care Trusts

5.8 The proposed work programme for the next two years is set out in further detail in Appendix 1. Once the overall work programme is agreed, the scope and exact timing of issues will be developed in consultation with relevant NHS partners and services. This will ensure that the work is focused and delivers its objectives. Appendix 2 provides further detail of how this would fit within the scheduled meetings of the Panel.

5.9 Previous Health Scrutiny Reviews have included diabetes, obesity and sexual health. The implementation of these scrutiny reviews and recommendations will continue to be monitored. In addition, other issues may be identified as the Panel develops its programme and links with both NHS and community organisations.

6. Other work of the Panel

6.1 The NHS is undergoing a period of unprecedented change and modernisation affecting the way health partners are developing and providing services to local people. It would be helpful for the Panel to develop a deeper understanding of these changes to inform its role and work. These include:

- Finance and funding of services including payment by results;
- Commissioning;
- Performance Management through the Annual Healthcheck
- Health Trusts migrating to Foundation Trust status

It would be important to include briefing sessions on these areas as they are put forward to the Health Scrutiny Panel.

6.2 Outside of the main work of the Panel there is potentially a huge agenda which needs to be considered over a number of years. It is envisaged that one substantial review will be conducted each year, alongside a programme of briefings, conferences and seminars to develop understanding of issues involved and service visits to inform and encourage discussion on health issues.

7. Role of Health Scrutiny Panel Members

7.1 To maximise the value of health scrutiny in improving services Members of the Panel can play various roles. These include:

- The Community Leadership Role linking with community groups, residents and LAP meetings to consult and engage residents – in particular deeper level of engagement with the Partnership work under the Healthy Community, Community Plan Theme;
- The active promotion of health scrutiny and gathering of information from residents and community groups to raise with the Panel and Health Partners;
- Undertaking an individual link role by liaising with health partners by visiting and meeting as appropriate and reporting back to the Panel.

7.2 Overall therefore learning and development will need to run alongside the rest of the work programme. The Scrutiny Policy Team will be supporting Members to tailor this to their individual needs.

8. Concurrent Report of the Assistant Chief Executive (Legal Services)

8.1 There are no immediate legal implications arising from this report.

9. Comments of the Chief Financial Officer

9.1 There are no specific financial implications arising from this report.

10. Anti-Poverty Implications

10.1 Reducing poverty is central to the work of the Overview and Scrutiny Committee and Health Scrutiny Panel and this is reflected in work around access to services.

11. Equal Opportunity Implications

11.1 Equal opportunities are central to the work of the Health Scrutiny Panel and this is reflected in work to consider the NHS as an employer, and work around health promotion and prevention. Equal opportunities and diversity implications will be considered during each of the scrutiny reviews.

12. Risk Management

12.1 There are no direct risk management implications arising from this report.

Appendix 1

Health Scrutiny Panel Work Programme 2008/09 & 2009/10

Method	2008/09	2009/10
Review topic	• End of Life Care	• Heart Disease / Mental Health
Visits	• Induction Visits • Follow up Service Visits	• Reviewing 'Healthcare for London' by testing patient pathways.
Member Led Fact finding sessions	• Organ Donation • Early Detection of Dyslexia • Mental health pathways to care for community based services	• Workforce to reflect the Community
Committee reports / Discussion Paper	• Commissioning Intentions • Joint Commissioning • Health Scrutiny Commentary on Trust performance as part of the Annual Healthcheck process. • Adult Protection Annual Report • Complaints information from all Three Trusts • Performance Reports • Alcohol related health problems • Childhood Obesity • Update on St Pauls Way • Aligning Health and Local Authority business cycles	• Commissioning Intentions • Joint Commissioning • Health Scrutiny Commentary on Trust performance as part of the Annual Healthcheck process. • Adult Protection Annual Report • Complaints information from all three Trusts
Thematic Meetings	• Pilot programme - reports from all three Trusts and other stakeholders on Healthcare for London - Next Stages Review.	
Consultation	• Service redesign and transformation – optimising patient-centred care pathways	
Spotlight	• Health Scrutiny Spotlight	• Health Scrutiny Spotlight
Challenge Session	• Planning gains / S106 contributions for Health • Update on St Pauls Way • Update on Smoking Cessation Review	• Evaluation of End of Life Care Review. • NHS as Employer – Workforce to Reflect the Community
Public Health Briefings	• Screening and testing for Cancer / Diabetes / Blood Pressure • TBA with Trusts	• TBA with Trusts

Appendix 2 – Health Scrutiny Panel Meetings

2008/09

Panel Date	Reports / Topic	Method
June 2008	• Induction Programme • Health Scrutiny Protocol	Presentation Meeting & Visits Report
July 2008	• LINk • Complaints reporting across all three Trusts • St Paul's Way • Pilot of centralised Stroke services • Health Scrutiny Protocol	Report Reports Report / Challenge Session Briefing Paper Comments / Report
September 2008	• Thematic Meeting on Lord Darzi's Next Stages Review. • Adult protection • LINk	Thematic Meeting / Pilot Briefing Briefing
January 2009	• Tobacco Cessation Scrutiny Review Action Plan • Public Health Briefing slot • PCT – Budget and Business Plan • Health Issues around Alcohol Consumption • Health Scrutiny Spotlight • Update on Review work	Challenge Session Briefing Report Report / Link to Scrutiny Review under Safe and Supportive Communities Spotlight Verbal update
March 2009	• LAA Targets and Performance Update • PCT – Budget and Business Plan • Update on Review work • Annual Health Check • Public Health Briefing slot • Aligning Health and Local Authority business cycle	Presentation Consultation Briefing & Report Verbal update Reports Briefing Discussion paper
TBA	• Organ Donation • Early Detection of Dyslexia • Mental health pathways to care for community based services	Member Led Fact finding sessions
TBA (March / April) Joint East London Boroughs Meeting	• Annual Health Check – City and East London Mental Health Trust	Report

2009/10

Panel Date	Reports / topics	Description
TBA	• Induction Programme • Annual Health Check • Review Report – Heart Disease / Mental Health	Presentation Briefing Report Presentation
TBA	• Work Programme • Annual Health Check – Key Issues	Report Briefing
TBA	• Commissioning Intentions • Workforce to Reflect the Community	Report Report
TBA Joint Meeting	• Annual Health Check – City and East London NHS Foundation Trust	Report
TBA	• Service redesign and transformation – optimising patient-centred care pathways	Presentation / Consultation
TBA	• Cardiac Centre of Excellence	Service Visit

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Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	22 July 2008	Unrestricted		4
Report of: Tower Hamlets PCT. **Originating Officer(s):** **Martin Cusack Asst CEO**		**Title:** Response to the Draft Protocol. **Ward(s) affected:All**		

1. Summary

1.1 The PCT has responded to the draft protocol issued for consultation by the Health Scrutiny Panel. The PCT supports the protocol and suggests a number of changes to clarify when issues should be submitted for scrutiny to the HSP and the particular role of the PCT as a commissioner of health services for the local community.

2. Recommendations

It is recommended that Members they consider closer working relations with the PCT in its commissioning role.

LOCAL GOVERNMENT ACT, 2000 (SECTION 97)
LIST OF "BACKGROUND PAPERS" USED IN THE PREPARATION OF THIS REPORT

Background paper	Name and telephone number of and address where open to inspection
Scrutiny Review File held in Scrutiny Policy Team	Afazul Hoque 020 7364 4636

3. Background

3.1 Tower Hamlets PCT is committed to working closely with the Health scrutiny Panel. The PCT recognises that this is both a statutory requirement but also in the best interests of the community. The PCT has a responsibility both of commission all of the health services received by the people of Tower Hamlets and to provide some of those services. The PCT therefore would share any concerns which the HSP would have about the quality or appropriateness of the services delivered to the community. The PCT would also want to use the expertise of the HSP as part of our process of developing plans for services.

3.2 The PCT would wish to develop a joint approach to scrutiny and review with the HSP while respecting its independence.

4. Concurrent Report of the Assistant Chief Executive (Legal Services)

4.1 N/A

5. Comments of the Chief Financial Officer

5.1 N/A

6. Equal Opportunity Implications

6.1 The work of the Health scrutiny Panel is key to ensuring that health services are provided appropriately to all parts of the community. Closer working relations with the PCT would enhance this aspect of both organisations responsibilities.

7. Anti-Poverty Implications

7.1 N/A

8. Sustainable Action for a Greener Environment

8.1 N/A

9. Risk Management Implications

9.1 Good working relationship and arrangements will reduce the risk of failures in health care delivery.

Tower Hamlets PCT

Response to the Tower Hamlets Health Scrutiny Protocol.

Section 4 - Substantial Variations in Service.

It is not clear why the panel would be concerned with major expansions of service and any switch between the provisions of services by primary, acute or specialist services. It is part of NHS strategy to move services nearer to people's homes and therefore there is a great deal of movement between NHS or LBTH providers. The HSP will be overwhelmed with referrals for consultation.

It is understood that the HSP would be interested in a switch to the voluntary or private sector.

It is suggested that section 5.3 states that the HSP should be consulted if any NHS provider in the borough plans to move an existing service to a private sector or voluntary sector provider. Moves of services between existing Tower hamlets NHS or LBTH providers do not need to be referred to the HSP unless there is a contraction of services.

It is suggested that reference to expansions of service should be removed.

Section 5 Roles and Responsibilities

This section needs to recognise the structure of the NHS and the difference between the roles of providers and commissioners of health services.

The East London Mental Health Foundation Trust and Barts and the London Trust are providers of health services to the people of Tower Hamlets but also beyond those boundaries. Tower Hamlets PCT is also a provider of health care services mostly to the population of Tower Hamlets.

However the PCT is also a commissioner of services solely to the population of Tower Hamlets.

As commissioner the PCT has a responsibility to commission the right services for the people of the borough in terms of volume, and quality. This includes services provided by independent practitioners (GPs Dentists, Opticians and Pharmacies) as well as hospitals. As such the PCT therefore has a lead role in the development, planning, provision and monitoring of all the services which it commissions. Any changes, failures or concerns with those services in any provider is of equal interest to both the PCT and the HSP. In order to avoid both the HSP and the PCT challenging providers it is important that the two organisations should co-ordinate closely there work while retaining independence. It is recommended that there should be a joint programme of review and that before the HSP raised concerns with a

particular provider the PCT is informed as it maybe best to undertake a joint approach.

In cases where the PCT is the provider of the service in question or the issue is one of the effectiveness of commissioning then clearly the HSP will approach the PCT directly.

Sections 5.4 to 5.6 could be revised and a possible restructuring is set out below (Comments inserted in bold,underlined and italicised.)

5 Role and Responsibilities

The Health Scrutiny Panel

5.1 The Tower Hamlets Health Scrutiny Panel has its own terms of reference and has a four year rolling work programme. The work programme is designed to ensure that the work of the committee is informed by longer term developments across the NHS Trusts so that a strategic approach can be taken in tackling health inequalities in the borough.

5.2 The primary role of the Health Scrutiny Panel is to:

- identify whether health and health services reflect the views and aspirations of the local community
- ensure all sections of the community have equal access to services
- and have an equal chance of a successful outcome from services.

5.3 ***The HSP recognises the difference in responsibility between the commissioning of health services function (PCT) and the provider function (BLT, ELMHT, Independent Contractors and voluntary sector). As a commissioning organisation the PCT has a similar interest in any failings in the quantity or quality of health services which it has commissioned; either independently or jointly with the LBTH. The HSP will discuss in advance with the PCT any concerns it has before taking action with a view to sharing information and reducing duplication of effort for all concerned.***

Duties and Responsibilities of the Tower Hamlets Health Economy consisting of Tower Hamlets Primary Care Trust, East London NHS Foundation Trust and Barts and the London NHS Trust

5.4 The NHS has been required to consult on changes to health services for many years. The Health and Social Care Act 2001, and subsequent Regulations, developed these requirements and identified new statutory consultees as well as conferring duties on NHS bodies in relation to local authority overview and scrutiny committees.

5.5 NHS trusts have a duty to consult scrutiny committees, to attend these committees when requested to answer questions, to respond to their requests for written information and to respond to scrutiny committee reports and recommendations within 28 days of the request of the committee.

5.6 The HSP recognises the commissioning responsibilities of the Tower Hamlets PCT mean that it shares the concerns about the provision and delivery of services to the people of Tower Hamlets, all of which the PCT will have commissioned. The PCT will therefore work with the HSP to review the services and to investigate jointly, where appropriate, concerns about quality or scope of health services. ***The PCT will involve the HSP at an early stage in the production of the following:***

Commissioning Strategic Plan (CSP)
Operational Plan
Strategic Plan
Joint Strategic Needs Assessment process

5.7 The health economy of Tower Hamlets will meet the following responsibilities as far as resources permit:

1. Provide information relating to the planning and operation of the Trusts that the Health Scrutiny Panel requires so that it can carry out its functions including commenting on NHS Plans, proposals and consultations, and carrying out health scrutiny reviews (excluding patient and NHS employee identifiable personal information or information that is non disclosable by law).
2. Provide the Panel with that information when requested within 14 days.
3. Respond to Health Scrutiny Panel review reports within 4 weeks.
4. Within 4 weeks copy that response to patient representative bodies including the Local Area Partnerships; CPAG; the Local Involvement Network (LINk); and anyone else who may have in interest in the content therein
5. Provide the Health Scrutiny Panel with Patient Survey or Customer Access information at least once a year.
6. Ensure that all reports are addressed to members of the panel and include an executive summary and clearly state the expectation of the Health Scrutiny Panel.
7. Present an “Issues and Options” paper as an integral part of all reports.
8. Nominate a single point of contact for panel members/Council officers.
9. Commit to providing reports on a single topic area (e.g. smoking cessation; obesity; mental Health) in order to present the panel with a strategic picture of the issue across the three trust areas.
10. Ensure that all acronyms are explained as an appendix to any papers/reports.
11. Present Trust self-assessment declarations against Core Standards to the Health Scrutiny Panel as part of the Annual Health Check process.

12. Consult with and provide information to the partner organisations at an early stage on its plans for substantial developments or variations in its service provision.
13. Report the outcome of the consultations to the next available committee/panel meeting.
14. Send the Chair and any other members who request them all trust board agendas and associated papers including the Annual Health Report.
15. Through its chair or Chief Executive maintain regular contact with the panel and partner organisations.

North East London
Cardiac and Stroke Network

Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	22 July 2008	Unrestricted		4
Report of: North East London Cardiac and Stroke Unit **Originating Officer(s):** Jane Davis, Network Manager		**Title:** Stroke Developments Paper for Health Overview and Scrutiny Committees of Local Authorities within the NEL Stroke Network **Ward(s) affected:** All		

4 July 08

Stroke Developments Paper for Health Overview and Scrutiny Committees of Local Authorities within the NEL Stroke Network :- City of London, Hackney, Tower Hamlets, Newham, Barking and Dagenham, Redbridge, Waltham Forest and Havering**.**

North East London Cardiac and Stroke Network

The role of the Network is to work with the 7 PCTs and 5 acute trusts in NEL to enhance and improve the delivery of care pathways. By bringing together clinicians, mangers, patients, commissioners and social care we are able to see the pathway as a whole and provide a powerful voice in the local health economy to ensure cost effective and clinically robust services.

The Network is funded through NHS Improvement at the Department of Health

During 2007 the Cardiac Network was tasked to expand its remit to cover stroke to ensure that NEL would be in a position to respond to the expected challenges the impending National Stroke Strategy would pose. In addition it is a sensible development as the wider CVD agenda has many areas which are co-terminus, including, prevention, treatment of hypertension, Atrial Fibrillation and End of Life Care.

Background

Stroke is the third largest cause of death in the UK, responsible for 11% of deaths in England and Wales, with 20–30% of people who have a stroke dying within a month. Stroke also contributes to the gap in life expectancy between the most deprived

areas and the population as a whole, with people from ethnic minorities at higher risk than the white population: incidence rates, adjusted for age and gender, are twice as high in black people as for white people (DH June 2007)

The age-adjusted prevalence of stroke in NEL is estimated to be approximately 1% (peaking at 1.3% in Tower Hamlets). The majority of deaths attributed to stroke occur in those aged 75 and over. However, due to the high incidence of risk factors (e.g. diabetes, hypertension, deprivation) there is a significant number of younger people having a stroke: Mortality rates for hypertensive disease and stroke in the younger population in NEL exceed that in England, particularly for men aged 35-64 years of age.

NEL has traditionally scored poorly overall against all the key indicators and standards for stroke and PSA targets.

In addition there are currently very wide variations in levels of access and quality outcomes across the sector between services provided by both acute trusts and PCTs and there is currently only one service offering thrombolysis. We will require those at the forefront to continue to move forward, while supporting the remainder to reach interim minimum standards before going forward to embrace the new strategy and models of care.

Stroke is a local, pan London and national priority, with an emerging evidence base against which we score poorly. Failure to address the issues will result in avoidable mortality and morbidity. Current investment is high, but services are ineffective in meeting the needs of the patients.

Stroke is treatable. There is now a robust evidence base that organised stroke services are associated with lower mortality, less disability in survivors and at lower cost when compared with services delivered within a traditional general medical framework.

Stroke is also preventable. Medical treatment for patients who have had a stroke or TIA can reduce the risk of recurrent stroke by 80%.

National Stroke Strategy

While stroke services in England have improved significantly over the last decade, there is clear evidence that further improvements are still required. There is now a consensus in favour of:

- Specialist stroke units
- Regarding acute stroke as an emergency
- Rapid access to services for people who have had a TIA
- Immediate access to diagnostic scans and to thrombolysis for patients whose stroke was caused by a clot
- Early supported discharge for people with moderate disability as a result of stroke

- More emphasis on prevention and public awareness
- Better support for all people living with stroke in the long term

NEL 'Hyper Acute' Stroke Pathway Pilot

In Sept 08 we will begin a pilot for a 'Hyper Acute' Stroke Pathway for those patients in NEL who are FAST + (The Face-Arm-Speech-Test) and within 3 hours of onset of their symptoms. This pilot will be in place until the NHS London process to designate hyper acute stroke centres comes into effect, this will be after June 2009.

Currently any patient who has had a stroke is taken to their local A&E. Only Barts and The London in NEL is delivering thrombolysis. During the pilot, those patients who are FAST + and within 3 hours of onset of their symptoms will be taken to the pilot centre rather than their local A&E.

The pilot centre will provide an enhanced service to facilitate the giving of thrombolysis and immediate after care. Patients on average will remain at the pilot centre for 72 hours before either being discharged home, repatriated to their local acute stroke unit or local in patient rehabilitation services as appropriate for each patient.

A specification has been produced based on national guidance and quality markers. Each acute trust within NEL has been asked if they wish to undertake the pilot, those trusts that respond will be reviewed by a panel that will assign the centre. The panel includes a patient representative and clinicians from outside of NEL.

The Network has instigated public and patient involvement, currently we have a partnership with the Stroke Association who sit on the Stroke Board and also a patient representation on the Board. The Network is currently engaging with varied stoke clubs and organisations with NEL to further ensure that stroke survivors and carers have a voice in the future developments of the stroke pathways

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Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	**22 July 2008**	**Unrestricted**		**4**
Report of: **Tower Hamlets PCT** **Originating Officer(s):** **Martin Cusack Asst CEO**		**Title:** **PCT Annual Report on Complaints** **Ward(s) affected: All**		

1. Summary

1.1 This is the annual report on complaints which the PCT presents to its Board for 2007/08. The report states that fort he period the PCT received 61 written complaints as well as enquires, informal complaints and compliments. All complaints are investigated and responded to as quickly as possible. The PCT has a system for monitoring and learning form the complaints in order to improve services.

2. Recommendations

2.1 The PCT would welcome comments from the Health Scrutiny Panel on any aspects of our complaints procedure and on how the HSP would like to be involved in using the information from complaints.

LOCAL GOVERNMENT ACT, 2000 (SECTION 97)
LIST OF "BACKGROUND PAPERS" USED IN THE PREPARATION OF THIS REPORT

Background paper	Name and telephone number of and address where open to inspection
Scrutiny Review File held in Scrutiny Policy Team	Afazul Hoque 020 7364 4636

3. Background

3.1 The report summarises the complaints and compliments which the PCT has received, what has been learnt from the main categories of complaints, the processes we have followed and the standards that were achieved. The report does not provide detailed descriptions of complaints but this is available if required. The PCT has a complaints team involved in the management of PCT provider and some independent contractor complaints and these are highlighted in the report.

3.2 As a provider of healthcare services the PCT employs 1200 staff providing a wide range of services to the population of Tower Hamlets in all forms of settings including home, clinics, GP Practices and hospitals. It is estimated that PCT staff deliver approximately 250,000 interventions per annum.

4. Concurrent Report of the Assistant Chief Executive (Legal Services)

4.1 N/A

5. Comments of the Chief Financial Officer

5.1 N/A

6. Equal Opportunity Implications

6.1 The PCT monitors the complaints by the 6 broad areas of equalities and diversity and these are reported separately to the PCTs Equality and Diversity group.

7. Anti-Poverty Implications

7.1 Complaints monitoring to improve services and address individual patient needs and experiences are key to mitigating against health inequalities that arise because of differences in wealth or income.

8. Sustainable Action for a Greener Environment

8.1 N/A

9. Risk Management Implications

9.1 N/A

Tower Hamlets Primary Care Trust

Annual Complaints Report
2007 - 2008

Quality & Governance Department

Circulation List

Internal

THPCT Clinical Governance & Risk Management Committee
THPCT Healthcare Governance Committee
THPCT Directors & Associate Directors (as appropriate)
THPCT PALS
THPCT Heads of Service
THPCT Communications Team

External

Complaints & Policy Unit – Healthcare Commission
POhWER ICAS

Content

1. Introduction

This is an annual report on complaints and compliments activity across the Trust during the period of April 2007 – March 2008.

2. Background

The report summarises the complaints and compliments which the PCT has received, what has been learnt from the main categories of complaints, the processes we have followed and the standards that were achieved. The report does not provide detailed descriptions of complaints but this is available if required. The PCT has a complaints team involved in the management of PCT provider and some independent contractor complaints and these are highlighted in the report.

As a provider of healthcare services the PCT employs 1200 staff providing a wide range of services to the population of Tower Hamlets in all forms of settings including home, clinics, GP Practices and hospitals. It is estimated that PCT staff deliver approximately 250,000 interventions per annum.

3. Service Delivery

3.1 The team's role

The team is involved in the facilitation of local resolution meetings, mediating in complex cases, supporting and advising independent contractors, providing training, collating and reporting independent contractors' complaints activity to the DoH, via the annual KO41 reporting system.

As part of the organisation's Governance structure, the role of the complaints team is to ensure that in compliance with the patient focus element of the Healthcare Standards, the PCT has systems in place that enables and empowers "patients, their relatives, and carers to register formal complaints and feedback on the quality of service" (DoH 2006).

Logging concerns: which are issues raised by service users or their relatives, as potential complaints they neither wish to be investigated nor responded to, but to be noted for future reference. Patterns of reported concerns are identified and discussed with Heads of Service.

Logging informal complaints: these are the smaller concerns brought to the attention of individual services and dealt with at service level. The complaints department collects and reports on these at the end of every quarter, in order to identify trends and support services with identifying these and preventing them from escalating into more serious complaints

Coordinating response to formal enquiries: these include enquiries from patients, their carers, MPs, councillors, and the Department of Health. The

complaints department is the organisation's central point for coordinating responses to these enquires and ensuring the deadlines set are met.

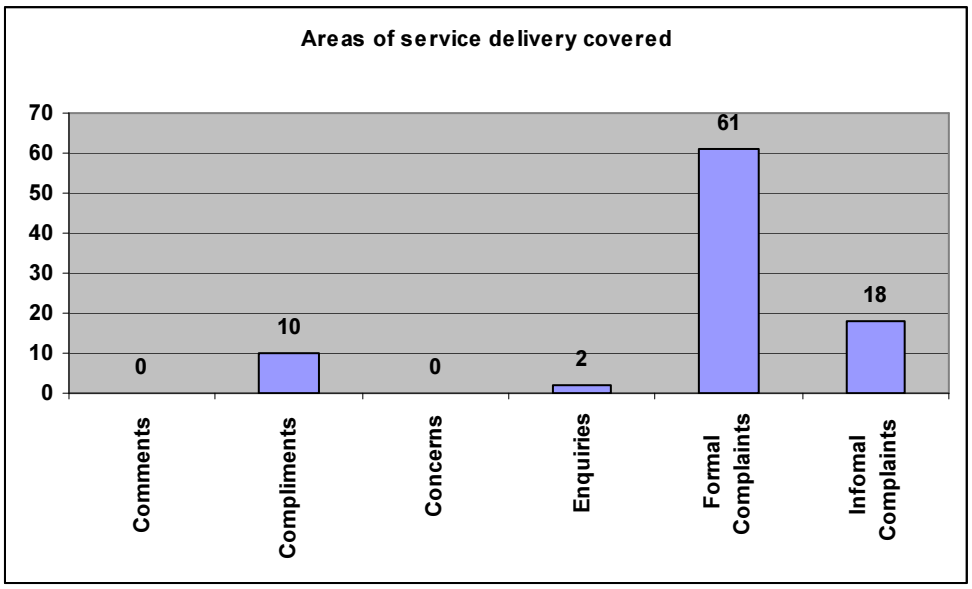
Formal complaints: Concerns raised which warrant a full investigation and response from the Chief Executive of the Trust in compliance with "The National Health Service (Complaints) Amendment Regulations 2006". These sometimes escalate further to stage 2 and 3 of the complaints process where complainants continue to remain dissatisfied. During 2007 – 2008, none of the complaints that went to stage 2 were upheld, and in the previous year, one case went to judicial review, which is stage 3, but was not upheld.

The chart below gives a breakdown of the activity of the team including the other areas of service delivery, besides formal complaints handling.

In addition to the above, the department is responsible for ensuring the organisation monitors and implements actions agreed as a result of complaints made. The department, via the Investigations Management Group reports on the quality of investigations and the implementation of actions from complaints as appropriate.

As part of its reporting agenda, the department feeds back to individual services via their local clinical governance and risk management meetings on their complaints activity. The complaints manger attends these meetings regularly to discuss, agree and receive updates on actions from complaints received.

Appendix I shows an outline of the complaints process and the approach taken to managing formal complaints within the organisation.

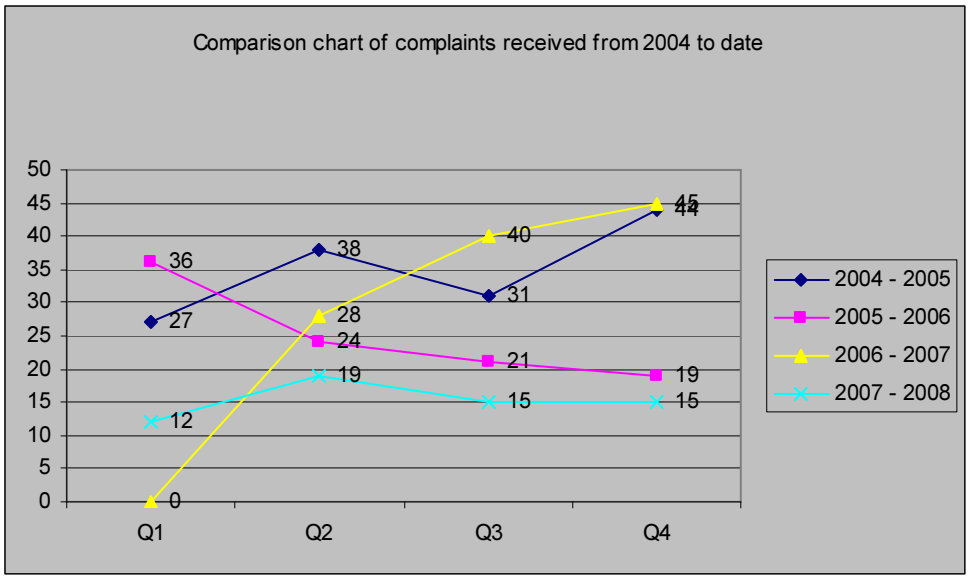


4. Complaints Activity

4.1 Number of complaints received in 06-07 and 07-08

Between April 2007 and March 2008, the PCT received a total of 61 formal complaints in comparison to 113, during the same period the year before. The PCT directly manages a small number of GP practices, whose complaints are normally included in the total numbers reported, however, service improvements in these practices has led to fewer complaints in total. Hence the significant difference in the number of complaints received this year.

The chart below shows comparison by quarter, of complaints received from 2004 to date.



Of the total number of complaints received during 2007 - 2008, 92% (56) of the complaints were acknowledged within the statutory timescale of 2 days, and 48% (29) were responded to within the statutory 25 days timescale.

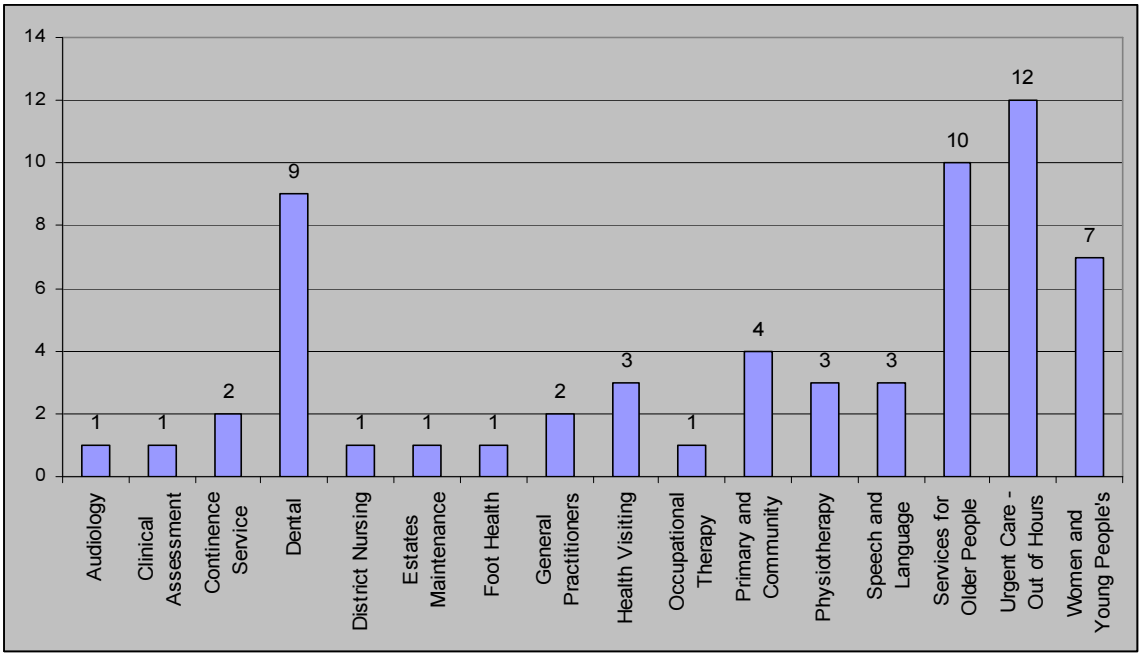
Number of complaints received	Performance against 25 days target	Performance against 2 days target
01/04/07 – 31/03/08 – 61	= 48% (29)	= 92% (56)

Some complaints were often very complex and required more than 25 days to complete a thorough and comprehensive investigation in order to provide the complainant with a full response. In other cases, multidisciplinary meetings across the acute and primary care Trusts were required to be able to achieve a clearer understanding of how the issues raised by complainants occurred.

As a result of this, a number of complaint responses were delayed beyond the statutory timescale before responses could be sent. In such cases the complainant was kept informed of the reasons for the delay and progress of the investigation.

4.2 Complaints by service provider

As can be noted from the chart below, the highest numbers of complaints were about dentistry, older people's services and the unscheduled care sections of the provider directorate. It is fair to say that all three services are the largest in the directorate and therefore it would be reasonable to expect that they had a higher number of formal complaints than the other services in the directorate.

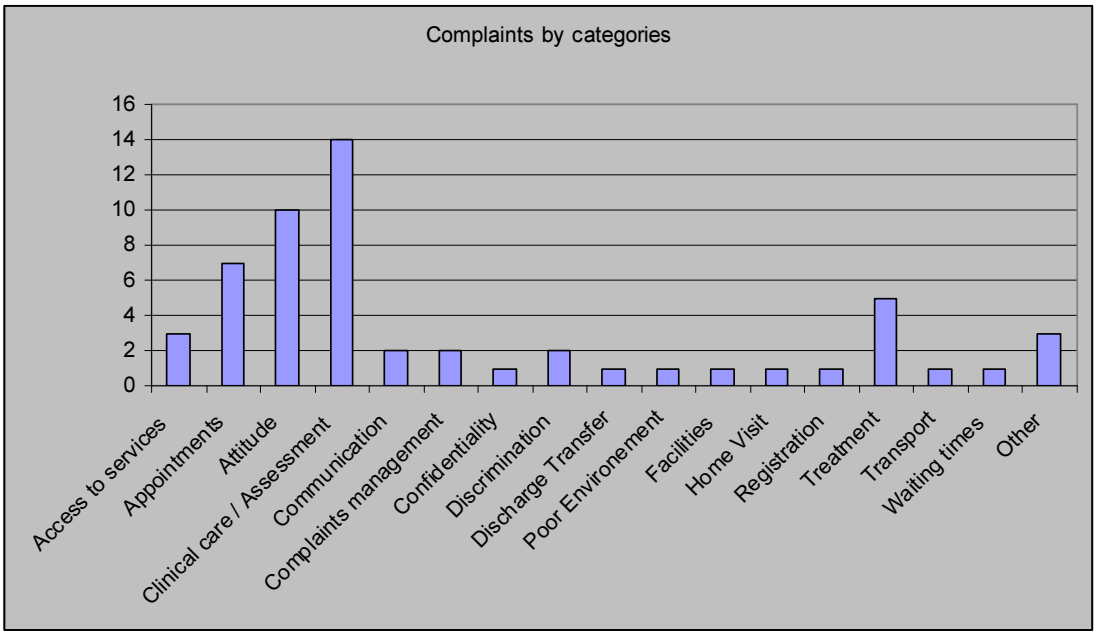


4.3 Complaints by categories

This year, the highest number of complaints received was about clinical care and assessments. In some cases, complainants had a pre-existing idea of what level of care they expected to receive and what constituted an assessment. However on arriving at the service, they would find that the service provided did not meet their expectation. Investigations did show in such cases that the level of care was adequate, and met set clinical standards, but was just different from what the patient expected, hence the formal complaint.

With regards to the issue of assessments, again patients had a different expectation of what assessments involved. For instance in one case, a patient complained that the Out of Hours doctor who came out on a home visit did not carry out an assessment or an examination during the visit. The investigation showed that before the doctor went out on the home visit, he had had a telephone consultation with the patient prior to visiting and therefore did not feel any further examination was necessary, but observed the presenting problem on arrival and gave advice as appropriate.

As a result of these complaints the PCT has taken measures to provide more information about what patients can expect in terms of assessment and clinical treatment.



4.4 Compliments

In a similar way to formal complaints, all compliments are formally responded to by the chief Executive of the Trust. Below are some of the compliments received in the Trust during the year.

The staff have been very good. They are really very helpful

I would like to say thank you for the high quality of the service provided, and the professionalism of the staff involved in the consultation

I would like to say the staff on Jubilee Ward are a great team

Thank you very much, lovely treatment, I felt privileged to receive the care I did.

I would just like to say that my session was very helpful and the member of staff was very helpful, polite and informative

5. Developments

5.1 The office of the Health Service Ombudsman has recently reviewed their system for investigating complaints and have stated in their report that part of improving the process should include 'remedying injustice'. Instructions on how public organisations should 'put things right' have been drafted as part of a three part document called the "Principles of Remedy".

In compliance with the Principles of Remedy, the PCT is reviewing its complaints procedure to ensure the process considers how circumstances of cases have affected complainants and the appropriate principles of remedy which should apply in each case. This could range from an apology to financial compensation, but each case will be considered on its own merit.

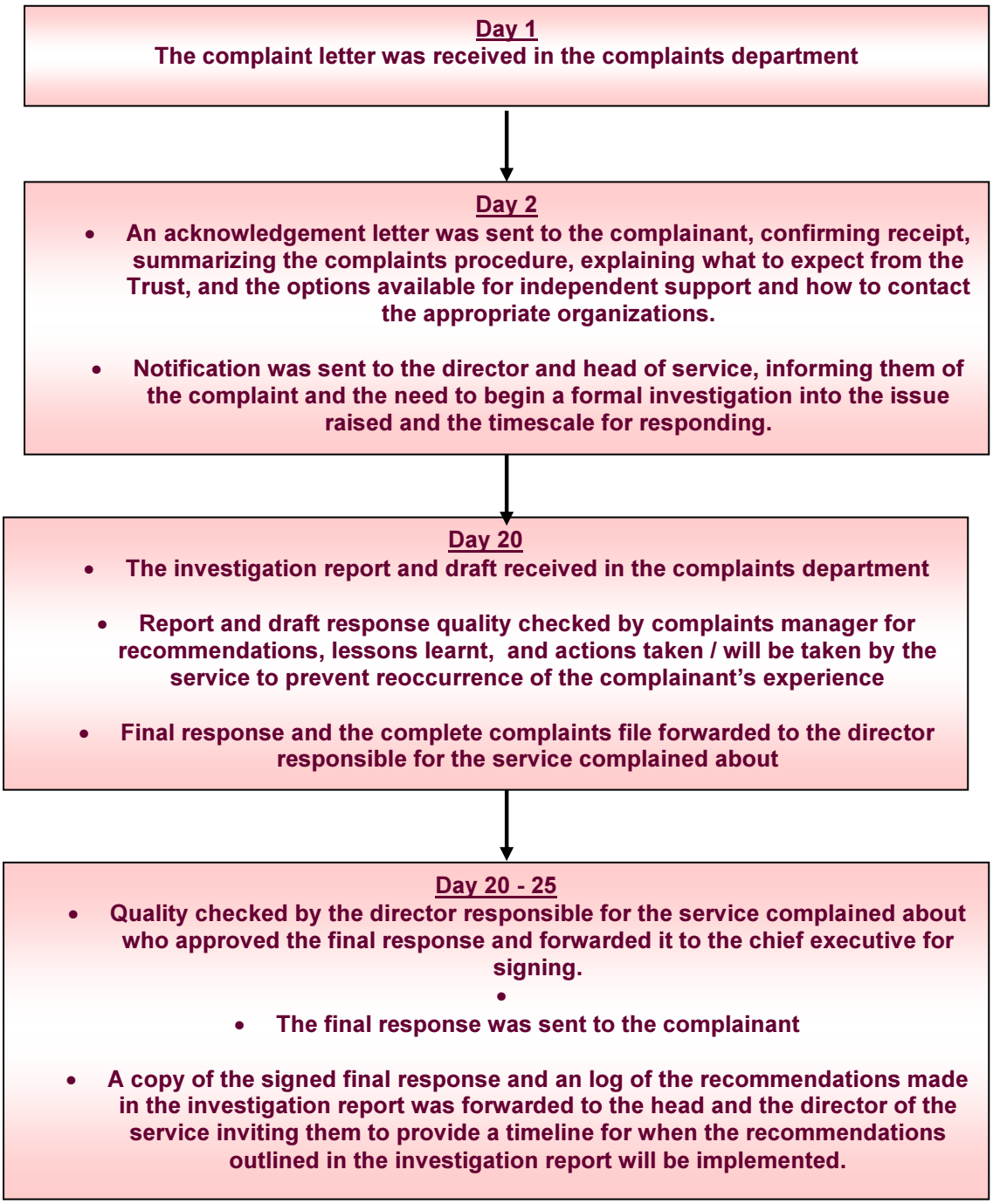
5,2 The PCT will be working on enhancing working relationships between the PCT and the neighbouring health & social care organisations to formalise existing arrangements for the management of joint complaints

5.3 Themes arising form complaints will be appropriately included in the PCT's wider information gathering on overall patient experiences across the organisation.

Appendix I

A complaint case study

A parent wrote to the Trust to raise concerns about difficulties she experienced with arranging transport for appointments for her disabled daughter. Below is a typical flow chart of the complainants journey through the complaints process which is applied in all formal cases.



Lessons learnt

In this case, the investigation identified that the patient's experience was due to an administrative error which if not resolved could lead to a reoccurrence of the same problem in future. As a result of this, the service initiated training for its entire administrative staff in the use of the transport booking system. Since the implementation of the training there have been no further complaints about transport from service users.

Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	22 July 2008	Unrestricted		4
Report of: East London NHS Foundation Trust Originating Officer(s): Leeanne McGee, Borough Director		Title: Annual Complaints Report 1 April 2007 – 31 March 2008 Ward(s) affected: all		

1.0 Purpose of the Report

This is an annual complaints report, which is a standard item on the Trust Board's agenda. The report details the number of complaints received and the performance against timescales as set in the NHS Complaints Procedure. The report also notes any requests for independent review.

2.0 Report Content

During the period 1 April 2007 to 31 March 2008 the Trust received 252 formal complaints. This represents an increase on the previous year of 66%.

Of the 252 complaints received 93% were acknowledged within two working days and 64% received a full written response within the timescale of 25 working days. This represents a decrease of 19% from 2006 to 2007. This decrease was, in the main, due to the extended absence on sick leave of a senior member of staff in the complaints department and despite best efforts the Trust was unable to find suitable cover. An additional senior member of staff has now been recruited to the new post of Complaints Manager. Amongst the key responsibilities of the new role will be to ensure that the Trust can demonstrate learning as a result of complaints as well as ensuring compliance to the timescales.

Of the 252 complaints received six complainants contacted the Healthcare Commission. Of these four cases were referred back to the Trust for investigation/local resolution and two are currently under review. During 2007 - 2008 the Trust was not informed of any requests for review by the Health Service Ombudsman.

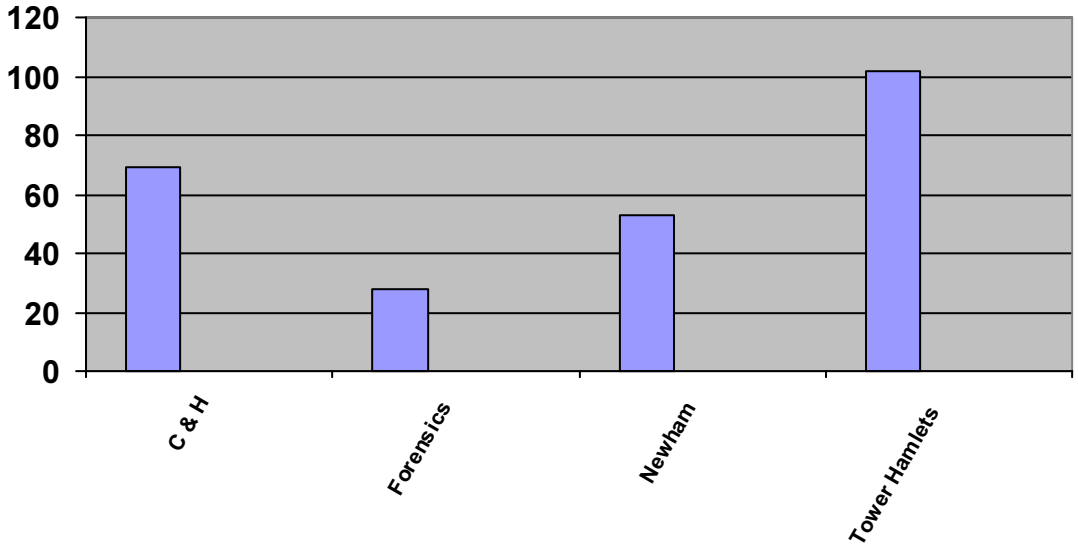
3.0 Looking forward

A new Complaints Procedure is due to be launched in April 2009 and the Trust is currently taking part in the Early Adopter Programme to support the development of an innovative approach to responding to complaints. The Programme and subsequently the new procedure aim to achieve an overall framework to:

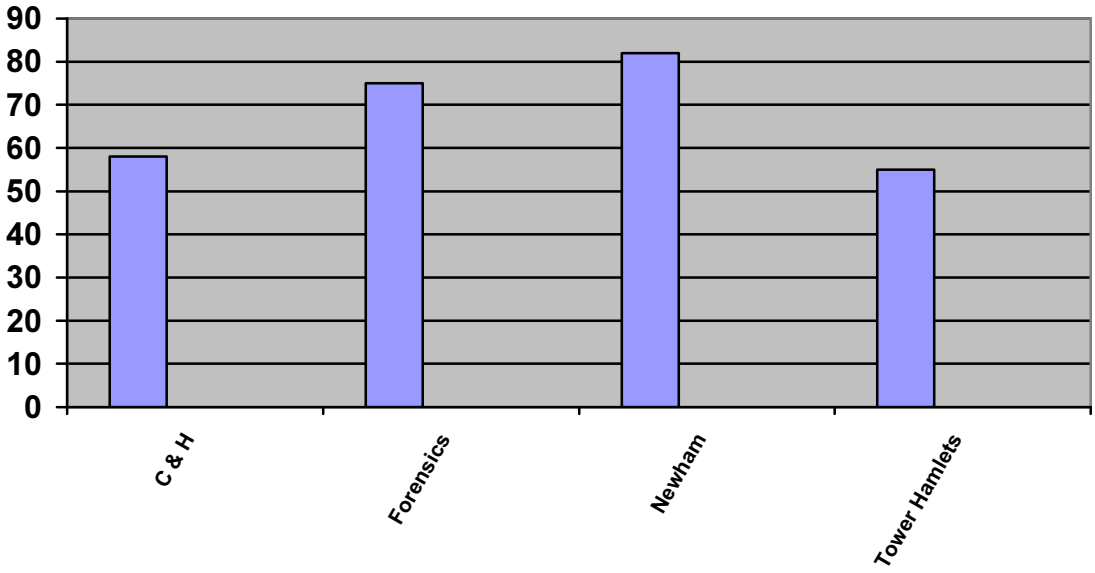
- Facilitate the resolution of complaints locally, through a more accessible, personal and flexible approach to handling complaints
- Treat and respond to each case according to its individual nature and wishes of the complainant
- Ensure organisations improve the services they provide by routinely learning from peoples experiences.

Performance against targets will be monitored through the Trust's performance management framework, including report to the Service Delivery Board.

Reports will also be provided to the Public Participation Committee.

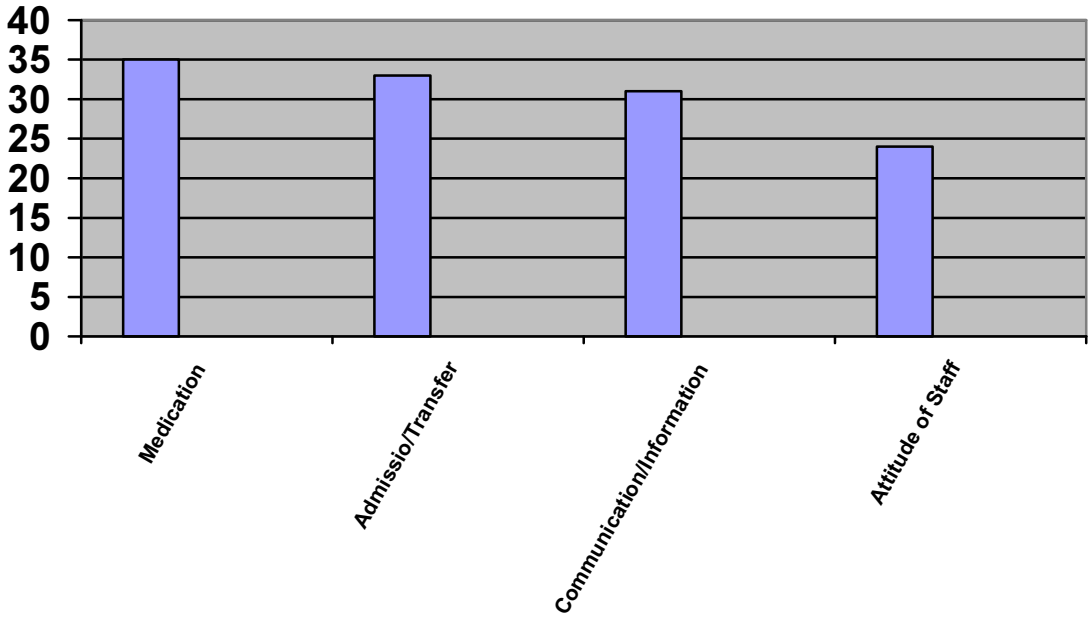


The chart below shows the percentage of complaints responded to within the 25 working day timescales, broken down by Directorate:



The Trust received the highest number of complaints regarding issues involving medication.

The chart below shows the subjects where the highest number of complaints were received.



The Trust keeps a comprehensive database of all formal complaints received and captures information on the subject of the complaints. The following chart shows the number of complaints received Trust wide, by subject category. These are grouped under the seven domains of the Healthcare Commission's Standards for Better Health.

	C&H	FOR	NEWH	TH	Total
Safety	**8**	**2**	**6**	**8**	**24**
Alleged Assault (Patient)	0	1	0	0	1
Alleged Assault (Staff)	0	0	3	2	5
Occupancy Rates and Access to Admission	1	0	0	0	1
Communication/Information (Written/Oral)	0	0	1	1	2
Control & Restraint	0	0	0	3	3
Inappropriate sexual behaviour (Patient)	1	1	1	0	3
Medication	2	0	0	1	3
MHA (Sectioning)	1	0	0	0	1
Physical Health	2	0	0	0	2
Security	0	0	0	1	1
Violence and Aggression (Staff)	1	0	1	0	2

Clinical Effectiveness	**51**	**18**	**48**	**64**	**181**
Admission/Discharge/Transfer arrangements	6	3	10	14	33
A&E	1	0	0	0	1
Staff Attitude	4	3	3	4	14
Attitude of Staff	1	0	0	1	2
Occupancy Rates and Access to Admission	1	0	0	0	1
Cleanliness/Upkeep	0	0	1	0	1
Communication/Information (Written/Oral)	8	4	8	8	28
Communication	0	0	0	2	2

Consent to Treatment	0	0	0	2	2
Control & Restraint	4	0	1	0	5
Control & Restraint	0	0	0	1	1
CPA	0	0	2	1	3
Appointments Delay/Cancellation	0	0	1	1	2
Diagnosis	2	0	5	1	8
Full Needs Assessment	1	0	0	1	2
Information & Choice	0	0	1	0	1
Leave	2	3	0	3	8
Medication	9	2	8	16	35
MHA (Sectioning)	8	0	4	1	13
Nursing Care	0	2	1	2	5
Occupancy Pressures	1	0	0	1	2
Physical Health	1	0	0	1	2
Records	0	0	1	1	2
Relationships with Professionals	2	1	2	3	8

Patient Focus	**38**	**12**	**26**	**57**	**133**
Access to Services	0	0	0	1	1
Access to Services	1	0	3	2	6
Admission/Discharge/Transfer arrangements	1	0	1	1	3
A&E	2	0	0	0	2
Staff Attitude	0	2	0	0	2
Attitude of Staff	6	1	4	12	23
Occupancy Rates and Access to Admission	4	0	1	5	10
Bullying/Harassment/Verbal Abuse (Patient)	0	0	0	2	2
Bullying/Harassment/Verbal Abuse (Staff)	5	0	0	3	8
Care Planning/CPA	0	0	0	1	1
Cleanliness/Upkeep	0	0	1	0	1
Communication/Information (Written/Oral)	1	0	1	1	3
Communication	0	0	2	1	3
Confidentiality	1	0	1	2	4
Control & Restraint	1	0	0	1	2
CPA	0	0	0	1	1
Diagnosis	0	0	0	0	0
Catering/Diet	1	0	1	1	3
Discrimination/Equality/Human Rights	0	1	0	0	1
Full Needs Assessment	0	0	0	1	1
Furniture & Fixtures	0	1	0	0	1
Inappropriate sexual behaviour (Patient)	1	0	1	0	2
Information & Choice	0	0	1	0	1
Leave	0	1	0	2	3
Medication	2	1	3	7	13
Nursing Care	0	0	1	0	1
Privacy & Dignity	1	0	0	2	3
Patients Property and Expenses	0	0	1	0	1
Patient Property & Expenses	2	1	0	1	4
Physical Health	1	0	0	0	1
Relationships with Professionals	3	0	0	2	5

Adequate Staffing & Skills	0	0	0	1	1
Support in the Community	4	0	4	6	14
Use of	0	0	0	1	1
Visiting Arrangements	1	4	0	0	5

Governance	**0**	**3**	**4**	**4**	**11**
Staff Attitude	0	0	1	0	1
Care Planning/CPA	0	0	0	1	1
Communication/Information (Written/Oral)	0	0	1	1	2
Discrimination/Equality/Human Rights	0	2	2	0	4
Furniture & Fixtures	0	1	0	0	1
Occupancy Pressures	0	0	0	2	2

Accessible and Responsive Care	**7**	**1**	**3**	**18**	**29**
Access to Services	1	1	0	2	4
Admission/Discharge/Transfer arrangements	0	0	0	1	1
Communication/Information (Written/Oral)	0	0	0	1	1
Appointments Delay/Cancellation	1	0	1	2	4
Diagnosis	0	0	1	0	1
Delayed Discharge/Transfer of Care	1	0	0	0	1
Funding	1	0	0	0	1
Occupancy Pressures	1	0	0	8	9
Privacy & Dignity	0	0	0	1	1
Support in the Community	0	0	1	1	2
Waiting Times (Therapy)	2	0	0	2	4

Care Environment and Amenities	**4**	**4**	**1**	**5**	**14**
Alleged Assault (Patient)	0	1	0	0	1
Attitude of Staff	0	0	0	1	1
Bullying/Harassment/Verbal Abuse (Staff)	1	0	0	0	1
Cleanliness/Upkeep	0	0	1	0	1
Furniture & Fixtures	0	1	0	0	1
Leave	0	1	0	0	1
Occupancy Pressures	0	0	0	1	1
Privacy	1	0	0	0	1
Physical Health	0	0	0	1	1
Safety/Security/Property	0	1	0	0	1
Security	0	0	0	1	1
Adequate Staffing & Skills	0	0	0	1	1
Ward Conditions	2	0	0	0	2

Public Health	**1**	**0**	**0**	**0**	**1**
Community Follow Up	1	0	0	0	1
Totals:	109	40	88	156	393

NB: Some complaints will contain more than one issue and in such circumstances more than one subject will be recorded.

4.0 Tower Hamlets synopsis 07/08

Complaints trends in Tower Hamlets are as follows:

- Attitude
- Medication
- Communication
- Occupancy / bed pressures
- Support in the community

In terms of in patient are the statistics are as follows:

- Globe ward 17
- Lea ward 10
- Out patients 13
- Roman ward 9
- Brick lane 7

In terms of service development the complaints analysis is shared with the PCT and Local Authority quarterly and trends and emergent themes and relevant action plans put in place to rectify and remedy service deficits. More recently this has manifested in a number of staff being subject to capability or disciplinary procedures.

Through User involvement forums and the work of the Patients Council we have developed strategies to improve and inform service development before complaints are made.

Leeanne McGee
08.07.08

Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	22 July 2008	Unrestricted		4
Report of: Barts and The London NHS Trust		Title: Complaints Overview, performance and quality Improvements		
Originating Officer(s): Jane Canny/ Jay O'Brien		Ward(s) affected: all		

1. Summary

1.1 Central complaints management is undertaken by the quality development team. The team are responsible for providing support for clinical services to follow the NHS complaints procedure; meet national and local standards; liaise with external bodies; assist with independent reviews and to monitor and report on the management and themes of complaints received by the Trust.

1.2 Since April 2008, there has been an increase in the amount of formal complaints received in the Trust, compared to the same period last year. Much of the increase is due to the problems experienced by patients accessing the appointment system. Alerts from the complaints team and PALS have prompted early detection and actions from the executive team. There is an increase in the number of complaints about diagnosis and treatment; however complaints about Transport, one the Trust's top five causes of complaint, have decreased following actions taken by the Trust and Carillion.

1.3 This year, the team have undertaken surveys of complainants and of staff who have been involved with the complaint process, in order to better understand what is wanted from the team and the process. The results have supported investment in staff training and provided some clear messages from complainants about resolution and letting them know what has changed as a result of their complaint

1.4 We are developing our work to focus on resolving patients' complaints and concerns through proactive joint working with PALS and the Patient Public Involvement team. The teams will be reviewing and making recommendations for change in response to the new complaints process.

1.5 Barts and the London Trust were named as the fourth best Trust in the country for responding to and answering complaints referred to the Health Care Commission

2. Recommendations

It is recommended that Members:

2.1 Receive the presentation, note improvements made and the actions identified for future development

2.2 For the panel make suggestions for further improvements to the complaints system

LOCAL GOVERNMENT ACT, 2000 (SECTION 97)
LIST OF "BACKGROUND PAPERS" USED IN THE PREPARATION OF THIS REPORT

Background paper	Name and telephone number of and address where open to inspection
Directorate Complaints Performance from 1 April 08 – 3 June 08	
Annual Complaints Report 06/07	Shanara Matin
Presentation for the Committee July 08	020 7364 4548
Scrutiny Review File held in Scrutiny Policy Team	

3. Background

3.1 Please see Directorate Complaints Performance Report (01/04/08 – 30/04/08)

4. Concurrent Report of the Assistant Chief Executive (Legal Services)

4.1 N/A

5. Comments of the Chief Financial Officer

5.1 N/A

6. Equal Opportunity Implications

6.1 All complaints received are monitored for complaints about equalities and diversity

7. Anti-Poverty Implications

7.1 N/A

8. Sustainable Action for a Greener Environment

8.1 N/A

9. Risk Management Implications

9.1 Aggregated with risk data

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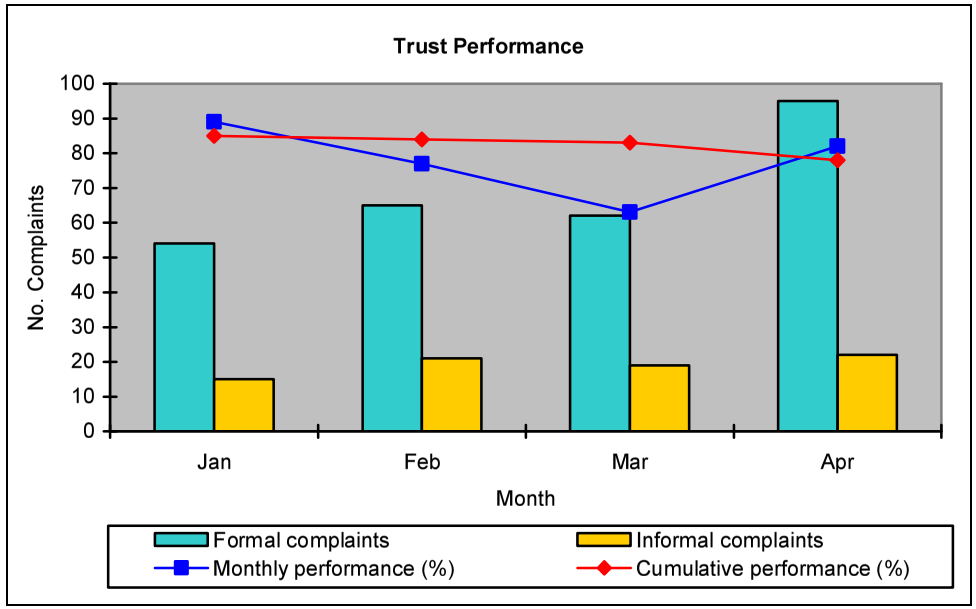
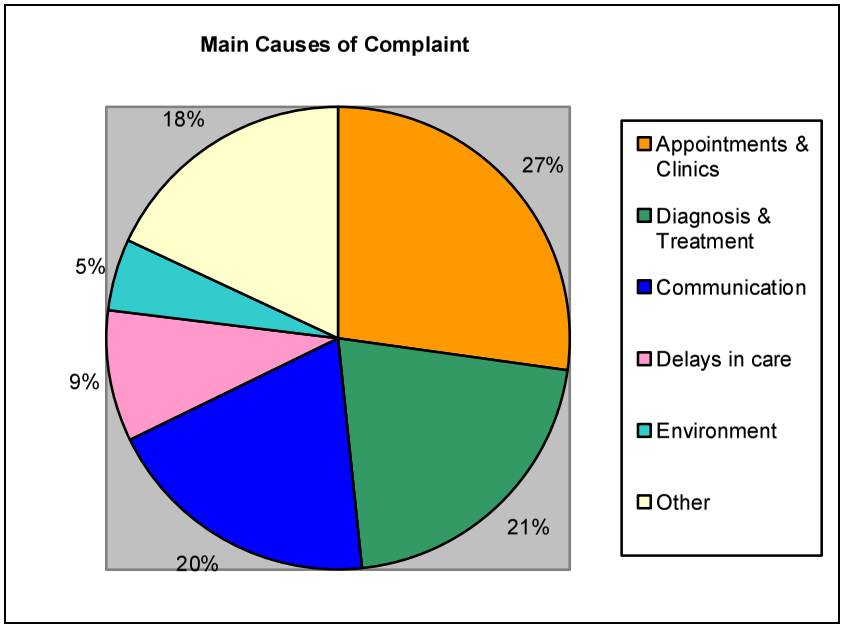
DIRECTORATE COMPLAINTS PERFORMANCE

01/04/08 – 30/04/08

OVERALL PERFORMANCE AGAINST TARGET AND TOP CATEGORIES OF COMPLAINT

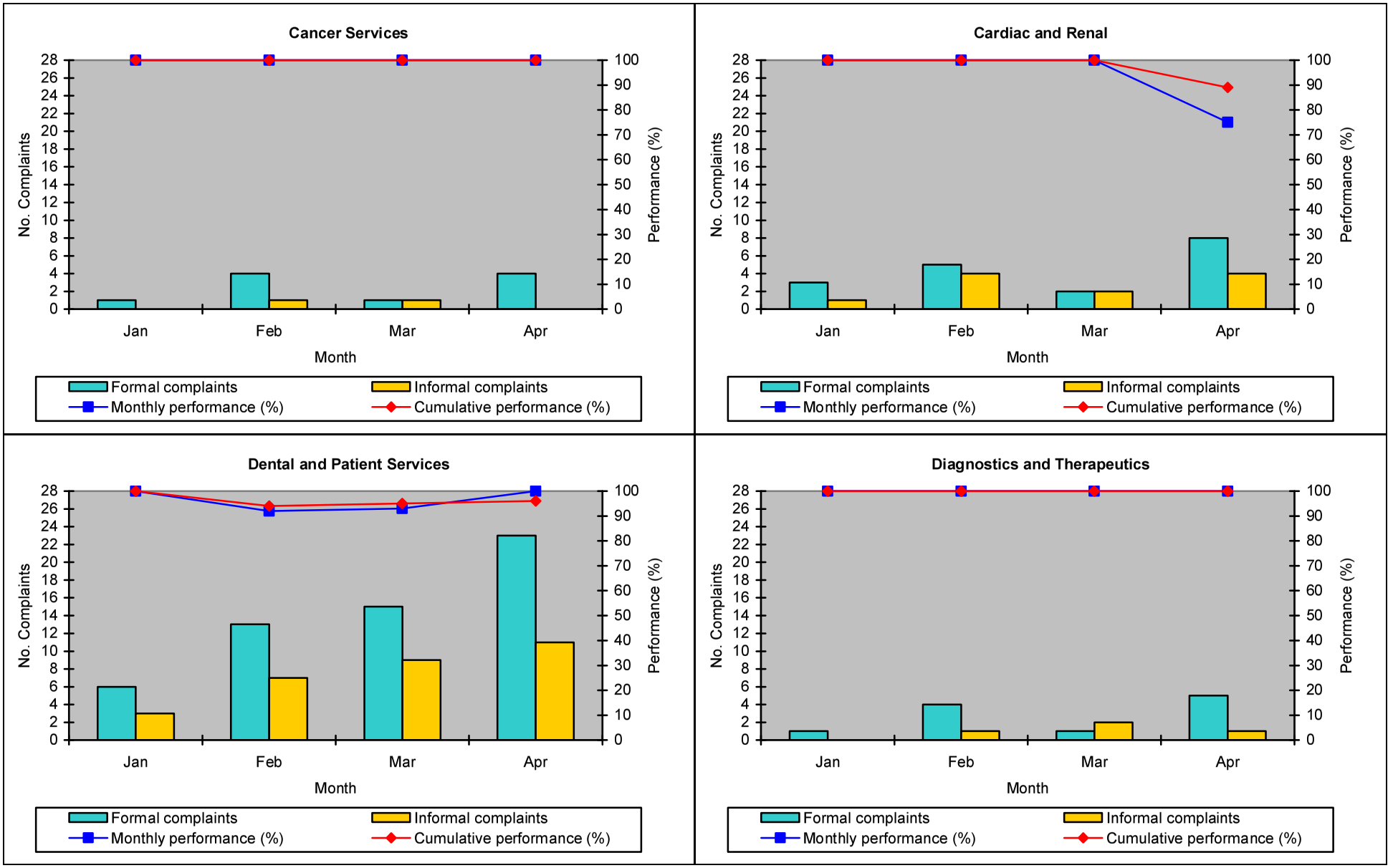




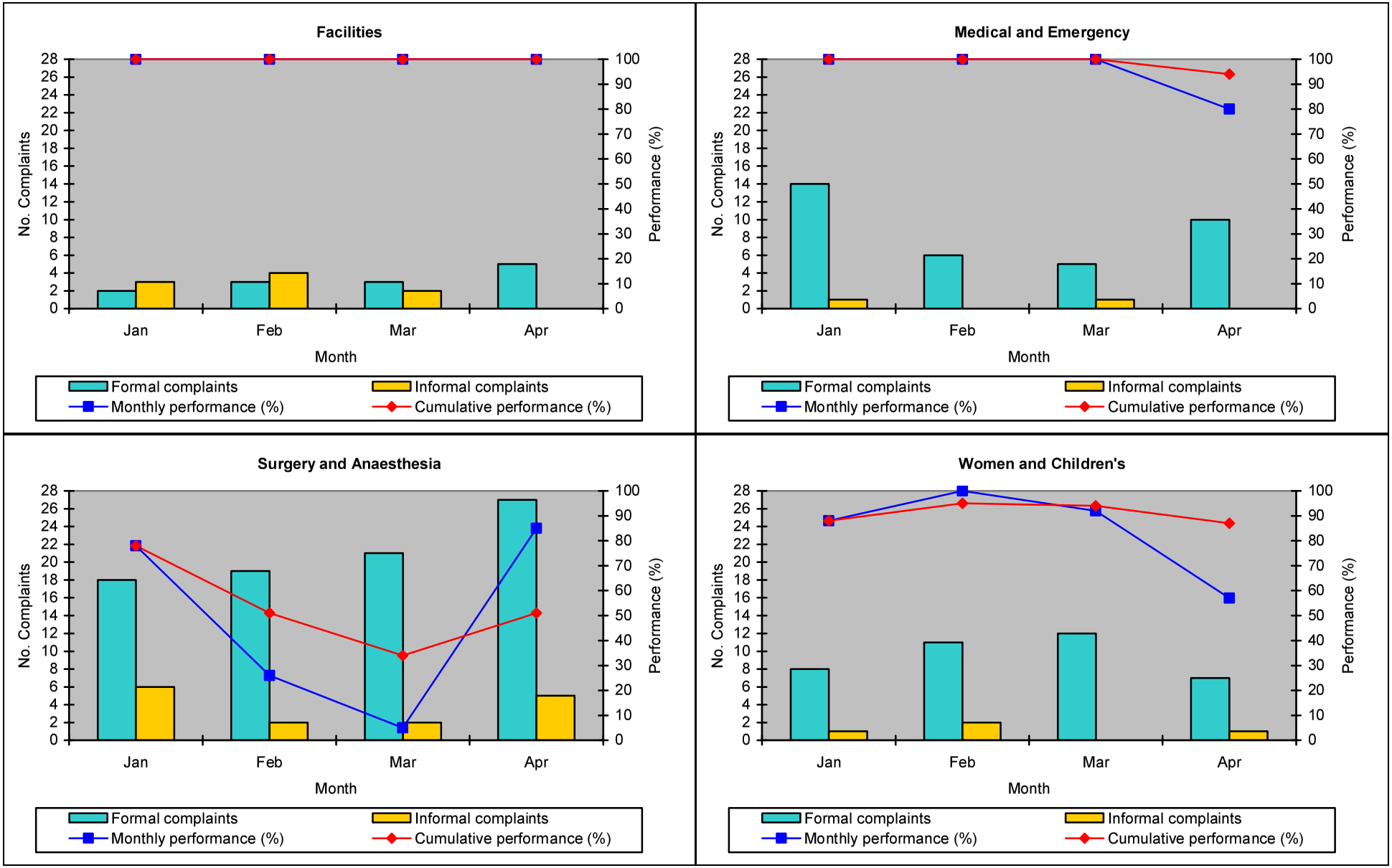
Between 1st and 30th April 2008, 95 formal complaints were received, 49 more than the same period last year. 82% have been responded to within 25 working days (tabulated results per directorate are shown in Appendix 1).

NB: Performance figures relate to formal complaints only.

COMPLAINTS PERFORMANCE BY DIRECTORATE



CGC 54- 08


Facilities
Medical and Emergency
Surgery and Anaesthesia
Women and Children's
No. Complaints
Performance (%)
Month
Jan
Feb
Mar
Apr
Formal complaints
Informal complaints
Monthly performance (%)
Cumulative performance (%)

OVERDUE COMPLAINT RESPONSES APRIL 2008				
Directorate	Delay in directorate	Delay in Quality Development	Delay in Trust HQ	Explanation and reference
CR	•			**CR/08-04** Late responses from clinicians.
	•			**CR/08-07** Difficulty locating medical records.
CORP	•			**QD/08-01** Delayed investigation due to number of staff involved in response
	•			**SA/08-06** Records missing
	•			**SA/08-11** Records missing
	•			**CR/08-10** Records missing
	•			**CR/08-15** Records missing
	•			**ME/08-13** Records missing
ME	•			**ME/08-04** Awaiting response from consultant
	•			**ME/08-07** Dispute over reimbursement
SA	•			**SA/07-288** Delay arranging patient's appointment
			•	**SA/08-01** Returned with comments after due date
		•		**SA/08-02** Delay in proofreading
		•		**SA/08-07** Delay in proofreading
WC	•			**WC/08-01** Complex case – investigation delayed due to staff sickness
	•			**WC/08-05** Complex case – investigation delayed due to staff sickness
	•			**WC/08-06** Complex case – investigation delayed due to staff sickness
Total	**14**	**2**	**1**	**17**

6 draft complaint responses were returned from Trust Offices for amendment in April. 2 needed simplifying, 2 were bureaucratic and needed personalising, and 2 needed further clarification as the explanations were ambiguous.

CGC 54- 08

DIRECTORATE COMPLAINT RISK GRADING						
Directorate	Sig	High	Mod	Low	Ungraded	Significant/ High Risk Case Synopsis
CORP		1			5	**QD/08-01** Missed diagnosis of undisplaced fracture in A&E. Patient subsequently spent time in various wards at BLT and MEH where her fracture was displaced. She died following post-operative complications.
CR					8	
CS			4			
DPS		19	3	1		**DPS/07-156** Problems contacting Central Appointments. **DPS/08-02** Problems contacting Central Appointments. **DPS/08-04** Problems contacting Central Appointments. **DPS/08-07** Problems contacting Central Appointments. **DPS/08-09** Patient did not receive notification of cancellation. **DPS/08-11** Problems contacting Central Appointments. Patient then received a standard letter saying she had not contacted the Trust. **DPS/08-12** Problems contacting Central Appointments. **DPS/08-16** Patient arrived for appointment to be told she had not been booked to see the correct consultant. Also has now been refused transport. **DPS/08-17** Problems contacting Central Appointments. **DPS/08-18** Problems contacting Central Appointments and no reply to email. **DPS/08-20** Problems contacting Central Appointments and was not given an appointment despite going to the department in person. **DPS/08-22** Problems contacting Central Appointments. **DPS/08-25** Problems contacting Central Appointments and no reply to email. **DPS/08-28** Patient was booked into the wrong clinic. **DPS/08-29** Problems contacting Central Appointments and no reply to email. Patient was not then notified that appointment had been cancelled. **DPS/08-31**

[redacted]						Problems contacting Central Appointments. **DPS/08-32** Problems contacting Central Appointments. **DPS/08-33** Problems contacting Central Appointments. **DPS/08-34** Problems contacting Central Appointments then was not called back as promised.
DT			2		3	
FAC				5		
MED		2	4	2	2	**ME/08-06** Missed fracture in A&E. **ME/08-07** Patient was given positive STI result in error.
SA		1		1	25	**SA/08-16** Patient experienced problems with Central Appointments and during pre-admission clinic.
WC			7			
Total		23	20	9	43	**95**

HEALTHCARE COMMISSION CASES SINCE 01/04/08

Dates noted in red show where submission to HCC failed to meet the deadline

Directorate	Agreed deadline	Date sent	Returned for LR	Not upheld	Partially upheld	Fully upheld	Awaiting decision	Summary
CR	16/05/08	File not sent					•	**CR/07-62** Complaint from family of deceased patient regarding many aspects of care prior to patient's death.
DT	23/04/08	21/04/08					•	**PIP/07-32** Patient was caused extreme pain when being moved in appropriate position for scanning.
Total	[redacted]						2	[redacted]
Total HCC cases received 2007/8		25						

HEALTH SERVICE OMBUDSMAN CASES SINCE 01/04/07

Dates noted in red show where submission to HSO failed to meet the deadline

Directorate	Agreed deadline	Date sent	Returned for LR	Not upheld	Partially upheld	Fully upheld	Awaiting decision	Summary
There have been no referrals to the HSO this year								

Jarrard O'Brien
Quality and Effectiveness Manager (Complaints)

CGC 54- 08

Appendix 1

DIRECTORATE COMPLAINT PERFORMANCE																		
Directorate	April			May			June			July			August			September		
	No.	Mon%	YTD%	No.	Mon%	YTD%	No.	Mon%	YTD%	No.	Mon%	YTD%	No.	Mon%	YTD%	No.	Mon%	YTD%
CS	4	100	100															
CORP	6	0	11															
CR	8	75	89															
DPS	23	100	96															
DT	5	100	100															
FAC	5	100	100															
MED	10	80	94															
SA	27	85	51															
WC	7	57	87															
Total	95	82	78															

Directorate	October			November			December			January			February			March		
	No.	Mon%	YTD%	No.	Mon%	YTD%	No.	Mon%	YTD%	No.	Mon%	YTD%	No.	Mon%	YTD%	No.	Mon%	YTD%
CS										1	100	100	4	100	100	1	100	100
CORP										1	0	44	0	N/A	44	2	50	45
CR										3	100	80	5	100	83	2	100	83
DPS										6	100	97	13	92	97	15	93	96
DT										1	100	100	4	100	100	1	100	100
FAC										2	100	93	3	100	93	3	100	94
MED										14	100	90	6	100	91	5	100	92
SA										18	78	79	19	26	74	21	5	67
WC										8	88	73	11	100	77	12	92	78
Total										54	89	86	65	77	85	62	63	83

Appendix 2

Formal Complaints Received 1 April - 3 June 2008 (2007)

	CS	CR	CORP	DT	DPS	FAC	ME	SA	WC	Total
Advice and Information					1 (1)		2	4		**7 (1)**
Anaesthetics								0 (1)		**0 (1)**
Appointments / Clinics	1	0 (4)		4	40 (5)		12	24 (3)	3 (1)	**84 (13)**
Communication - verbal / written / electronic	3	3		1 (4)	4 (6)	1	2 (3)	5 (5)	4 (5)	**23 (23)**
Consent		1								**1**
Delays in care	2	0 (1)		1	1		2 (3)	2 (8)	2	**10 (12)**
Diagnosis / Treatment		6 (1)	1	0 (1)			5 (1)	11 (9)	1	**24 (12)**
Environment				1		5 (8)	3	1	0 (2)	**10 (10)**
Equipment and supplies		1								**1**
Food								1		**1**
Healthcare records / X-rays / Scans				0 (1)	5 (1)		0 (1)		1	**6 (3)**
Infection related	0 (1)						1 (1)	3 (1)		**4 (3)**
Medication / Radiation				3						**3**
Obstetrics									3	**3**
Patient action							1			**1**
Patient falls					1					**1**
Privacy and dignity		0 (2)								**0 (2)**
Security and unacceptable behaviour						2 (1)				**2 (1)**
Specimen issues / Pneumatic tube									1	**1**
Surgical / Invasive procedures		3						6 (4)		**9 (4)**
Transport	0 (8)					6 (1)				**6 (9)**
Totals:	**6 (9)**	**14 (8)**	**1**	**10 (6)**	**52 (13)**	**14 (10)**	**28 (9)**	**57 (31)**	**15 (8)**	**197 (94)**

The Trust received 103 more formal complaints than the same period last year. 71 (69%) of these are due to appointment issues, largely from DPS, MED and SA. There was also double the number of clinical complaints about diagnosis/ treatment. Complaints about transport have gone down and this topic is no longer one of the top five causes of complaint.

Only 1 extra informal complaint was recorded than for the same period last year, from 33 to 34. However, this figure is grossly under-reported as the numbers were so high that it was not feasible to capture these on Datix. DPS alone received 309 informal complaints about appointments in April 2008 and added to this are those received in Quality Development and by PALS.

Committee	Date	Classification	Report No.	Agenda Item No.
Health Scrutiny Panel	**22 July 2008**	**Unrestricted**		**4**
Report of: **Tower Hamlets PCT** **Originating Officer(s):** **Jane Hughes**		**Title:** **St Pauls way Medical Centre Briefing Note** **Ward(s) affected: Mile End East & neighbouring Wards using the Centre**		

1. Summary

1.1 This briefing note summarises the General Medical Services now operated from the St Paul's Way, Bow, site in North East Locality (LAP 6) by ATOS Healthcare in contract to Tower Hamlets PCT. ATOS Healthcare now operate and run the full service from the same site within a commercial contract with the PCT. The contract period is 10 years. Clinical quality has improved, availability increased and the list size of 10,820 registered patients has been maintained.

2. Recommendations

2.1 The PCT would welcome a discussion with the Panel on any aspects of the quality of care provided by the practice which is causing residents concern so that these can be addressed by the PCT with ATOS.

LOCAL GOVERNMENT ACT, 2000 (SECTION 97)
LIST OF "BACKGROUND PAPERS" USED IN THE PREPARATION OF THIS REPORT

Background paper	Name and telephone number of and address where open to inspection
Scrutiny Review File held in Scrutiny Policy Team	Afazul Hoque 020 7364 4636

3. Background

3.1 The practice was taken over by the Primary Care Trust (PCT) from a two doctor partnership because of the low standard of clinical services provided by the GPs. The interim arrangement was that the service would be run by the PCT Community Services Directorate. Throughout the interim period the service improved clinical care for patients and complaints reduced. However the cost of the service rose and remained above average, mostly because many staff were locums and agency. In 2007 the practice scored only 53% for patient satisfaction in the national Mori poll. The PCT undertook a competitive tendering process which involved all of the stakeholders, including the HSP. In January 2008 following a competitive tender process, a new provider was procured.

4. Concurrent Report of the Assistant Chief Executive (Legal Services)

4.1 N/A

5. Comments of the Chief Financial Officer

5.1 N/A

6. Equal Opportunity Implications

6.1 The contract with ATOS Healthcare is providing a high quality GP service to a deprived part of the Borough. It is providing increased access and a wider range of culturally sensitive services.

7. Anti-Poverty Implications

7.1 The company are employing local staff in the Practice.

8. Sustainable Action for a Greener Environment

8.1 N/A

9. Risk Management Implications

9.1 N/A

Tower Hamlets Primary Care Trust

St Pauls Way Medical Centre Briefing Note

July 2008

1 Introduction

This briefing note summarises the General Medical Services now operated from the St Paul's Way, Bow, site in North East Locality (LAP 6)

The practice was taken over by the Primary Care Trust (PCT) from a two doctor partnership because of the low standard of clinical services provided by the GPs. The interim arrangement was that the service would be run by the PCT Community Services Directorate. Throughout the interim period the service improved clinical care for patients and complaints reduced. However the cost of the service rose and remained above average, mostly because many staff were locums and agency. In 2007 the practice scored only 53% for patient satisfaction in the national Mori poll.

In January 2008 following a competitive tender process, a new provider was procured. ATOS Healthcare now operate and run the full service from the same site within a commercial contract with the PCT. The contract period is 10 years. The list size was 10,820 registered patients and this has been maintained.

2 Service changes from January 2008.

2.1 Planned service changes

The specification for the new service comprised a broader and more flexible approach to primary care resulting in significant changes to the model of service. The key non negotiable aspects of the specification were:

Longer opening hours	0800 – 2000 hours, Monday to Friday 0900 - 1700 hours, Saturdays
Improved clinician availability	A doctor and nurse available throughout the day, every day to see patients
Flexibility of access	A walk in service to see a clinician every day A telephone service to speak to a clinician every day

The experience of the PCT taking over a GP practice is that the sustainable changes can take up to a year to bed down. The staff and patients naturally become unsettled before and immediately after the transfer and it is important for the new provider to be sensitive to this and be responsive. The change takes two levels, organisational and clinical care. Organisational

ones have the greatest impact to the perception of staff and patients and are early wins. Clinical improvements however, do take longer relying on both organisational improvements and robust clinical systems including governance.

2.2 Actual changes since the service began

The service opened 31 January 2008. In March 2008 ATOS Healthcare implemented the planned changes above. They had a number of other changes required which were broadly:

- Recruit more staff for the longer opening hours
- Reorganise the entire staffing compliment to provide the new service
- Implement the community engagement plan so that the patients and local community have effective dialogue and can influence the nature of how services are provided
- Implement the full range of enhanced (specialist services) that the PCT wishes all patients to receive such as smoking cessation, sexual health, BCG, Phlebotomy.

On handover of the service and building (leased) the PCT had just completed a refurbishment which is almost complete.

The next section described the current activities in more detail

3 Detailed progress to date

3.1 Opening hours and services offered

1st March 2008 the service is now open 0800 – 2000 hours, Monday to Friday and 0900 - 1700 hours on Saturdays

There is improved clinician availability as the service does not close at any time during these hours and a GP and/or nurse is always available to see patients.

The service is more flexible by providing the following:

1. Standard pre-booked general practice clinics with General Practitioners and Practice Nurses.
2. a “walk-in” service for patients presenting with uncomplicated illnesses or injuries requiring an urgent consultation
3. A telephone advice service is in place in which a GP speaks to patients to give advice on minor illnesses, test results, and medication queries.
4. Undertakes home visits.
5. Practice nurse clinics include services such as cervical cytology, travel vaccinations, blood pressure checks, asthma clinics, diabetic clinics and baby vaccinations.

There is an agreed roll out programme in place for enhanced services to the patients over the next 18 months, which include smoking cessation clinics, coil insertion, Chlamydia testing, minor surgery and anti-coagulation clinics. As the PCT develops more services form all of

Tower Hamlets, ATOS Healthcare will be invited along with other GP Practices to provide them to their patients.

3.2 Recruitment

The recruitment process for extra staff is underway. Appointments for doctors are almost complete which has included female doctors because of the need and demand from patients.

Nursing recruitment for a nurse practitioner is continuing.

3.3 Reorganising the staffing compliment

Due to the need to optimise service delivery and ensure the PCT's quality and service requirements are met, in particular in relation to the extended opening hours, the Atos Healthcare service delivery model is built on a local management structure that differs from the structure previously in place at the practice. This process will be finished this month.

3.4 Community Engagement

Atos Healthcare has appointed a senior manager in their team to take responsibility for planning the community engagement activity for St Paul's Way.

i) The patients: Atos Healthcare met with the Patient Participation Group (PPG) in February 2008 and found the patients very receptive to meeting with ATOS.

ii) The locality neighbourhood manager has met with Atos and is facilitating meetings with residential groups locally.

ii) Local environment: a plan for art work in St Pauls Way is being developed with Claire Palmier, and includes the Students at St Pauls Way community school

iii) heath economy: the pharmacy in St Pauls Way has now increased their opening hours to 0800 – 2000 hours in response to the GP surgery being open.

v) since March 2008 a patient satisfaction was begun using feedback slips. Although early days the feedback is valuable and indicating a wide range of experiences which will be used for discussed with the PPG.

4 Quality control and contract compliance

4.1 Quality measures

ATOS took over in January 2008 so the quality outcome framework scores (QOF) the public are aware of have not yet been published but based on 2007/8 figures are expected to be high.

Access has improved significantly for patients as ATOS operate a ratio of 105 appointments per 1,000 patients per week whereas the PCT expects all practices to offer 72 appointments per 1,000 patients per week. The service is one of only three in the borough to operate the range of opening hours and the cost per patients is not amongst the highest indicatating significant value for money. In the recent access Mori Poll the practice scored 64% satisfaction rate for the ability to get an appointment within 48 hours. This is a 11% improvement on the 2006/07s Poll and just below the average across the whole of the PCT.

The QOF scores are available as one indicator of quality, in 2005 when the PCT took over the practice much work was done to validate the patient's records and QOF. As a result a fairer assessment of the QOF achievement was established in 2006/7. In 2007/08 the practice achieved 90% of the total available QoF points and 98% of the available clinical QoF indicators. This is an 8.4% improvement.

Clinical governance is an essential component of safe clinical care. A plan of activity has been agreed with the PCT to improve the quality and consistency of care that patients receive at St Paul's Way Medical Centre. This is being achieved by the full implementation of the ATOS Clinical Governance Programme. The local team is supported by experienced colleagues from the wider Atos Healthcare. The lead practitioners work closely with operational managers in all clinical governance areas to support continual review and service improvement with processes embedded in clinical audit, incident reporting and risk assessment. Increasingly high standards of care are promoted. A summary of the Clinical Governance Programme includes:

i) A St Paul's Way Clinical Governance team established within the practice led by the Practice Manager and assisted by a Clinical Governance Lead GP and Lead Nurse. The Lead GP holds accountability for clinical governance in the practice and is be closely supported by Dr Peter Taylor, ATOS Clinical Director of Primary Care, who is a member of Atos Healthcare's Clinical Governance Board chaired by Dr Carol Hudson, Chief Medical Officer. Dr Taylor also practices two days a week as a GP at St Paul's Way and has a good knowledge of the practice and the patients.

Ii) Monthly clinical governance meetings to focus on enhancing the clinical improvements that have already been made over the last 18 months. There is an open invitation for a representative from the PCT to attend the meetings and the practice will participate in the clinical governance arrangements of the PCT.

Iii) The practice's clinical and administrative standards are being reviewed and updated to ensure that all aspects of practice operation are covered, that local best practices and policies are included and guidance is in line with Healthcare Commission standards, the requirements of Standards for Better Health and the PCT's Balanced Scorecard Performance Management System.

Iv) Nominated clinical leads for each clinical disease area will be responsible for overseeing best clinical practice, supporting the practice manager in the achievement of QOF indices and meeting the relevant clinical parameters of the PCT's Balanced Scorecard Performance Management System.

v) Newly recruited staff receive comprehensive induction and training which combine a welcome to Atos Healthcare with specific training for the requirements of St Paul's Way. During induction, the relevant members of the practice team will receive mandatory training in resuscitation and life

support, health and safety, manual handling and infection control, vulnerable people as well as medicines management, patient confidentiality, medical records management, incident reporting and risk assessment and other aspects of clinical and administrative procedures. A training needs analysis will identify potential skill-gaps in existing service delivery and the training development requirements for the provision of the additional enhanced services. Ongoing professional development will be managed by the Centre Manager and Lead GP.

Complaints; During the period of 31st January 2008 to 9th April 2008, St Paul's Way Medical Centre received six letters of complaint, which were fully investigated and responded to. ATOS informs the PCT of all complaints and the nature of them.

The PCT incorporated a stronger range of key performance indicators into the contract which emphasise the need to improve clinical care. The indicators do apply from day one of the contract but penalties will not be incurred in year one as the PCT recognises from its own experience that up to a year is needed for a new provider to improve a GP service. Experience with Atos so far has been very positive and It is anticipated that Atos will develop the service and exceed the performance indicators.

4.2 Contract management.

The PCT meets with ATOS Healthcare weekly and has done since the start to ensure progress against the contract requirements. The service is being delivered in accordance with the contract.

5 Summary

Since ATOS origin took over the contract from the 31st January 2008 there has been an increase in the range of services provided to patients as well as access to clinical staff. Monitoring of performance is very regular, taking place on a monthly, quarterly and annual basis with weekly meetings to address any operational issues. Time is still required to embed the service and for the practice to further develop engagement with the local community.

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