LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY PANEL

HELD AT 6.30 P.M. ON TUESDAY, 18 MARCH 2008

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

Members Present:

Councillor Stephanie Eaton (Chair)

Councillor Ann Jackson
Councillor Dr. Emma Jones (Vice-Chair)
Councillor Abjol Miah
Councillor A A Sardar

Guests Present:

Caroline Alexander	–	(Director of Nursing, Tower Hamlets PCT)
Judith Bottriell	–	Associate Director Governance, Barts & The London Trust
Madli Jones	–	Tower Hamlets PCT
Julian Nettel	–	Chief Executive, Barts & The London Trust
Esther Trenchard-Mabere	–	Tower Hamlets PCT

Officers Present:

Jerry Bell	–	Planning Applications Manager
Afazul Hoque	–	(Acting Scrutiny Policy Manager, Scrutiny and Equalities, Chief Executive's)
Michael Keating	–	(Acting Assistant Chief Executive, Chief Executive's)
Shanara Matin	–	(Scrutiny Policy Officer)
Alan Ingram	–	(Democratic Services)

Following the opening of the meeting and introductions, the Chair indicated that this would be the last meeting of the Panel in the current Municipal Year. She extended particular thanks to the Vice-Chair, Councillor Dr. Emma Jones, who had acted as Chair of the Panel on a number of occasions.

1. APOLOGIES FOR ABSENCE

Apologies were submitted on behalf of Deborah Cohen, Service Head Disabilities and Health.

2. DECLARATIONS OF INTEREST

Councillor A.A. Sardar declared a personal interest in that his daughter was employed by the Tower Hamlets Primary Care Trust.

3. UNRESTRICTED MINUTES

Councillor Jackson asked that it be recorded that, during discussion of agenda item 4.1 “Cardiology and Research at the London Chest Hospital” she had asked that the PCT consider a communications link with the Council in regard to all their current research projects.

RESOLVED

That, subject to the above addition, the minutes of the meeting of the Health Scrutiny Panel held on 18th December 2007 be approved as a correct record and the Chair be authorised to sign them accordingly,

MATTERS ARISING

(a) Page 6 – Agenda Item 4.3 – Annual Health Check Results 2006/07

The Chair asked whether a response had yet been received from Linnie Evans concerning safeguards that might be in place for underperforming PCTs with regard to securing finance. Shanara Matin, Scrutiny Policy Officer, replied that that the information had not been received and she would progress the matter.

(b) Page 6 – Agenda Item 4.4 – Links – Verbal Update

The Chair queried the position regarding the submission of a written update and Shanara Matin confirmed that this had been circulated to Members.

(c) Page 8 – Agenda Item 4.7 – 2008/09 Commissioning Intentions and Operating Plan

The Chair requested an update on the request for Jeremy Burden to provide a comprehensive list of programmes being funded in the next year. Shanara Matin replied that the Drugs Action Team had been asked for the information and she would chase up the request.

4. REPORTS FOR CONSIDERATION

4.1 Tower Hamlets PCT Declaration to the Healthcare Commission 2007/2008

Caroline Alexander, Director of Nursing, Tower Hamlets PCT, introduced the report setting out the Tower Hamlets Primary Care Trust Declaration to the Healthcare Commission. The PCT Board had to carry out an annual self-assessment and particular attention had to be given to the co-ordination of health care and monitoring and core standards processes. 44 core standards had to be monitored, with particular reference to the Hygiene Code implementation measures, including their application by commissioned service providers.

The final assessment session would be held on 25th March, for submission to the PCT Board of the completed assessment on 4th April 2008. The annual review of health care had already been signed off by the Board and there had been no major concerns regarding commissioning.

Following a detailed presentation, Ms Alexander, together with Madli Jones and Esther Trenchard-Mabere of the PCT, responded to questions from Members concerning the following:

- Measures adopted to ensure the full application and monitoring of the Hygiene Code.
- Action that was possible to address underperforming GP practices.
- The launch of a recruitment strategy to address the need for more Bangladeshi health care staff, especially in the fields of nursing and midwifery. This was being rolled out London-wide.
- Core Standard C11 (staff training): this would ensure that staff provided smoking cessation advice in meetings with clients. This requirement was strongly embedded in the contract for service providers and would be closely monitored throughout the year.
- The provision of customer care training that would extend from top management to cleaning staff. An ongoing programme would ensure that each GP practice would receive three days' training in how to transform the patient experience, with attention directed also to cultural sensitivities, privacy measures and the interpreting process. The Shah Jalal medical centre reception area had been redesigned with patient privacy in mind.
- Smoking cessation work to be undertaken to address the high levels of cigarette smoking by Eastern European immigrants.
- Improvements to be made to the PCT website, which had not previously been considered user-friendly.
- Core standard C21, concerning the environment for healthcare service provision, would comprise a huge capital programme to ensure that each area would have new facilities, to be provided over a 10 year period. It was pointed out that the Newby Street medical centre, to be opened in two years, would be at least as large as the new Barkantine centre.
- Concerns had arisen about the Darzi proposals for closing small GP practices; however, the aim was to increase primary care and provide additional facilities. A network federated model was being developed to avoid closures and work was in progress with developers and partners in this connection.

- In connection with core standard C23, Smoking Cessation, a Tobacco Control Team had been established to develop a more systematic approach to the production of anti-smoking measures and the evaluation of related publicity material. A targeted approach was also being developed with regard to pregnant women and Bangladeshi men. In addition, the use of khat and paan was under scrutiny.

RESOLVED

That the Tower Hamlets Primary Care Trust Declaration to the Healthcare Commission be noted and that the following comments of the Scrutiny Panel also be taken on board by PCT officers:

- Consideration of the development of advice to be given when medical help/ambulances are required for mental health patients.
- Transport for London had asked if the PCT could consult with them more frequently, especially concerning patient access to facilities.
- The PCT Access Strategy Group should be reviewed to look at the possibility of including patients on its membership (currently there are no patient members).
- A review was needed of how the PCT engaged with LAPs to increase community involvement. (At present, engagement seems mostly to comprise links with LAPs 1 and 5.)

4.2 Barts and the London NHS Trust Declaration to the Healthcare Commission 2007/2008

The Panel received a presentation made by Julian Nettel, Chief Executive of the Barts and The London Trust (BLT) and Judith Bottriell, Associate Director of Governance, BLT, on the matter of the organisation's Annual Health Check 2007/08. Relevant documentation was tabled at the meeting.

Julian Nettel commented that research studies were especially easy to run in the Borough, as communities were particularly delineated. The Trust had to consider the necessary competencies, skills and mindsets of people who would be providing services in future. He added that the Barts and The London Hospital redevelopment was probably the biggest such scheme currently in progress in the world. The Trust recognised that, in the past, too much emphasis had been placed on government targets and finances. Improvements in the safety environment were underway and lay people were being involved in development processes.

Judith Bottriell provided a detailed commentary on processes relating to the Annual Health Check and its underlying principles. She indicated that the annual assessment was almost ready and would be signed off by the Trust Board on 23rd April 2008. Points of particular significance arose around the proactive role for Patient Environment Action Teams (PEAT) for inspection purposes and analysis of subsequent results, which could be shared with the Council. It was necessary to provide a statement on the Hygiene Code and no material breaches of the code had been discovered in spot visits. This

was important in the control of c-difficile and much money had been invested in infection control measures.

Ms Bottriell added that Patient Forums had also addressed the matter of privacy/dignity on wards. In this regard, Nightingale mixed wards would still pose a challenge until the new hospital was built but efforts were made to cohort patients on the wards by gender. The red tray system was used to identify elderly patients who might need assistance with eating and a bedside questionnaire was in place for a patient satisfaction survey.

Ms Bottriell provided further information on improvements to waiting times for cancer patients; the identification of ethnicity data; improved day case rates for BADS procedures; low rates of elective operations cancelled on the day; good progress on the 18 week target for treatment following initial GP referrals.

In the public health domain, it was anticipated that, again, there would be no significant lapses. There were new screening measures for haemoglobin variants and the reduction in MRSA cases in renal treatments had been commended. Staff still found difficulties in challenging smoking by patients and their relatives in Trust premises and this was being addressed. A multi-agency Major Incident Plan was now in place.

The Chair invited Members' questions and responses were provided by Mr Nettel and Ms Bottriell on the following matters:

- Patients could be recruited for research by their GP or through particular clinics. Any blood or tissue samples taken had to be obtained, stored and subsequently destroyed in accordance with the requirements of the Human Tissue Act.
- Treatment times for non-urgent in-patients were included with the 18 week period from first referral. The target for achieving such pathways for admitted pathways was 85% by the end of March and the Trust was already achieving around the 80% mark.
- The bedside questionnaire would not be an extra duty for nursing staff as it was provided as part of the bedside folder information and was to be completed voluntarily by patients. Analysis of results would be undertaken by the clinical audit department. The questionnaire was only one of the data gathering tools available and Matrons were keen to maintain it.
- It was confirmed that collaborations into researching of new care and treatment would include the London Chest Hospital (for stem cell research) and would benefit the East London community.
- With regard to specific ailments in particular communities, it was confirmed that means of prevention were being developed, including influencing cardiac disease, diabetes and obesity through lifestyle and dietary changes.
- Accountability for the Trust's functions was delegated to the Trust members by the Secretary of State and they were also accountable to Commissioners and to the public through various forums.

- On quality of service, the view was taken that provision of a fast and responsive service would result in targets being achieved. Emphasis was always placed on doing what was right for the patient. It was acknowledged that feedback arrangements could also be reviewed to include visitors, carers and volunteers.
- The poor result of the maternity services evaluation had caused concern but Trust members had given firm views about improvements that were needed. Extra resources were being directed to improve midwifery and obstetrics facilities, along with the introduction of minimum standards of acceptability. Uncompromising monitoring was also being introduced and this was to be extended to all service areas Trust-wide.
- Evidence was available which showed that academic hospitals involving patients in studies made a big difference in reducing mortality rates and providing a better service to patients.
- The difficulties recently experienced in identifying different staff due to lack of uniforms would be given further consideration.

The BLT representatives confirmed that they would take back Members' comments for further attention and the Chair added that the Scrutiny Panel would continue to feed back information to the BLT and PCT.

RESOLVED

That the information be noted.

4.3 Draft Health Scrutiny Protocol

The Chair expressed the hope that the introduction of the protocol would help improve the way in which the Panel worked with its partners.

Jerry Bell, Planning Applications Manager, commented on how the protocol had been developed and added that members of the Panel's Trust partners were keen for Panel members to visit premises to see the work processes. It was also felt desirable that there should be a single point of contact at the Council for all Trusts to use for a complete year period for the Panel.

Julian Nettel pointed out that the proposed requirement for the Panel to be involved in all service moves/variations of NHS bodies could be problematic given the constant shift in arrangements for service provision. The Panel could be better informed by receiving details of major proposed service variations, in view of preparations being made for moving into the new hospital. This could be adopted as a matter of principal, with the details being worked out later and would avoid services being hidebound by administrative processes.

The Chair added that the Panel would also like to be in the position of affecting NHS bodies' decisions and make relevant decisions themselves.

RESOLVED

That the draft protocol be agreed, subject to the comments made above.

4.4 Tobacco/Smoking Cessation Review - Draft Report

The Chair commented that the circulated report was to be regarded as the final draft for confirmation.

Members asked that the conclusions and recommendations in the report should be included on the young Mayor's agenda because of the importance of ensuring young people do not take up smoking. In addition, targeted anti-smoking advertising was requested specifically around schools, in newsagents, etc., so as to affect children directly.

The Chair thanked all involved in work on what had been a difficult review.

RESOLVED

(1) That the additional comments be noted.
(2) That final approval of the report be delegated to the Acting Assistant Chief Executive after consultation with the Chair of the Health Scrutiny Panel.

4.5 Challenge Session on Access to GP and Dentistry Services Review Action Plan

Councillor Dr Emma Jones reported on the outcome of the Scrutiny Challenge Session held on 19th February 2008, which had produced satisfactory results.

The Chair expressed the view that this should be an ongoing, year on year process, irrespective of any changes in Scrutiny Panel membership.

RESOLVED

That the outcome of the consideration of the report on the Integrated Commissioning of health and social care services for adults be agreed.

4.6 Interim Findings of the Joint Overview and Scrutiny Committee considering the Healthcare for London Report

The Chair opened the discussion and asked whether it was felt that the Panel would want to contribute comments to the Joint Overview and Scrutiny Committee.

Members expressed the opinion that the provision of polyclinics should not rule out the existence of smaller GP surgeries where patients were known personally. In addition, the Panel had a role in engaging with other areas of Adult Social Care.

RESOLVED

That a response be put forward to the Joint Overview and Scrutiny Committee after consultation with colleagues in Social Care.

The meeting ended at 8.35 p.m.

Chair, Councillor Stephanie Eaton
Health Scrutiny Panel