Public Document Pack

# JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

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|---|---|---|
| **4.00 pm** | **Tuesday 18 April 2017** | **Waltham Forest Town Hall, Forest Road, Walthamstow, E17 4JF** |

**LONDON BOROUGH OF BARKING & DAGENHAM**

**Councillor Peter Chand**
**Councillor Linda Zanitchkhah**
**Councillor Jane Jones**

**LONDON BOROUGH OF WALTHAM FOREST**

**Councillor Richard Sweden (Chairman)**
**Councillor Anna Mbachu**
**Councillor Tim James**

**LONDON BOROUGH OF HAVERING**

**Councillor Dilip Patel**
**Councillor Michael White**
**Councillor June Alexander**

**ESSEX COUNTY COUNCIL**
**Councillor Chris Pond**

**LONDON BOROUGH OF REDBRIDGE**

**Councillor Stuart Bellwood**
**Councillor Suzanne Nolan**
**Councillor Neil Zammett**

**EPPING FOREST DISTRICT COUNCIL**
**Councillor Gagan Mohindra**
**(Observer Member)**

**CO-OPTED MEMBERS:**

**Ian Buckmaster, Healthwatch Havering**
**Mike New, Healthwatch Redbridge**
**Richard Vann, Healthwatch Barking & Dagenham**
**Alli Anthony, Healthwatch Waltham Forest**

**For information about the meeting please contact:**
**Anthony Clements**
**anthony.clements@oneSource.co.uk 01708 433065**

## Protocol for members of the public wishing to report on meetings of the London Borough of Havering

Members of the public are entitled to report on meetings of Council, Committees and Cabinet, except in circumstances where the public have been excluded as permitted by law.

Reporting means:-

- filming, photographing or making an audio recording of the proceedings of the meeting;
- using any other means for enabling persons not present to see or hear proceedings at a meeting as it takes place or later; or
- reporting or providing commentary on proceedings at a meeting, orally or in writing, so that the report or commentary is available as the meeting takes place or later if the person is not present.

Anyone present at a meeting as it takes place is not permitted to carry out an oral commentary or report. This is to prevent the business of the meeting being disrupted.

Anyone attending a meeting is asked to advise Democratic Services staff on 01708 433076 that they wish to report on the meeting and how they wish to do so. This is to enable employees to guide anyone choosing to report on proceedings to an appropriate place from which to be able to report effectively.

Members of the public are asked to remain seated throughout the meeting as standing up and walking around could distract from the business in hand.

Essex County Council

Waltham Forest

Havering LONDON BOROUGH

London Borough of Redbridge

London Borough of Barking & Dagenham lbbd.gov.uk

# NOTES ABOUT THE MEETING

## 1. HEALTH AND SAFETY

The Joint Committee is committed to protecting the health and safety of everyone who attends its meetings.

At the beginning of the meeting, there will be an announcement about what you should do if there is an emergency during its course. **For your own safety and that of others at the meeting, please comply with any instructions given to you about evacuation of the building, or any other safety related matters.**

## 2. CONDUCT AT THE MEETING

Although members of the public are welcome to attend meetings of the Joint Committee, they have no right to speak at them. Seating for the public is, however, limited and the Joint Committee cannot guarantee that everyone who wants to be present in the meeting room can be accommodated. When it is known in advance that there is likely to be particular public interest in an item the Joint Committee will endeavour to provide an overspill room in which, by use of television links, members of the public will be able to see and hear most of the proceedings.

The Chairman of the meeting has discretion, however, to invite members of the public to ask questions or to respond to points raised by Members. Those who wish to do that may find it helpful to advise the Clerk before the meeting so that the Chairman is aware that someone wishes to ask a question.

PLEASE REMEMBER THAT THE CHAIRMAN MAY REQUIRE ANYONE WHO ACTS IN A DISRUPTIVE MANNER TO LEAVE THE MEETING AND THAT THE MEETING MAY BE ADJOURNED IF NECESSARY WHILE THAT IS ARRANGED.

If you need to leave the meeting before its end, please remember that others present have the right to listen to the proceedings without disruption. Please leave quietly and do not engage others in conversation until you have left the meeting room.

## AGENDA ITEMS

**1 CHAIRMAN'S ANNOUNCEMENTS**

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

**2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.**

**3 DISCLOSURE OF INTERESTS**

Members are invited to declare any interests in any of the items on the agenda at this point of the meeting. Members may still declare an interest in an item at any point prior to the consideration of the matter.

**4 MINUTES OF PREVIOUS MEETING** (Pages 1 - 8)

To agree as a correct record the minutes of the meeting of the Committee held on 17 January 2017 (attached) and to authorise the Chairman to sign them.

**5 INTEGRATED URGENT CARE AND NHS 111 PROCUREMENT UPDATE** (Pages 9 - 20)

Report and presentation attached.

**6 OUTCOME OF BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS' NHS TRUST CARE QUALITY COMMISSION INSPECTION** (Pages 21 - 86)

Report and presentation attached.

**7 PRIMARY MEDICAL SERVICES CONTRACT UPDATE** (Pages 87 - 106)

Report and presentation attached.

**8 SPENDING NHS MONEY WISELY CONSULTATION** (Pages 107 - 172)

Report, presentation and engagement document attached.

## 9 DATES OF FUTURE MEETINGS

The Committee is asked to agree the following dates and provisional venues for its meetings in the 2017/18 municipal year.

Tuesday 18 July 2017, Barking & Dagenham
Tuesday 10 October 2017, Redbridge
Tuesday 16 January 2018, Havering
Tuesday 3 April 2018, Waltham Forest

The Committee is also asked to agree the start times for the meetings (currently 4 pm).

## 10 URGENT BUSINESS

To consider any item of which the Chairman is of the opinion, by means of special circumstances which shall be specified in the minutes, that the item be considered as a matter of urgency.

**Anthony Clements**
**Clerk to the Joint Committee**

**MINUTES OF A MEETING OF THE**
**JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE**
**Redbridge Town Hall, Ilford**
**17 January 2017 (4.00 - 6.24 pm)**

**Present:**

**COUNCILLORS**

| | |
|---|---|
| **London Borough of Barking & Dagenham** | Peter Chand and Jane Jones |
| **London Borough of Havering** | Michael White and June Alexander |
| **London Borough of Redbridge** | Stuart Bellwood, Suzanne Nolan and Dev Sharma (Chairman) |
| **London Borough of Waltham Forest** | Richard Sweden |
| **Essex County Council** | Chris Pond |
| **Epping Forest District Councillor** | Gagan Mohnidra |
| **Co-opted Members** | Ian Buckmaster (Healthwatch Havering) and Mike New (Healthwatch Redbridge) |

Councillor Neil Zammett, London Borough of Redbridge was also present.

NHS officers present:

Jane Milligan, Executive Lead for North East London Sustainability and Transformation Plan (STP)

Julie Lowe, Director of Provider Transformation, North East London STP

Henry Black, Chief Finance Officer, North East London STP

Ian Tomkins, Director of Communications and Engagement, North East London STP

Dr Russell Razzaque, Associate Medical Director, North East London NHS Foundation Trust (NELFT)

Terry Williamson, Stakeholder Engagement Manager, London Ambulance Service NHS Trust (LAS)

Natasha Wills, LAS
Tim Peachey, Deputy CEO, Barts Health NHS Trust
Debbie Maddern, Operations Director, Whipps Cross Hospital

Scrutiny Officers present:
Masuma Ahmed, Barking & Dagenham
Anthony Clements, Havering (minutes)
Jilly Szymanski, Redbridge

Approximately 20 members of the public were in attendance.

All decisions were taken with no votes against.

The Chairman reminded Members of the action to be taken in an emergency.

## 23 CHAIRMAN'S ANNOUNCEMENTS

The Chairman gave details of arrangements to be followed in case of fire or other event that might require the meeting room or building's evacuation.

## 24 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.

Apologies were received from Councillor Dilip Patel, London Borough of Havering, Councillor Anna Mbachu, London Borough of Waltham Forest and Richard Vann, Healthwatch Barking & Dagenham.

## 25 DISCLOSURE OF INTERESTS

Councillor Sweden disclosed a personal interest in agenda item 6 (Results of Open Dialogue Trial) as he was managed by (though not employed by) NELFT.

## 26 MINUTES OF PREVIOUS MEETING

The minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on 18 October 2016 were agreed as a correct record and signed by the Chairman.

## 27 SUSTAINABILITY AND TRANSFORMATION PLAN

Save Our NHS Group

The Joint Committee was addressed by two representatives from the Save Our NHS group. The group's view was that the Sustainability and

Transformation Plan (STP) aimed to close the A&E department at King George Hospital where 115 acute beds had been removed since 2011. The group was concerned the closure of acute beds would lead to overcrowded A&E departments and hence to more acute deaths.

The group did not feel that the STP would be appropriately resourced to make the proposed changes successful and that the STP had been drawn up in secret with a lack of democratic accountability. In the view of Save Our NHS, key financial details of the STP were being withheld.

It was also felt by the group's representatives that there needed to be better public engagement around the STP. The group was also concerned that the predicted population growth in London over the next 15 years had not been accounted for as no additional hospital was being proposed and it was still planned to close the A&E at King George. The representatives felt that the STP would be devastating for the Ilford South area where a lot of new housing had been proposed but no details had been given of where new health facilities would be located.

There were also concerns that surgeries were forming into larger networks but that there were insufficient GPs to support this. The group felt that the public wished to have care close to home and to trust health professionals.

Presentation from STP team

The STP officers accepted that there been challenges in the STP process. There were a total of 44 STPs across the UK. In North East London, the STP aimed to support local delivery systems.

Work had been undertaken with Local Healthwatch and Community Council organisations and it was accepted that the current health system was not giving the right outcome for patients. The STP aimed to create a new way of working based on a partnership model. It was hoped that North East London would become a place where people wished to live and work. The STP would also seek to establish a career pathway for staff.

Questions and discussion

Councillor Zammett from the London Borough of Redbridge addressed the Committee and felt that the shortfall in NHS beds would not be sustainable in the future. He also asked when bed forecast reconciliation figures would be provided. Officers responded that the decision to close the A&E at King George had been made by the Secretary of State rather than BHRUT. Bed modelling data was likely to be available by the end of April but officers would confirm the timescale for this.

Members asked for clarity over what services would be retained on the King George site if A&E was closed. It was felt important that A&E continued to provide the required standards in terms of both skills and staff numbers.

Other concerns raised by Members included the rising demand on NHS services and how the public could be educated to use other facilities rather than A&E. It was also raised that some 95,000 residents of South west Essex used health services in North East London but there had been little work undertaken with Local Authorities in Essex concerning the STP.

Officers accepted that there had been a lack of engagement with Essex and this would be addressed in the next phase of the STP work. A representative from the Princess Alexandra Hospital in Harlow was on the maternity working group for the plans. Councillor Pond would report these responses back to the chairman of the Essex Health Overview and Scrutiny Committee.

A representative of Healthwatch Havering raised concerns that Queen's Hospital, with one of the busiest A&E departments in London, would not be able to cope if the A&E at King George was closed. Officers agreed that Queen's A&E was already extremely busy and a lot of capital would be required to improve and expand the department at Queen's. Some 50-60% of current A&E cases at King George could still be treated at a planned enhanced urgent care centre on the site where blood tests, x-rays etc could be carried out. Work to expand the A&E at Queen's would take over a year and this depended on capital availability.

The renal dialysis unit at Queen's was currently located next to A&E and there were no plans to close this. It was possible that the facility could move to an alternative site in the local area in order that A&E could be expanded.

Revised figures for population growth in the local area would be factored into the STP plans. The effect of the Private Finance Initiative process for Queen's Hospital would be fed into an estates strategy that was in the process of being developed. As regards housing for hospital staff, capital receipts received for NHS land were not in the control of the STP and this could be part of a London-wide approach. The linking of prescribing pharmacists with GPs was under consideration.

Officers recognised the crisis in primary care and wished to use the STP to bring key components together in order to work differently. The STP team were also starting to meet with different consultant bodies including the British Medical Association.

Officers accepted that health services were not currently delivering best outcomes and the STP was therefore needed in order to develop a different way of working. The impact on Whipps Cross on any closure of A&E at King George would also be considered.

Members felt that the current STP documents were not clear or accessible and that concern about STPs was shared by Councillors across London. Issues such as the expected 18% rise in the population of North East London in the next 15 years had not been taken into account nor had the

NHS financial deficit locally or the shortage of GPs and social care facilities. A national march concerning the NHS was planned for 4 March.

In response, offices felt that the STP could be implemented and a more accessible document would be produced saying what differences the STP would make.

The Chairman thanked the STP and Save Our NHS representatives for their input. The Committee **NOTED** the position.

## 28 RESULTS OF OPEN DIALOGUE TRIAL

The Associate Medical Director at NELFT explained that Open Dialogue was a new technique that allowed people with mental health issues to be seen with their family or friends network. Use of the technique in areas such as Finland and the USA had seen considerable rises in discharge rates from mental health services.

NELFT had formed a coalition of Trusts to develop the technique in the UK, had organised training in Open Dialogue and had submitted a grant application for the evaluation of pilots of the technique that it planned to run in Havering and Waltham Forest. It was hoped that the funding would enable the largest single trial of Open Dialogue to be carried out. It was hoped to evaluate outcomes of the technique over the next 3-4 years and show that Open Dialogue produced marked reductions in the relapse rate and hence that people would not need to return to mental health services. Confirmation of grant funding was hoped to be received by March with pilot teams starting work from mid-2017.

Havering and Waltham Forest had been chosen as pilot sites as on a clinical basis as consultants from these areas had expressed most interest in Open Dialogue. There had also been interest in Open Dialogue from clinicians in Essex but they were not directly involved in the research project. It was hoped to expand the technique into the Essex area in the future. Teams would be based in the Community Recovery Team offices but would also carry out home visits with a 24 hour target response time.

If the funding was not received, other sources of funds would be considered. It was also hoped that local CCGs would fund 1-2 consultant posts specialising in Open Dialogue. The Associate Medical Director would provide details of articles published on Open Dialogue.

The Committee **NOTED** the update.

## 29 GREAT ORMOND STREET HOSPITAL

The Committee recorded its disappointment that, for the second meeting in succession, Great Ormond Street Hospital had sent apologies and not sent a representative to the meeting.

## 30 LONDON AMBULANCE SERVICE

Officers from London Ambulance Service NHS Trust (LAS) agreed that it had been a challenging time for the Trust with rising numbers of category A calls being received across all Outer North East London boroughs. Growth in demand was due to a number of factors including more referrals from both GPs and the NHS 111 service. Work was in progress to seek to manage this demand with organisations including NHS 111, NHS England to improve hospital handover times, and the Police. More proactive efforts were also being made to reduce demand via social media etc. Intelligent conveyancing was also being introduced whereby patients could be taken to less busy A&Es.

The LAS computer aided dispatch system had failed for some hours on 1 January and officers apologised for the long patient waits during this time. One patient was known to have died during this period and this matter was currently being investigated.

A quality improvement plan had been published on the LAS website and the purchase of 160 replacement ambulances had been funded. As regards governance, a new monitoring system had been introduced for medicines management.

Around 700 front line staff had been recruited in the last year and LAS was now fully staffed across London. There were however some local shortfalls in recruitment and these were being addressed.

It was acknowledged that there were sometimes delays at Queen's Hospital in handing an ambulance patient over to a clinical member of staff. It was not usually possible however to divert ambulances elsewhere as there were similar pressures at other hospitals. Targets for responding to category A calls were agreed with London commissioners.

Offices would send through a breakdown of the different categories of call received as well as details of the targeted recruitment campaign at the Trust.

The location of ambulance stations was reviewed in light of the changing population of London but it was noted that the LAS fleet tended to move considerable distances around London over the course of a shift. There was not a shortage of ambulances themselves.

The Committee **NOTED** the position.

## 31 WHIPPS CROSS UNIVERSITY HOSPITAL

Officers from Barts Health NHS Trust reported that, following an inspection by the Car Quality Commission (CQC) in March 2015, Whipps Cross had been rated as 'inadequate' and the Trust had been put into special measures. The CQC had reinspected Whipps Cross in July 2016 and issued its report on 15 December. This had shown very significant improvements at Whipps Cross although the hospital's overall rating had remained at 'inadequate'. Services at the hospital for children and older people were however now rated as 'good'.

Changes at the hospital had included more collaborative working with mental health and social care partners. Whilst some vacancies remained among medical and nursing staff, 150 additional nursing posts had been funded and staff retention had also improved. It was accepted however that further work was required to improve recruitment. There was still some reliance on bank and other nursing agency staff but 83% of all posts at Whipps Cross were now filled with permanent staff. Staff turnover and morale had also improved.

Since the reinspection by CQC, two new operating theatres had been opened at Whipps Cross as well as a new clinical decision unit. It was clarified that A&E at the hospital was now rated as 'requires improvement' rather than 'inadequate'.

The Committee **NOTED** the update.

## 32 DATE OF NEXT MEETING

The next meeting would be on 18 April 2017at 4 pm at Waltham Forest Town Hall.

It was agreed that details of the reprocurement of NHS 111 urgent care services should be brought to the next meeting of the Committee.

## 33 URGENT BUSINESS

There was no urgent business raised.

**Chairman**

# OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 18 APRIL 2017

| | |
|---|---|
| **Subject Heading:** | NEL Integrated Urgent Care Procurement - Update |
| **Report Author and contact details:** | **Enrico Panizzo,**<br>**Senior Commissioning Manager (Urgent Care and CCG Performance)**<br>**Waltham Forest Clinical Commissioning Group** |
| **Policy context:** | **The information presented will allow effective scrutiny of the current position with the Urgent Care procurement.** |
| **Financial summary:** | **No impact of presenting of information itself which is for information/scrutiny only.** |

## SUMMARY

Information will be presented that will detail the current position with the procurement of a new local NHS 111 service.

## RECOMMENDATIONS

1. The Joint Committee to review the information presented and make any appropriate recommendations.

## REPORT DETAIL

Officers will present and summarise details of the current position with the procurement of a new NHS 111 service for Outer North East London. This is

presented to the Committee for its information and the Committee is invited to make any recommendations on the issue that it considers appropriate.

## IMPLICATIONS AND RISKS

**Financial implications and risks:** None of this covering report.

**Legal implications and risks:** None of this covering report.

**Human Resources implications and risks:** None of this covering report.

**Equalities implications and risks:** None of this covering report.

## BACKGROUND PAPERS

None.

# Update for the Outer North East London (ONEL) Joint Health and Overview Scrutiny Committee

## April 2017



# NEL Integrated Urgent Care Procurement

- As set out in the paper circulated to JHOSC members in January 2017, the seven Clinical Commissioning Groups (CCGs) are working together to commission a local NHS 111 service that is a single point of access for all urgent care needs across north east London.

- We want a service that meets patients' needs and delivers the eight new national standards for Integrated Urgent Care. Nationally, the NHS want NHS 111 to become the first point of contact to access urgent health and social care, so people get the right care in the right place, first time.

- We have used feedback from local people on the current service and how it can be improved to design our future service. The new service will ensure that more patients calling NHS 111 have direct access to clinician assessment and will enable direct booking into appropriate services.

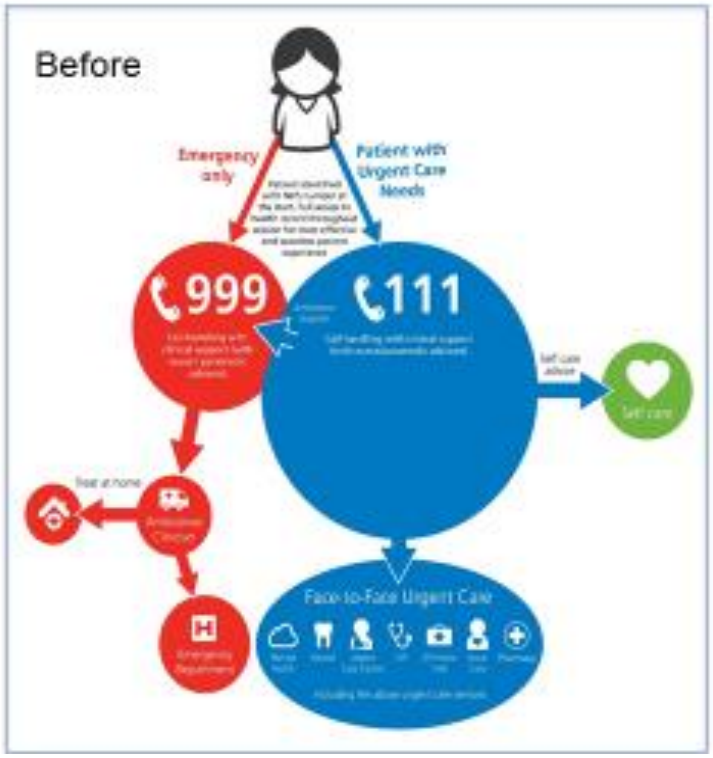


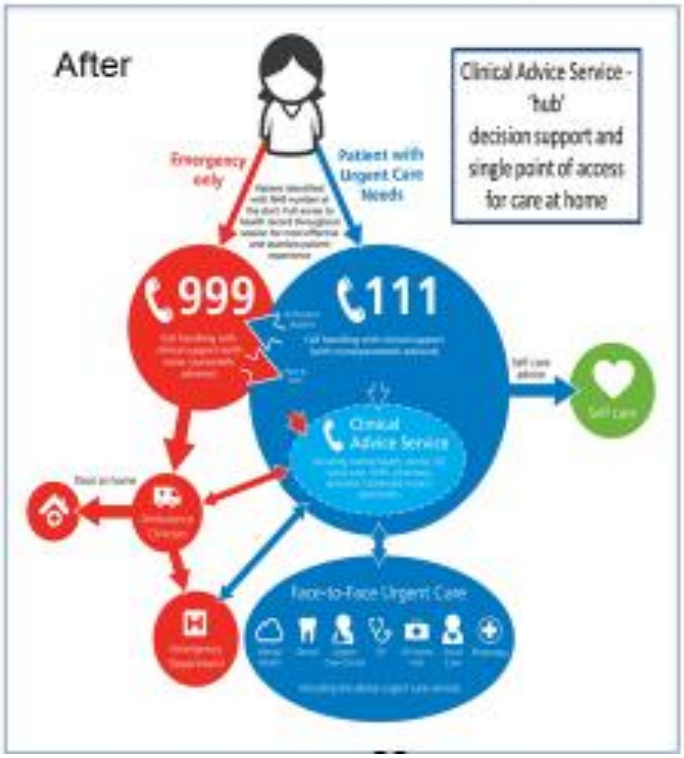
# Vision for Integrated Urgent Care

## Integrated Urgent Care Model

**To deliver the objectives of the Urgent and Emergency Care Review, the national aim is to pull together the separate working arrangements between current NHS 111 providers and GP Out-of-Hours (OOH) services and more closely align both with community, emergency departments and ambulance services. This will enable commissioners to deliver 24/7 access to urgent clinical assessment, advice and treatment.**

CALL 111 when it's less urgent than 999






# Engagement

The seven North east London CCGs engaged with patients in each of their boroughs on the Integrated Urgent Care procurement process in autumn 2016. Feedback was shared with the JHOSC in a paper circulated in January 2017.

**Surveys**

170

responses

**Community Engagement Sessions**

837

people reached

**Community Groups**

600

sent notice of procurement

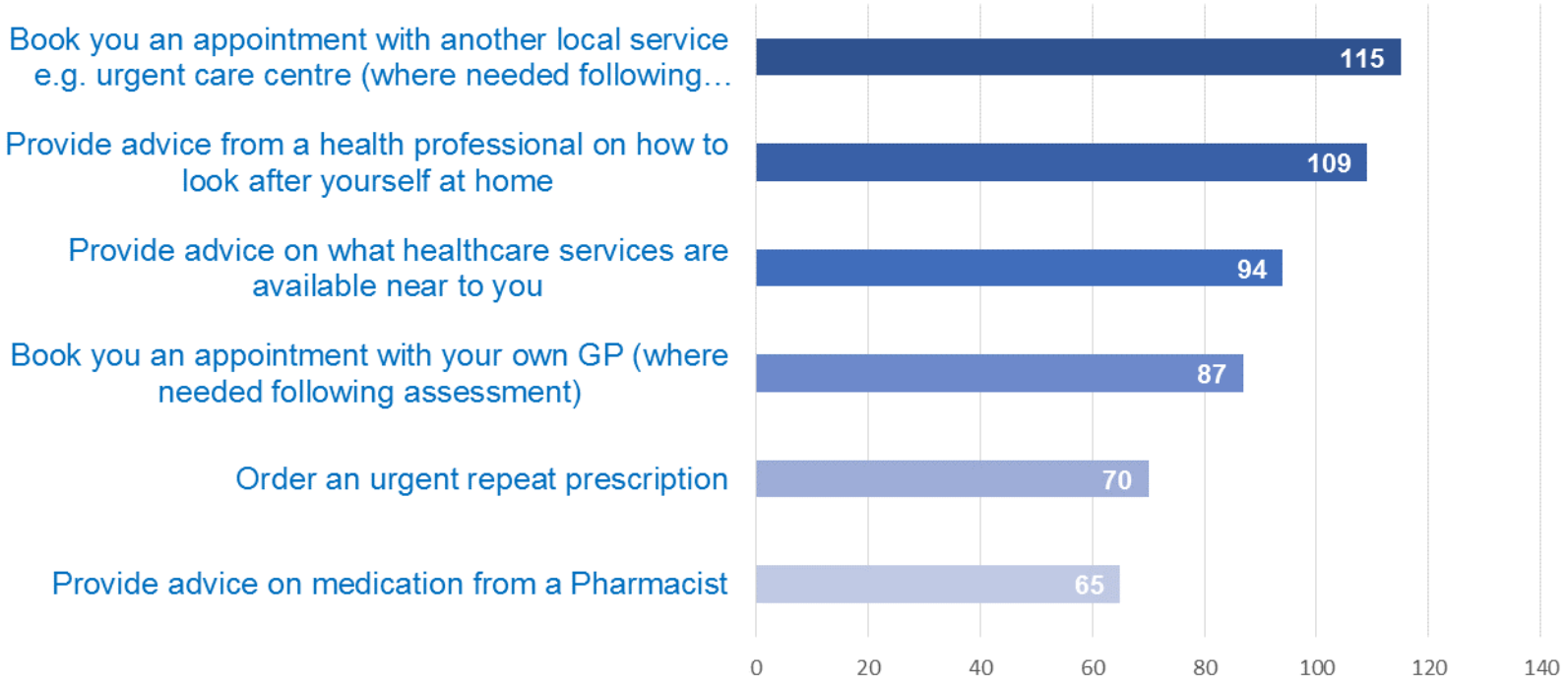
**Patients / Members of Public**

1,010

feedback gathered

# Feedback from engagement

Question: “We’d like to understand how you want to be helped when you call 111. Please pick up to a maximum of three from the list below”





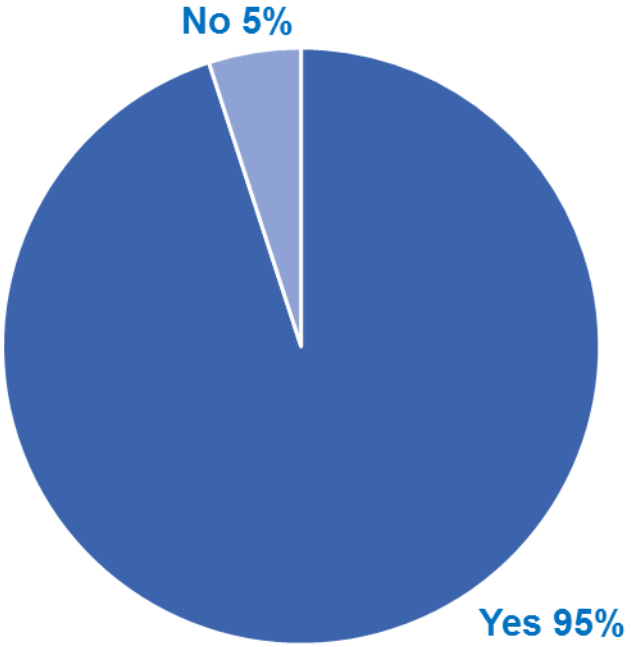

# Feedback from engagement

"Parents or carers of ill children aged under one, people aged over 75 or those with an existing care plan could be put in direct contact with a health professional through NHS 111. Do you think this would be useful?"

There was an overwhelmingly positive response to the idea of fast tracking these patients.

The main reasons people gave were:

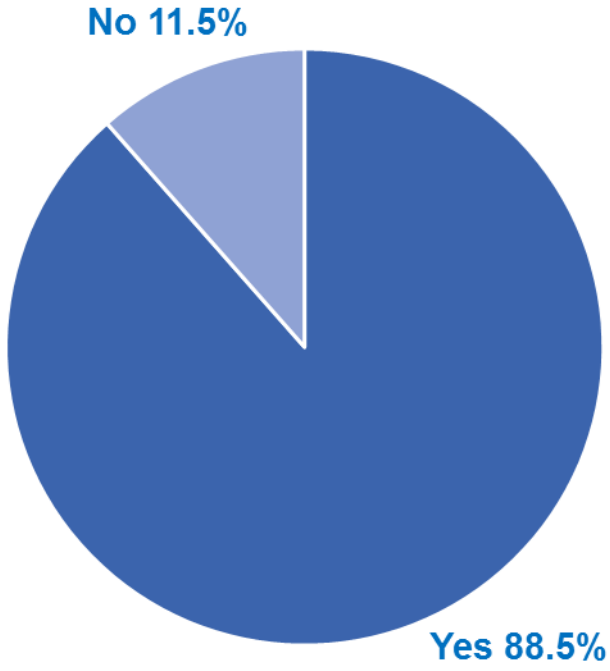
- These patients may block the system so it will save time for everyone if they are redirected and fast-tracked
- The elderly and very young are at greater risk and can deteriorate very quickly so time is of the essence




# Feedback from engagement

"Do you think having one phone number to call for all advice or support if you have an urgent health issue would be useful?"

Patients liked this idea mainly because it would be easier to remember even in a panic AND less confusing



# Ongoing patient and public engagement

- Patient and public engagement (PPE) sub-group
  - ➢ Representatives from across the seven CCGs
  - ➢ Helped to develop questions for the procurement process
  - ➢ Five sub-group members will be part of the evaluation process
- Patient representative on the programme board
- Links made with the patient representative on the North east London STP Board



# What will be different ?

## Integrated Urgent Care Model

111 will be used as the first point of access (in time online access will be enabled)

Callers will receive an initial assessment by a trained health advisor (expedited for specific cohorts of patients

Where specific criteria exist the call will be forwarded for early clinical advice e.g. people with special care plan's, children under 1yr or people over 75yrs

The Clinical Advice Service (CAS) will be staffed by a multidisciplinary team for example GP's, nurses, paramedics, mental health practitioners, pharmacist's who will have direct booking access to local area services

The CAS will be able to directly book people into services such as Primary Care, Urgent Care Centres and ED's as the technology becomes enabled

Patient records will be accessible to health care professionals (subject to patient consent) and will be updated so that there is a continuous record of care and treatment

# Next steps and key points

All seven CCGs will be asked to sign-off the procurement plan (including the service specification and timeline) at Governing Body meetings in March / April

In line with procurement rules and given the issue of commercial confidentiality, we will be able to update the JHOSC following the award of the contract



# OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 18 APRIL 2017

| | |
|---|---|
| **Subject Heading:** | Barking, Havering and Redbridge University Hospitals' NHS Trust (BHRUT) – Outcome of Care Quality Commission Inspection |
| **Report Author and contact details:** | **Jeff Buggle,**<br>**Director of Finance and Investment,**<br>**BHRUT** |
| **Policy context:** | **The information presented will allow effective scrutiny of the Trust's plans following the recent Care Quality Commission Inspection.** |
| **Financial summary:** | **No impact of presenting of information itself which is for information/scrutiny only.** |

## SUMMARY

Information will be presented that will detail the current plans and position of the Trust following the outcome of the recent inspection by the Care Quality Commission (CQC). .

## RECOMMENDATIONS

1. The Joint Committee to review the information presented and make any appropriate recommendations.

## REPORT DETAIL

Officers will present and summarise details (attached) of the current position and plans the Trust has following the announcement of the outcome of the recent inspection of the Trust by the CQC and the decision to remove the Trust from special measures. The report of the CQC inspection is also attached.

## IMPLICATIONS AND RISKS

**Financial implications and risks:** None of this covering report.

**Legal implications and risks:** None of this covering report.

**Human Resources implications and risks:** None of this covering report.

**Equalities implications and risks:** None of this covering report.

## BACKGROUND PAPERS

None.

# PRESENTATION TO JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

**18 April 2017**



**Jeff Buggle**
**Acting Chief Executive**

TAKING PRIDE IN OUR CARE

Barking, Havering and Redbridge University Hospitals NHS Trust

# CONTENT

- CQC outcome – leaving special measures; then and now
- Clinical Services Strategy
- Operational Plan
- Constitutional Standards
- Patient Experience/improving patient care
- Nursing recruitment and training programme

# WE'RE OUT OF SPECIAL MEASURES!

A big thank you to all our staff, volunteers, patients and partners for your support

# CQC PROCESS – KEY NUMBERS

- Targeted Inspections – 5 (2 planned, 3 unannounced)
  - Acute and specialist medical in patient wards
  - Emergency departments
  - Paediatric services
  - Outpatients and diagnostics
- Requested by the CQC
  - 18 focus groups: 530 staff including Patient Partners, Doctors, Nurses, AHP's and Support Staff
  - 34 interviews
  - 210 requests for evidence, 628 documents submitted
- Draft report received January 2017
  - Trust challenged 52 points
  - 93% successful
- Final report received March 2017
  - 7 Must do's
  - 35 should do's

# 2015 CQC REPORT

## KING GEORGE HOSPITAL

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement |
| Medical care | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |
| Outpatients and diagnostic imaging | Inadequate | N/A | Requires improvement | Inadequate | Requires improvement | Inadequate |

## QUEEN'S HOSPITAL

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Inadequate | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement |
| Medical care | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |
| Services for children and young people | Requires improvement | Requires improvement | Good | Inadequate | Requires improvement | Requires improvement |
| Outpatients and diagnostic imaging | Requires improvement | N/A | Good | Inadequate | Requires improvement | Requires improvement |

# 2016 CQC REPORT

## KING GEORGE HOSPITAL

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Requires improvement | Requires improvement | Good | Good | Requires improvement | Requires improvement |
| Medical care | Requires improvement | Requires improvement | Good | Requires improvement | Good | Requires improvement |
| Outpatients and diagnostic imaging | Requires improvement | N/A | Good | Requires improvement | Good | Requires improvement |

## QUEEN'S HOSPITAL

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement |
| Medical care | Requires improvement | Good | Good | Requires improvement | Good | Requires improvement |
| Services for children and young people | Requires improvement | Good | Good | Good | Good | Good |
| Outpatients and diagnostic imaging | Good | N/A | Good | Requires improvement | Good | Good |

# THE HEADLINES

- Trust leaves ‘special measures’ after three years
- All four core services featured in ‘targeted inspection’ show broad improvements
- ‘Services for children and young people’; and ‘Outpatients and diagnostic imaging’ show transformational improvement and now rated ‘Good’
- Three core services at Queen’s Hospital now rated ‘Good’
- “Outstanding practice” cited in work with children and young people and on dementia
- No domains or services rated ‘Inadequate’

# FOCUS – CHILDREN'S AND YOUNG PEOPLE

- From 'Inadequate' to 'Good' rating
- Inspectors identify "outstanding practice"
- Trust's work with neonatal and community teams for providing babies with oxygen home therapy
- Dedicated paediatric learning disability nurse in improving our care for young patients, which received very good feedback from parents
- Acknowledgement of how we have embedded and changed attitudes and approach to provision of services for children and young people across all specialties

# FOCUS – DEMENTIA

- “Outstanding practice”
- Tailored care offered to patients with dementia
- Specialist training for staff
- Implementing the ‘Butterfly Scheme’
- Practical day-to-day methods to provide the best possible care for patients
- Described by CQC as “compassionate and thoughtful”.

# CQC 'MUST DOS'

- Ensure all patients attending the ED are seen by a clinician in a timely manner
- Take action to improve levels of resuscitation training
- Ensure there is oversight of all training done by locums, particularly around advanced life support training
- Improve levels of resuscitation training
- Improve the response to patients with suspected sepsis
- Take action to address the poor levels of hand hygiene compliance
- Ensure fire safety is maintained by ensuring fire doors are not forced to remain open.

# A MOMENT FOR REFLECTION – THEN AND NOW

| 2013 | 2017 |
|---|---|
| Just over 50% of staff satisfied with the quality of the care they were providing | Now at 83% - 30% more than in 2013 |
| Low reporting levels of safety incidents – no mechanisms to reflect/share learning | 95% of staff know process to report; Weekly patient safety summit |
| No social media, poor relationships with stakeholders and the media | #Twitterati – over 3,500 followers; stakeholder and public communications channels; GP Liaison |
| -£38m deficit, turnover of £450m | Aiming for third consecutive control total, and to break even next year |
| ED visits – 20,079 December 2013 | 25,039 – a 25% increase |
| Staffing – 4,000 Medical/Nursing (total 6,346) | 4,500 Medical/Nursing team members in 2017 (total 7,200) |

# NEXT STEPS… CLINICAL SERVICES STRATEGY

## OUR CLINICAL SERVICES STRATEGY WILL DELIVER OUR VISION THROUGH THE FOLLOWING PROPOSALS:

### MATERNITY

At Queen's Hospital we will have the right maternity capacity to meet the needs of our local communities. We will continue to have an adjacent neonatal intensive care unit to provide specialist treatment for the sickest babies

### PAEDIATRICS

At Queen's Hospital we will provide enhanced services for children, with new paediatric short stay assessment facilities. We will develop stronger links with GPs and community services to care for children closer to their homes

## SUSTAINING OUR EMERGENCY SERVICE

We will provide excellent emergency care supported by comprehensive urgent care services 24 hours a day, seven days a week to meet the needs of our communities. This will ensure that we provide the right care at the right time and in the right place

## SPECIALIST CARE

We will invest in our neurosciences, stroke and cancer services. We will work with other specialist hospitals to provide the best treatment possible for our patients across North East London and Essex

## OUT OF HOSPITAL CARE

We are committed to improving out of hospital care for our local communities. We will work with our patients and local care providers in Barking and Dagenham, Havering and Redbridge, to bring care closer to home and to improve patient pathways

## INPATIENTS

King George Hospital will be our centre for planned surgery to give patients a dedicated and consistently high standard of service. Queen's Hospital will be our centre for emergency care and complex surgery, with an expanded critical care facility

## CLINICAL SUPPORT SERVICES

Both our hospitals will provide a full range of diagnostic services, so patients can be tested and receive their results quickly

## TEACHING AND RESEARCH

We will focus on strengthening our teaching, training, research and development

# OPERATIONAL PLAN

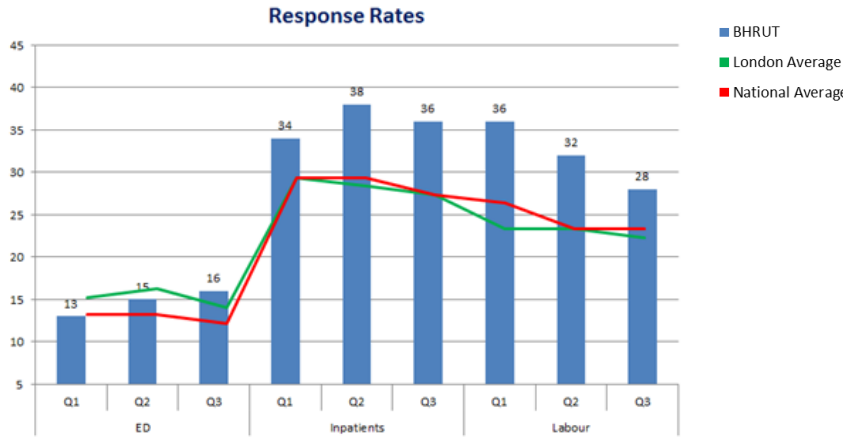
# OPERATIONAL PLAN

- Our Operational Plan for the 2017-19 period has also been published
- We have published this for a two-year period, to take us up to 2019
- The Operational Plan is set out under the five key areas of:
  - Delivering high quality care
  - Running our hospitals efficiently
  - Becoming an employer of choice
  - Managing our finances
  - Working in partnership

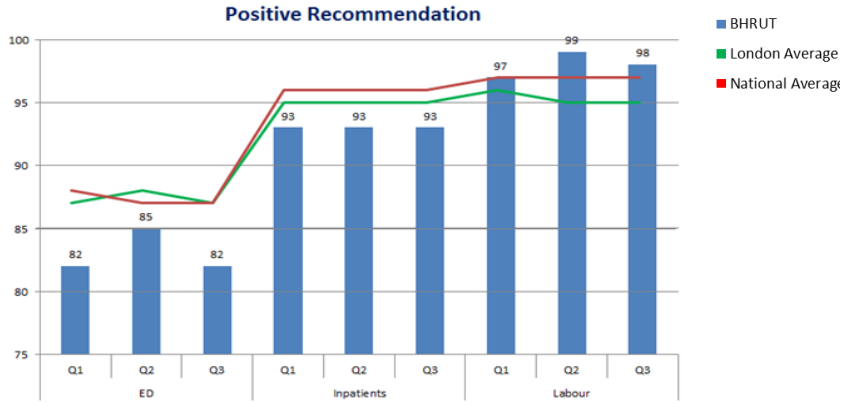
# CONSTITUTIONAL STANDARDS

- **Emergency Department** – a busy winter. NHS across the UK under pressure
- Very strong February performance – **87%** seen within four hours (national standard 95%)
- **Referral To Treatment** – still ahead of schedule agreed with CCG to return to constitutional standard by September
- From **1,000+** people waiting for more than a year, down to **3**

# CONTINUED FOCUS – PATIENT EXPERIENCE




Response rates show the % of discharged patients who completed a survey




Positive recommendations shows the % of responders who would be extremely likely or likely to recommend our services



## What have we done…

- Providing assistance to patients during mealtimes
- Deaf Awareness Training
- Outsourced Friends and Family Test survey to iWantGreatCare
- Individual clinician webpages for patients to provide personalised feedback
- Patient Partnership Council (PPC)

## What are we doing…

- Introducing ‘Hello my name is’ across all areas of the Trust
- New three year Patient Experience Strategy – focusing on listening and responding to feedback, Patient Partners and Accessibility
- Deaf People Quality Mark
- Increasing patient participation through service user groups

# WORKFORCE DEVELOPMENT – NURSE TRAINING

- BHRUT is committed to delivering outstanding care to its local community delivered with PRIDE
- Outstanding nursing care can only be achieved where there is an engaged, motivated and responsive workforce who feel supported to do their very best for patients, carers, colleagues and BHRUT
- Challenging national picture of declining numbers

# NURSE RECRUITMENT

- Major recruitment campaign
- Harness the opportunity – more attractive employment prospects
- Dedicated experienced nurses leading the team
- Specialist communications support to successfully engage and get the message out
- Social media and face-to-face events – e.g. shopping centres
- Reducing time from offer to 1st day at work

# NURSE TRAINING - PLANNED INITIATIVES

**Widening participation in education and professional development**

- Implement an explicit career map for unregistered nursing staff
- New Nursing Associates role
- Nursing Degree Apprenticeships
- Work with University of East London to launch BSc Adult Nursing Programme in January 2018.



**Enabling and supporting staff retention**

- Design and implement rotational development programme for Bands 5 and 6 nurses including rotations in mental health and community services.

# Barking, Havering and Redbridge University Hospitals NHS Trust

## Quality Report

Rom Valley Way
Romford RM7 0AG
Tel: 01708 435000
Website: www.bhrhospitals.nhs.uk

Date of inspection visit: 7 - 8 September; 11 - 12 October 2016
Date of publication: 07/03/2017

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

## Ratings

| Overall rating for this trust | Requires improvement  |
|---|---|
| Are services at this trust safe? | |
| Are services at this trust effective? | |
| Are services at this trust caring? | |
| Are services at this trust responsive? | |
| Are services at this trust well-led? | **Requires improvement**  |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Barking, Havering and Redbridge University Hospitals NHS Trust is a large provider of acute services, serving a population of over 750,000 in outer North East London. The trust operates from two sites; Queen's Hospital and King George Hospital.

Queens Hospital is the trust's main acute hospital and opened as a private finance initiative (PFI) in 2006, bringing together the services previously run at Oldchurch and Harold Wood Hospitals. It is the main hospital for people living in Havering, Dagenham and Brentwood. The hospital has over 900 beds, including a hyper acute stroke unit (HASU). The Emergency Department (ED) treats over 150,000 walk-in and ambulance emergencies each year.

King George Hospital opened at its current site in Ilford in 1995 and provides acute and rehabilitation services for residents across Redbridge, Barking & Dagenham, and Havering, as well as providing some services to patients from South West Essex. The hospital has approximately 450 beds.

The trust had an annual revenue of around £560 million and projected year-end deficit of £11.9 million, at the time of the inspection. The trust employs 5,713 staff, with a budget for 6,676 staff. The trust provides a full range of adult, older people's and children's services across medical and surgical disciplines.

Over a twelve month period the trust reported activity figures of 101,685 inpatient admissions, which is made up of 52,536 emergency admissions and 49,149 elective admissions. Between the period of October 2015 and September 2016 there were 829,011 outpatient attendances, 280,795 attendances through the Accident and Emergency (A&E) department.

The CQC undertook a comprehensive inspection of Barking, Havering and Redbridge University Hospitals NHS Trust in October 2013 and found serious failures in the quality of care and concerns that the management could not make the necessary improvements without support. Following this inspection, the trust was placed in special measures in December 2013.

A further comprehensive inspection took place in March 2015. In this inspection it was recognised that progress had been made, however the trust continued to carry significant risks and therefore remained under special measures. Overall the trust was rated as requires improvement, with the responsive domain rated as inadequate.

We carried out an unannounced inspection of three core services between the 7th and 8th September 2016. We then carried out a further announced core service inspection, alongside a well led assessment between the 11th and 12th October 2016.

In March 2015 we rated the organisation as requires improvement. Following the recent core service inspection and well led review, the trust remains rated as requires improvement.

This inspection was specifically designed to test the requirement for the continued application of Special Measures to the trust. Prior to inspection we risk assessed services provided by the trust using national and local data and intelligence we received from a number of sources. That assessment led us to include four services (emergency care, medical services, outpatients and diagnostics and services for children and young people) in this inspection which were inspected at Queens Hospital and the King George Hospital. The remaining services were not inspected as they had indicated strong improvement at our last inspection and our information review indicated that the level of service seen at our last inspection had been sustained.

In our most recent inspection we were particularly encouraged by the significant improvements that have been made by the trust since March 2015. Our overall rating for the trust is now requires improvement and there are no areas rated Inadequate.

We were particularly encouraged by the improvements made in a number of areas.These were

- Improvements in a number of domains within the services that we inspected since our last inspection.
- Improvements in the overarching governance processes.

**Queens Hospital**

# Summary of findings

In March 2015 we rated the urgent and emergency care service as requires improvement overall, with an inadequate rating for the safe domain. Following our recent review we have rated urgent and emergency care at Queens Hospital as requires improvement across the five domains.

In March 2015 medical care was rated as requires improvement within the safe, responsive and well led domains. Following the September inspection we recognised the progress made within the well led domain, along with the continued performance in the effective and caring domains, which we rated as good. The safe and responsive domains remain as requires improvement, resulting in an overall rating of requires improvement for medical care.

In March 2015 we rated services for children and young people as requires improvement, with an inadequate rating for the responsive domain. Following the October inspection we rated services for children and young people as good, with the safe domain rated as requires improvement.

In March 2015 we rated outpatients and diagnostics as requires improvement, with an inadequate rating for the responsive domain. Following the September inspection we rated this service as good, recognising progress in the safe, caring and well led domains which we rated as good.

**King George Hospital**

In March 2015 urgent and emergency care was rated as requires improvement across all domains. Following the September inspection we rated this service as requires improvement, recognising the progress made within the caring and responsive domains which we rated as good.

In March 2015 medicine was rated as requires improvement across four domains (safe, effective, responsive and well led). Following the September inspection we rated medical services as requires improvement, with the caring and well led domains rated as good.

In March 2015 outpatients and diagnostics was rated as inadequate. This service received two ratings of inadequate under the safe and responsive domains. Following the September inspection we rated the service as requires improvement, recognising progress in the caring and well led domains which we rated as good.

The rating for well led has remained at requires improvement as ascribed in the 2015 inspection. However, the senior leadership team were visible and involved in clinical activity. Time and resource had been invested into improving clinical governance structures and risk management and the trust actively promoted innovation and improvement to the patient experience.

It is apparent that the trust is on a journey of improvement and significant progress is being made both clinically and in the trust's governance. It is also clear that there is still further work to do to ensure that these improvements are sustained and that further progress is made.

Our key findings were as follows:

**Are services safe?**

- Compliance with infection prevention and control (IPC) practices across the services we inspected were found to be inconsistent.
- Rates of Methicillin-resistant Staphylococcus aureus (MRSA) infections had breached the trust zero tolerance target for the year.
- Fire safety standards in CYP services, including areas around the NICU were not always maintained.
- The emergency department (ED) cooling system at the King George Hospital had been out of order for at least three weeks prior to our inspection. This made it difficult to regulate safe temperatures within which to store drugs.
- Although nursing staffing levels had improved since the last inspection, some areas still had significant vacancy and turnover rates.
- We found high usage of locum across the organisation. Feedback from some locums was that access to training was poor and we had concerns that this meant they might not be appropriately skilled with up to date competencies.
- Since our previous inspection in March 2015 the organisation had improved its' processes around incident reporting across both sites and staff told us that they were encouraged to record incidents.

# Summary of findings

- The inspection raised concerns about the diagnostic imaging department at the King George Hospital not comply with all the policies and procedures based on the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and the Ionising Radiation Regulations 1999 (IRR99).

**Are services effective?**

- We found a number of clinical guidelines on the trust intranet were out of date. There was also issues with access to trust policies and guidelines for agency staff who had no computer access.
- The ED's performed worse than the national average in a number of Royal College of Emergency Medicine (RCEM) audits, including sepsis and septic shock, asthma in children, and paracetamol overdose.
- In medicine at Queens Hospital we found there was a backlog of National Institute for Health and Care Excellence (NICE) guidance that was awaiting confirmation of compliance across the trust.
- For non-elective medicine admissions, the standardised relative risk of readmission was high, particularly for geriatric medicine.
- Clinical staff completed a variety of local audits to monitor compliance and improvement. Staff of all levels told us that these led to meaningful change across the service.
- The standardised relative risk of readmission for all elective procedures was slightly lower than expected when compared to the England average. This meant that patients were less likely to require unplanned readmission after non-emergency procedures.
- In the National Diabetes Inpatient Audit (NaDIA) 2015, the hospital scored better than the England average for nine indicators out of sixteen indicators. Actions had been taken to improve the service in those measures where they were underperforming.

**Are services caring?**

- The majority of patients were positive about the care they received and we observed courteous interactions between staff and patients.
- Patients and relatives told us staff were respectful and helpful and gave them regular updates.
- We observed some negative interactions in the ED at Queens Hospital. We also observed a patient calling out for help and was ignored until we escalated to the nurse in charge.

**Are services responsive?**

- The percentage of patients being seen and treated within the ED recommended four hour timeframe at both hospital sites and the number of patients who left the department without being seen was worse than the national average.
- In medicine at the King George Hospital patients were not always able to be located on the specialist ward appropriate for their condition. In some wards, bed moves were consistently occurring out of hours (between 10pm and 6am).
- Environments on some wards in the King George Hospital were not ideal, with high levels of noise and heat observed and reported. There was a lack of bedside televisions or radios across the wards, which some patients reported made them feel isolated and bored.
- The trust was consistently failing to meet NHS waiting time indicators relating to 62-day cancer treatment. This issue had been added to the corporate risk register and actions had been undertaken to improve performance.
- The trust was not meeting 18-week waiting time indicator for non-urgent referral to treatment (RTT) times.
- The Patient Advice and Liaison Service (PALS) did not always respond to complaints in a timely manner.
- The ED's at both sites worked closely with local GP's to stream patients effectively, including back to their own GP.
- People living with dementia received tailored care and treatment. Care of the elderly wards at the King George Hospital had been designed to be dementia friendly and the hospital used the butterfly scheme to help identify those living with dementia who may require extra help.

**Are services well led?**

- Senior Leadership was visible and involved in clinical activity. Staff were positive about changes and were starting to feel more optimistic.
- Time and resource had been invested into improving clinical governance structures and risk management since the past inspection in March 2015.
- Quality improvement and research projects took place that drove innovation and improved the patient experience.

# Summary of findings

We saw several areas of outstanding practice including:

- The hospital provided tailored care to those patients living with dementia. The environment in which they were cared for was well considered and the staff were trained to deliver compassionate and thoughtful care to these individuals. Measures had been implemented to m ake their stay in hospital easier and reduce any emotional distress.
- The trust had awarded the neonatal and community teams for their work in providing babies with oxygen home therapy, which improved the quality of life for families.
- A dedicated paediatric learning disability nurse had introduced support resources for patients, including a children's hospital passport and visual communication tools. This helped staff to build a relationship with patients who found it challenging to make themselves understood. This had been positively evaluated and received a high standard of feedback from parents and patients.
- Child to adult transition services were comprehensive and conducted with the full involvement of the patient and their parents. This included individualised stages of empowering the person to gradually increase their independence, the opportunity to spend time with paediatric and adult nurses together and facilities for parents to spend the night in adult wards when the young person first transitioned.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure all patients attending the ED are seen by a clinician in a timely manner.
- Take action to improve levels of resuscitation training.
- Ensure there is oversight of all training done by locums, particularly around advanced life support training.
- Take action to improve levels of resuscitation training.
- Take action to improve the response to patients with suspected sepsis.
- Take action to address the poor levels of hand hygiene compliance.
- Ensure fire safety is maintained by ensuring fire doors are not forced to remain open.
- Ensure staff have a full understanding of local fire safety procedures, including the use of fire doors and location of emergency equipment
- Ensure hazardous waste, including sharps bins, is stored according to related national guidance and EU directives. This includes the consistent use of locked storage facilities.

In addition the trust should:

- Endeavour to recruit full time medical staff in an effort to reduce reliance on agency staff.
- Ensure there is sufficient number of nurses and doctors with adult and paediatric life support training in line with RCEM guidance on duty.
- Improve paediatric nursing capacity.
- Improve documentation of falls.
- Document skin inspection at care rounds.
- Document nutrition and hydration intake.
- Review arrangements for the consistent sharing of complaints and ensure that learning is always conveyed to staff.
- Make repairs to the departmental air cooling system.
- Ensure policies are up to date and reflect current evidence based guidance and improve access to guidelines and protocols for agency staff.
- Take action to improve the completion of early warning scores.
- Improve appraisal rates for nursing and medical staff.
- Regularise play specialist provision in the paediatric ED.
- Consider how to improve ambulance turn around to meet the national standard of 15 minutes.
- Ensure staff and public are kept informed about future plans for the ED.
- Restructure the submission of safety thermometer data to match the current divisional structure.
- Monitor both nursing and medical staffing levels. Follow actions detailed on corporate and divisional risk registers relating to this.
- Monitor and improve mandatory training compliance rates for medical staff. Improve completion rates for basic life support for nursing and medical staff.
- Review out-of-hours provision of services and consider how to more effectively provide a truly seven day service.
- Continue to work to improve endoscopy availability and service, as detailed on the corporate risk register.

# Summary of findings

- Make patient information leaflets readily available to those whose first language is not English.
- Ensure leaflets detailing how to make a formal complaint are available across all wards and departments.
- Ensure consent to care and treatment is always documented clearly.
- Ensure each inpatient has an adequate and documented nutrition and hydration assessment.
- Ensure there are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.
- Ensure there are appropriate processes and monitoring arrangements in place to improve the 31 and 62 day cancer waiting time indicator in line with national standards.
- Ensure the 18 week waiting time indicator is met in the outpatients department.
- Ensure the 52 week waiting time indicator is consistently met in the outpatients department.
- Ensure percentage of patients with an urgent cancer GP referral are seen by a specialist within two weeks consistently meets the England average.
- Ensure the number of patients that 'did not attend' (DNA) appointments are consistent with the England average.
- Ensure the number of hospital cancelled outpatient appointments reduce and are consistent with the England average.
- There is improved access for beds to clinical areas in diagnostic imaging.
- Address the risks associated with non-compliance in IR(ME)R and IRR99 regulations.
- Ensure the number of hospital cancelled outpatient appointments reduce and are consistent with the England average.
- Ensure diagnostic and imaging staff mandatory training meets the trust target of 85% compliance.
- Develop a departmental strategy in diagnostic imaging looking at capacity and demand and capital equipment needs.
- Improve staffing in radiology for sonographers.

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

# Summary of findings

## Background to Barking, Havering and Redbridge University Hospitals NHS Trust

Barking, Havering and Redbridge University Hospitals NHS Trust is a large provider of acute services, serving a population of over 750,000 in outer North East London. The trust operates from two sites; Queen's Hospital and King George Hospital.

In the 2015 indices of multiple deprivation, Barking and Dagenham was ranked in the most deprived quintile. Havering and Redbridge were both ranked in the third (middle) quintile.

The trust had an annual revenue of around £505.2 million and projected year-end deficit of £33.6 million, at the time of the inspection. The trust employs 5,713 staff, with a budget for 6,676 staff. The trust provides a full range of adult, older people's and children's services across medical and surgical disciplines.

Over a twelve month period the trust reported activity figures of 101,685 inpatient admissions, which is made up of 52,536 emergency admissions and 49,149 elective admissions. Between the period of October 2015 and September 2016 there were 829,011 outpatient attendances, 280,795 attendances through the Accident and Emergency (A&E) department.

We inspected four of the core acute services including: urgent and emergency care, medical care (including older people's care), services for children and young people, and outpatients and diagnostic services, at both the Queen's Hospital and King George Hospital sites. In conjunction with the core service review, we carried out a well led review of the trust.

## Our inspection team

Our inspection team was led by

Chair: Dr Bill Cunliffe, secondary care clinician, Newcastle Gateshead CCG Team Leader: Nicola Wise, head of hospital inspection, Care Quality Commission

The trust was visited by a team of CQC inspectors and a variety of clinical and non-clinical specialists. There were consultants in emergency medicine and medical care. The team also included nurses with backgrounds in medicine and outpatients. The trust-wide team consisted of specialist advisors with board-level experience and national regulatory experience.

## How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

As part of this bespoke re-inspection the inspection team carried out an unannounced inspection of the following core services:

- Urgent and emergency services
- Medical care (including older people's care)
- Outpatients and diagnostic imaging

In addition to this, the inspection team carried out an announced inspection of:

- Services for children and young people.

# Summary of findings

• Well led review

As part of inspection we: observed how patients were being cared for, spoke with patients, carers and/or family members and reviewed patients' personal care or treatment records. We held focus groups with a range of staff in the hospitals, including doctors, nurses, allied health professionals, administration, and other staff. We also interviewed senior members of staff at the trust.

## What people who use the trust's services say

**NHS Friends and Family Test**

Barking, Havering and Redbridge University Hospitals NHS Trust have consistently maintained a higher response rate to the NHS staff survey in the preceding twelve months prior to our inspection. In September 2016 the trust achieved a response rate of 39%, compared to an England average of 23.9%.

The percentage of respondents who would recommend the trust was consistently below the national average for the preceding twelve months, with September indicating that 92.9% of respondents would recommend the trust, compared to a national average of 95.4%.

## Facts and data about this trust

Barking, Havering and Redbridge University Hospitals NHS Trust is large acute trust with around 1139 beds, serving approximately 750,000 people living in Barking, Havering and Redbridge and the surrounding areas. It employs around 5,713 staff that deliver care across two acute hospital sites.

**Key Figures**

**Beds**:

King George Hospital:

283 inpatient and 26 day case beds

Queens Hospital

830 inpatient and 71 day case beds

**Staffing a**s of 1st April 2016**:**

5,713 WTE (against an establishment of 6,676 WTE)

849.5 medical (against an establishment of 920)

1,922.2 nursing (against an establishment of 2,100)

336.1 allied health professionals (against an establishment of 368)

1,418.4 other (against an establishment of 1,577)

**Financial data 2015/16**

Revenue: £505.2 million

Full Cost: £569.6 million

Deficit: £33.6 million

**Activity type 2015/16**

Inpatient admissions 101,685, ff which there were

Emergency admissions: 52,536

Elective admissions: 49,149

Outpatient (total attendances): 829,011

Accident & Emergency (total attendances): 280,795

**Is this trust well led?**

**Staff sickness**

The trust's sickness levels between May 2015 and April 2016 were lower than the England average.

**Staff turnover**

The trust's staff turnover of nurses was 359. The turnover of medical staff was 114. The overall percentage cannot be provided due to the format of the data provided by the trust. The trust did not provide the date range for the data provided.

**NHS staff survey results**

# Summary of findings

In the 2015 NHS staff survey the trust scored higher than the England average for acute NHS trusts, against the following measures:

- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Against both of these questions there was no significant difference between white or BME staff.

Against question KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

The results showed that 82% of staff from a white ethnic origin responded positively, compared to 64% of BME staff.

Against question Q17b In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?

Response rates indicated 9% from a white ethnic background responded positively, as opposed to 18% of BME staff.

In the 2016 staff survey the trust had improved the staff response rate by 6.2% from the previous year. Compared with other organisations the trust scored the same as or better on 60 of the 88 measures.

# Summary of findings

## Our judgements about each of our five key questions

| | Rating |
|---|---|
| **Are services at this trust safe?**<br>We examined the safe domain in the context of the core services that we inspected but for the purpose of this report we did not rate it.<br>• We observed poor compliance with infection prevention and control (IPC) practices in multiple areas. Hand hygiene audits across the trust showed compliance in some areas to be poor.<br>• Rates of Methicillin-resistant Staphylococcus aureus (MRSA) infections had breached the trusts' zero tolerance target for the year.<br>• There was poor recognition of and response to patients with suspected sepsis in the ED at King George Hospital.<br>• The ED cooling system at the King George Hospital had been out of order for at least three weeks prior to our inspection. This made it difficult to regulate safe temperatures within which to store drugs.<br>• There were breaches in the fire resisting compartmentation across the hospital site, which had been caused by previous contractors drilling holes for data cables and services.<br>• We found high vacancy rates for nursing positions across the organisation. There was a high rate of senior band six nurse vacancies in the ED at Queens Hospital. The service had over recruited on band 5 nurses to compensate for this gap. However, band 6 nurses are often more experienced and therefore we had concerns regarding the skill mix.<br>• We found high usage of locum across the organisation. This was particularly high in the ED's at Queens Hospital and King George Hospital there was a high usage of locum medical staffing for consultants and middle grade doctors. Feedback from some locums was that access to training was poor and we had concerns that this meant they might not be appropriately skilled with up to date competencies.<br>• Compliance with resuscitation training in both the ED at Queens Hospital and King George Hospital was poor. We had no assurance that locum medical staff had up to date resuscitation training.<br>• In services for children and young people the neonatal unit (NICU) did not always meet the minimum staffing requirements of the British Association of Perinatal Medicine.<br>However, | |

- Since our previous inspection in March 2015 the organisation had improved its' processes around incident reporting across both sites and staff told us that they were encouraged to record incidents.
- Staff were aware of their responsibilities with regards to Duty of Candour requirements, confirming there was an expectation of openness when care and treatment did not go according to plan.
- Staff had a good understanding of their roles and responsibilities with regards to safeguarding adults and children.
- We found a lot of educational work around sepsis pathways and the early identification of sepsis was in place in the ED at Queens Hospital.
- The trust had changed their electronic system records system and introduced the electronic patient record (EPR).

**Incidents**

- We found systems for reporting and learning from incidents across services. Staff were aware of how to report patient safety incidents and knew about the trust-wide electronic system for incident reporting. However, agency staff had no access to trust computers and relied on permanent staff to complete incident forms for them.
- Serious incidents (SI) are those that require investigation. Data provided by the trust showed in the ED at Queens Hospital there were 10 SI's which had breached their internal deadline.
- Most staff were able to describe action points from incidents and changes in practice as a result of learning.
- We saw examples whereby learning from incidents had been encouraged, for example through email and intranet messages, as well as 'keep in touch' days, which were held four times per year, where SI's were discussed.
- Patient Safety Summit meetings were held every week and attended by multidisciplinary staff from all divisions and co-chaired by the Medical Director and Chief Nurse. The focus of these meetings was to review recent serious incidents or a case study presentation and discuss what could be learnt and shared more widely to prevent a similar incident happening again.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant

persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff that we spoke with understood the term 'duty of candour' and their responsibilities in relation to this.

- Mortality and morbidity was considered during the monthly mortality assurance group. This group was introduced in 2015 as part of the 'sign up to safety' initiative, which aimed to improve the monitoring and identification of mortality outliers to identify potential areas where deaths could be prevented.
- NHS trusts are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R and to the Health and Safety Executive (HSE) under the Ionising Radiation Regulations 1999 (IRR99). Diagnostic and imaging services had procedures to report incidents to the correct organisations, including CQC. At the time of the inspection, there were two open cases with the CQC which were also classified as SI's. We saw evidence that these were being dealt with appropriately with review meetings, action plans and wider learning.

**Cleanliness, infection control and hygiene**

- The trust had up to date policies and procedures for hand hygiene and infection prevention and control (IPC).
- Each ward / clinical area had an IPC link nurse. The link nurse acts as a link between the clinical area and the infection control team. Their role is to increase awareness of infection control issues and motivate staff to improve practice. There was also a lead IPC nurse for the trust and head of IPC, who staff were aware of and knew how to contact if necessary.
- Infection control audits were completed by the Infection Prevention and Control team (IPCT), with frequency depending on the score the area had achieved in a baseline audit at the beginning of the year.
- Hand hygiene audit data submitted to the CQC for August 2015 to August 2016 showed that there to be high variability in adherence to hand hygiene practice. With the results in the ED's at both sites, and some of the medicine wards, being consistently poor.
- There were dispensers with hand sanitising gel across the organisation. However, we found a number of empty dispensers during the course of our unannounced inspection including the ED's at both sites, some areas of medicine and the outpatient departments.
- During our inspection, we observed staff in a number of departments did not consistently comply with hand hygiene

practice. Not all staff regularly cleaned their hands as they moved from one area to another, or when leaving or entering departments. This was raised as a consistent issue in a cross-section of staff meeting minutes that we reviewed.

- We found evidence of non-compliance with IPC rules for isolated patients. We observed a patient within medicine at the Queens Hospital site who had been isolated due to an infection of carbapenemase-producing Enterobacteriaceae (CPE) infection. Enterobacteriaceae are a family of bacteria, many of which live naturally in the bowels. These bacteria produce carbapenemase enzymes that can break down many types of antibiotics, making the bacteria very resistant. We noticed the isolation room door left open on more than one occasion, despite alerting this issue to a staff member.

**Environment and equipment**

- The cooling system in the ED at the King George Hospital was not working on the day of our inspection. There were fans strategically placed around the department to mitigate this. Staff told us this had been recorded as an incident three weeks earlier. We were told that it had made working conditions very challenging for staff during periods of hot weather. There was a lack of clarity as to when this situation would be addressed.
- We saw this had been added to the corporate risk register on the first of August, with a review date set for October. The risk register referenced the fact that drugs fridges were unable to remain within safe temperature limits which resulted in medication wastage.
- We noted that the drugs room temperature in the ED had reached a maximum temperature of 25 degrees. There were fans in situ to control the temperature and we saw an action plan in place should the temperature exceed 25 degrees on seven consecutive days.
- In medicine services at the King George Hospital patients commented that the wards could be very noisy at night. We observed that Fern ward was quite unsettled in the morning, with lots of corridor traffic and high noise levels.
- The trust had identified breaches in the fire resisting compartmentation across the hospital site, which had been caused by previous contractors drilling holes for data cables and services. At the time of inspection, approximately 70% of repair work had been undertaken but some breaches still existed and were not expected to be repaired fully until summer 2017. This issue had been added to the corporate risk register.
- In outpatients at the King George Hospital the audiology room venting system was not working. The room was small and did

not have any other means of ventilation such as windows. We saw a patient experience an episode of dizziness and breathlessness in the room, which the patient felt was due to a lack of air in the room. We were informed by staff that this issue had been highlighted as an issue but had not been resolved.

- In CYP services a secure corridor linked the neonatal intensive care unit (NICU) with the main hospital and contained a kitchen. On one day of our inspection we found both fire safety doors between the corridor and the kitchen were wedged open and the kitchen was unattended. This meant if the fire alarm sounded, the automatic door closure mechanism would fail to operate. There was also no firefighting equipment in the kitchen. A member of catering staff told us there was no fire safety equipment in the kitchen and said they did not know where the nearest fire extinguishers were.

**Records**

- The trust had changed their electronic records system in December 2015 with the introduction of the electronic patient record (EPR), having previously used the patient administration system (PAS). The EPR provided staff with access to patient letters, reports, imaging and test results. However, most patient records were paper based, including risk assessments. Most staff we spoke with commented positively on the EPR.
- The trust had launched 'iFit' a records management system in to address identified issues in regards to missing information in patient records, the over use of temporary records, and the tracking of patient records. Outpatients' department staff had completed workshops on the iFit system. Staff we spoke with confirmed records management had improved and there was decreased use of temporary records.
- In most areas we found that records were kept in lockable trolleys. However we also found sets of patient notes in an unlocked and unsupervised room which was accessible by the public. This was brought to the attention of the service lead and the room subsequently locked.

**Safeguarding**

- In line with statutory guidance the trust had named nurses and named doctors, and safeguarding teams for child protection and safeguarding vulnerable adults.
- The safeguarding adult and children policies were available on the trust intranet and were up to date. Safeguarding was part of the trust annual mandatory training.
- Staff we spoke with were aware of their responsibilities in relation to safeguarding adults and children. Staff were able to

give us examples of what would constitute a safeguarding concern and told us they would seek advice from senior staff members and the trust safeguarding team if they had any concerns.
- All staff we spoke with knew the safeguarding team and could identify where to find the contact details if required.
- There was a monthly safeguarding and learning disability operations group, where any issues around safeguarding or staff awareness of processes were shared.
- Staff had a good understanding of female genital mutilation (FGM) and knew they could access the safeguarding lead for any support.
- However in the ED at the King George Hospital completion of safeguarding training by doctors was low. Compliance with safeguarding adults level 2 was 73% and safeguarding children level 3 was 60%.

**Assessing and responding to patient risk**

- Ambulance turnaround time did not meet the national standard of handover for the ED at the King George Hospital. The standard for ambulance handover is 95% within 15 minutes. This means that they should have an initial assessment with a nurse or doctor. The percentage of patients seen within 15 minutes between August 2015 and August 2016 averaged 52%, with the lowest average at 39.8% in March 2016.
- We found a lot of educational work around sepsis pathways and the early identification of sepsis was in place in the ED at Queens Hospital. However, we had concerns around staff awareness of sepsis and the early identification of sepsis in the ED at the King George Hospital.
- The hospital used a national early warning score (NEWS) system to identify when patients were deteriorating using variations in different observations such as heart rate, blood pressure and oxygen levels. Patient records we reviewed showed patient observations were completed.
- The hospital used the paediatric early warning scores (PEWS) system to monitor patients for signs of deterioration. PEWS were completed at regular intervals based on the condition of the patient and staff escalated patients with an increasing score to an appropriate doctor. Each patient records folder included the protocol for caring for a child between one and ten years old in cardiac arrest, which followed Resuscitation Council (UK) guidance.

- Patients at risk of deterioration were discussed in daily safety huddles or board rounds, where members of the multidisciplinary team (MDT) gathered to review individual patient treatment plans and conditions.

**Staffing**

- The trust had vacancies across all staff groups, however mitigation plans were in place to ensure staffing levels met minimum requirements with the use of bank, agency and locum staff. Staff who we spoke with told us how staffing had improved since the previous CQC inspection in March 2015.
- The Trust used the Safer Nursing Care Tool (SNCT) as an indicator for safe staffing levels across relevant ward areas within the Trust. This tool calculated serious staffing deficiencies and these were flagged as 'black' risks to signal a concern within the given area.
- Wards displayed nurse staffing information on a board at the ward entrance. This included the staffing levels that should be on duty and the actual staffing levels. This meant that people who used the services were aware of the numbers of staff available that day and whether this met the planned requirement. This was in line with Department of Health guidance.
- Within the ED at Queens Hospital we found a 47% vacancy rate for senior band six nursing posts. The department had mitigated against this risk through additional recruitment of band five nursing, however we had concerns regarding the skill-mix of the nursing establishment.
- National standards for children and young people in emergency care settings state that there must be a nurse with advanced paediatric life support qualification on each shift. We found, in the ED at Queens Hospital, that 35% of shifts within the prior three months had not met this standard. The lack of adequate paediatric nursing capacity was rated as high on the recent corporate risk register.
- We found high rates of Consultant vacancies across the organisation. Within the ED there was a 40.6% vacancy rate for Consultant posts who worked across both hospital sites. Locum posts were utilised to cover this shortfall in substantive staff numbers.
- During the week and weekend the emergency department had consultant cover between the hours of 8am and till midnight. This ensured the department was meeting the Royal College of Emergency Medicine (RCEM) standard around consultant presence. The RCEM states that there should be a consultant

present for a minimum of 16 hours a day. The department had recently introduced consultants who worked during the night, which meant on some days there was 24 hour consultant presence.

- We found a high number of middle grade doctor shifts filled by locums across both the ED's and Queens Hospital and the King George Hospital. Senior leaders told us there were challenges in recruiting middle grade doctors to the department.
- Locum medical staff are fully qualified doctors but they do not always have the specialist skills required for treating patients in emergency situations. We spoke to some locums during the inspection who told us they could not access training in the same way junior doctors could. We were told since the junior doctors had left the weekly training sessions had stopped taking place. This meant there were no assurances that their clinical skills were up to date. We asked the trust how they monitored whether locum staff had up to date advanced life support training. We were told this was done via a third party. The trust were unable to provide us with assurance that locum staff had appropriate resuscitation training.
- A trust recruitment and retention group had been established and met monthly to drive action and monitor progress in recruitment.

**Are services at this trust effective?**

We examined the effective domain in the context of the core services that we inspected but for the purpose of this report we did not rate it.

- The majority of patients were assessed for pain and offered appropriate pain relief.
- Clinical areas, such as the ED at both sites ran multidisciplinary keeping in touch (KIT) days in order to provide staff with training for their development.
- Nursing and medical staff completed a variety of local audits to monitor compliance and improvement. Staff of all levels told us that these led to meaningful change across the service.
- The standardised relative risk of readmission for all elective procedures was slightly lower than expected when compared to the England average. This meant that patients were less likely to require unplanned readmission after non-emergency procedures, suggesting that the hospital's care and discharge arrangements were appropriate.

- In the National Diabetes Inpatient Audit (NaDIA) 2015, the hospital scored better than the England average for nine indicators out of sixteen indicators. Actions had been taken to improve the service in those measures where they were underperforming.

However,

- We found a number of clinical guidelines on the trust intranet were out of date. There was also issues with access to trust policies and guidelines for agency staff who had no computer access.
- The ED department at Queen Hospital performed worse than the national average in a number of Royal College of Emergency Medicine (RCEM) audits, including sepsis and septic shock, asthma in children, and paracetamol overdose.
- In medicine at Queens Hospital we found there was a backlog of National Institute for Health and Care Excellence (NICE) guidance that was awaiting confirmation of compliance across the trust.
- For non-elective medicine admissions, the standardised relative risk of readmission was high, particularly for geriatric medicine.
- We had concerns about the diagnostic imaging department not complying with all the policies and procedures based on the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and the Ionising Radiation Regulations 1999 (IRR99).

**Evidence based care and treatment**

- The organisation used National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment they provided to patients.
- We found a backlog of of NICE guidance that was awaiting confirmation of compliance. This was identified as a risk on the corporate risk register in 2014. A number of measures had been put into place to improve compliance, such as a monthly trust wide NICE guidance implementation committee. This reviewed current practice and developed action plans to ensure compliance with the latest NICE guidance.
- Patient assessments were based on national tools, such as the Malnutrition National Screening Tool (MUST) and the Braden scale for predicting pressure ulcer risk. Care pathways based on national guidance were in place for conditions such as sepsis, stroke and pressure ulcers.
- Services for children and young people met nine of the ten standards of the Royal College of Paediatrics and Child Health

Facing the Future 2015 guidelines. This included an admissions review by a paediatric doctor within four hours and by a paediatric consultant with 24 hours, daily consultant-led handovers and level three child protection training amongst all clinicians. The guidance recommends a consultant always be available at peak times. Although consultant rotas did not evidence this, all of the doctors we spoke with said consultants routinely stayed on site longer than their shift. This meant services met this recommendation in practice but could not provide evidence this was always the case.

- Staff showed us how they would access local guidelines on the trust intranet. Full time staff told us that clinical guidelines were easily accessible. We were told guidelines and pathways were available on a downloadable mobile phone application.
- However, agency staff in the ED did not have access to the computer terminals in the department which limited their access to trust protocols and guidelines. There was no other way to access guidelines.
- There were examples of recent local audits that had been completed across the organisation.
- We found documents for diagnostic imaging relating to the IR(ME)R and IRR99 regulations were held on the hospital's shared drive. The local rules for the hospital had not been updated since 2012. The procedures that all employers are required to have in place when using ionising radiation had also not been updated since 2012.

**Patient outcomes**

- The trust participated in a range of national audits so that it could benchmark its practice and performance against best practice and other hospitals.
- In the 2013/14 RCEM audit of severe sepsis and septic shock the ED at Queens Hospital department performed worse that than the England average in eight of the twelve indicators.
- Queen's hospital generally performed similar to the England average in the RCEM mental health in the ED audit. However, the department did not meet the fundamental standard that all patients should have a risk assessment taken and recorded in their clinical record.
- The unplanned re-attendance rate (number of patient re-attending within seven days of a previous attendance at A&E) for the ED at Queens Hospital between May 2015 and April 2016 was between 10% and 11%. This was consistently worse than the England average of 7.6% and worse than the national standard of 5%.

# Summary of findings

- At Queen's Hospital, the standardised relative risk of readmission for all elective procedures was higher than expected in comparison to the England average. This meant that patients were more likely to require unplanned readmission after non-emergency procedures. This suggests that the hospital's care and discharge arrangements might be inappropriate. However, other factors could be involved, such as patients having other comorbidities (the presence of one or more additional diseases or disorders co-occurring with a primary disease or disorder) or poorly organised rehabilitation and support services when a patient is transferred home following treatment.
- At King George hospital, the standardised relative risk of readmission for all elective procedures was slightly lower than expected when compared to the England average. This meant that patients were less likely to require unplanned readmission after non-emergency procedures, suggesting that the hospital's care and discharge arrangements were appropriate. However, for non-elective admissions, the standardised relative risk of readmission was higher, particularly for geriatric medicine.
- In the National Heart Failure Audit (2013/14), the hospital performed equal to, or better than, the England average in five out of 11 measures. However, the results showed no improvement from the previous year when measured against the England average, as it performed equal to or better on the same five measures overall.
- Queen's hospital High Acute Stroke Unit (HASU) saw a steady performance in the Sentinel Stroke National Audit Programme (SSNAP) from April 15 – December 15 with SSNAP level remaining at performance level 'B' (on an A-E rating scale, where A is the highest) across all quarters. However, January 16 – March 16 saw a decline in performance with SSNAP level dropping to level 'D'.
- For the most recently published National Diabetes Inpatient Audit (NaDIA) in September 2015, Queen's hospital performed better than the England average in 13 out of the 21 audit measures. Significant improvements had been made in foot risk assessment since the previous audit. However, one of the measures where the hospital performed below the England average is where patients were not seen by the multidisciplinary foot team (MDFT) within 24 hours. King George Hospital scored better than the England average for nine indicators.
- In the Lung Cancer Audit 2015, the trust was below expected standards for three key indicators relating to process, imaging and nursing measures. Only 78.7% of patients were seen by a

nurse specialist (against an expected standard of 80%). Only 80.9% were discussed in a multidisciplinary team (MDT) meeting (against an expected standard of 95%). Only 64% received a pathological diagnosis (against an expected minimum standard of 75%). Action plans had been put into place to improve patient outcomes in this area. Further work was being done to introduce a nurse-led triage system and achieve cancer waiting time indicators.

- The organisation performed worse than the England average in the paediatric diabetes audit 2014/15 with 12% of patients having an HbA1c balance of less than 58 mmol/l compared with the national average of 22%. The mean HbA1c of patients was 3% worse than the England average. HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time and hospitals benchmark their performance against NICE quality standard 6, which states that a HbA1c balanced of over 58 mmol/l indicates a poorly controlled diabetes.
- An IR(ME)R audit was last done in 2014. We saw that King George Hospital was not compliant with the audit. We did not see an updated action plan. The radiation protection advisor (RPA) told us the IR(ME)R procedures were being updated but these still currently showed a review date of 2012 on the electronic system.

**Multi-disciplinary working and coordinated care pathways**

- We observed good multidisciplinary (MDT) working across the trust. Most staff spoke positively about MDT working and we found evidence of good multidisciplinary relationships supporting patient care.
- We found that the ED's at both sites had a good working relationship with other hospital departments and noted that staff across the hospital acknowledged that the ED was a collective responsibility.
- We found evidence of good MDT working with external organisations such as primary care GP's, community safeguarding teams, the Police and ambulance services.
- The trust had introduced Schwartz rounds across both hospital sites to share working practices and increase support amongst staff of different disciplines. Schwartz Rounds are an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. Staff that we spoke to had varying awareness of these sessions.

**Seven day services**

- Many teams worked normal office hours such as: speech and language therapists, occupational therapy and physiotherapy. However, the physiotherapy department provided an on-call service at the weekend.
- Pathology services were unable to provide an adequately staffed service outside of the core working hours of 9am to 5.30pm, Monday to Friday. Outside of these hours, existing staff provided a service on a voluntary rostered basis, which meant staffing was not always at establishment.
- The radiology service provided emergency cover 24 hours a day, seven days a week across CT, ultrasound, interventional radiology, and plain film imaging.

**Consent, Mental Capacity act and Deprivation of Liberty Safeguards**

- Staff we spoke with had mixed knowledge of the principles of consent and mental capacity, including the treatment of patients with Deprivation of Liberty Safeguards (DoLS) orders and were not familiar with the term 'mental capacity.'
- There was a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Advisor, who provided support and training to staff as necessary. We saw evidence that they regularly emailed senior staff to remind them of the key issues surrounding capacity, and provided additional training around topics such as independent mental capacity advocacy and the MCA itself. Training in relation to the Mental Capacity Act 2005 was incorporated into safeguarding training.

**Are services at this trust caring?**

We examined the caring domain in the context of the core services that we inspected but for the purpose of this report we did not rate it.

- The majority of patients were positive about the care they received and we observed courteous interactions between staff and patients.
- Patients and relatives told us staff were respectful and helpful and gave them regular updates.
- Staff provided emotional support to patients and relatives and could signpost them to other support services if required.

However,

- We observed some negative interactions in the emergency department (ED) at Queens Hospital. We also observed a patient calling out for help and was ignored until we escalated to the nurse in charge.
- We found privacy curtains were not being drawn in the main diagnostic and imaging department and the emergency room in ophthalmology had bays that did not promote patients privacy and dignity.

**Compassionate Care**

- We saw that most staff demonstrated empathy and compassion towards patients. Staff introduced themselves to patients in a welcoming way and sought permission to enter their bed space.
- General observations confirmed staff respected the privacy and dignity of patients. In most areas we observed curtains being drawn around cubicles and blankets being offered to cover patients if required.
- The wards that we visited had a performance noticeboard on display which showed the most recent FFT scores. Most wards were scoring recommendation scores comparable to the England average of 96% (May 2016). However, the ED at both sites was slightly lower than the England average.
- However, we found the emergency room in ophthalmology did not promote patients privacy or dignity. The room had three bays separated by room dividers and curtains. The front area of the room was used as a patient triage area and there was also a screen in the area for conducting eye testing. Staff we spoke with acknowledged that the lay out of the room could compromise patients privacy and dignity, but said that space was an issue in the ophthalmology clinic.
- Positive interactions were not always demonstrated in the ED. For instance, we observed a patient ask a nurse if they could go to the toilet and the nurse responded in an unfriendly manner. We also observed a confused patient asking a doctor for help at the nurses station, who was responded to in an unfriendly and dismissive manner. The patient continued to ask for help and was ignored until a nurse came to help. We observed one patient shouting out for help numerous times and was ignored. We raised this with the nurse in charge who then attended to the patient.

**Understanding and involvement of patients and those close to them**

- We found good evidence of clinical staff involving patients, and their relatives, in their care. Patients fed back that staff talked to them at an appropriate level of understanding and valued that staff listened to their views.
- We saw that the trust had implemented the use of 'you said, we did' boards in the ED at Queens Hospital which gave feedback on changes that were being made as a result of patient and relative feedback.
- Some patients and relatives on the King George site felt that more could be done to involve them in their care, especially surrounding discharge.

**Emotional support**

- We observed staff demonstrating an understanding of the emotional impact of the patients' condition during various interactions and observation. Feedback from patients and relatives was positive and they told us staff were supportive and had been reassuring.
- The chaplaincy service provided good support for patients and relatives. We heard that it was accessible and the team responded promptly when requested. Chaplains were representative of several major religions including Church of England, Baptist, Roman Catholic, Islam, Judaism, and Sikhism.
- There were two prayer rooms available at Queen's Hospital, with ablution facilities available in one of the multi-faith prayer rooms. The King George Hospital had a multi-faith prayer room that was open 24 hours a day.
- Psycho-oncology services and complementary therapies were available on-site, as well as alcohol liaison and counselling service for inpatients. However, nursing staff that we spoke with had not received any training specific to caring for patients with mental health conditions.

**Are services at this trust responsive?**

We examined the responsive domain in the context of the core services that we inspected but for the purpose of this report we did not rate it.

This was because:

- The percentage of patients being seen and treated within the emergency department (ED) recommended four hour timeframe at both hospital sites and the number of patients who left the department without being seen was worse than the national average.

# Summary of findings

- The service was not meeting its 15 minutes triage standard for a high proportion of patients. The average time to triage was 28 minutes
- At the King George Hospital ED there was no viewing room where people could see their deceased relatives.
- In medical care at the King George Hospital patients were not always able to be located on the specialist ward appropriate for their condition. It was noted that management of these patients had improved since the previous inspection. However, the number of patients moved four or more times per admission had increased (although this may have been due to the trust incorrectly counting clinically appropriate moves within the hospital as ward moves). In some wards, bed moves were consistently occurring out of hours (between 10pm and 6am).
- Environments on some wards in the King George Hospital were not ideal, with high levels of noise and heat observed and reported. There was a lack of bedside televisions or radios across the wards, which some patients reported made them feel isolated and bored.
- The trust was consistently failing to meet NHS national indicators relating to 62-day cancer treatment. This issue had been added to the corporate risk register and actions had been undertaken to improve performance. The trust was also not meeting 18-week indicators for non-urgent referral to treatment (RTT) times.
- Staff across in the King George Hospital told us that they could not always discharge patients promptly due to capacity issues within the hospital or community provisions had not been put into place. The specialist medicine division was currently working on an early discharge flow programme to address excessive lengths of stay.
- At the King George Hospital patient information leaflets were not available in languages other than English. Although face-to-face and telephone translation services were available, many staff were not familiar with how to access these.
- The Patient Advice and Liaison Service (PALS) at the King George Hospital did not always respond to complaints in a timely manner.
- The percentage of appointments were cancelled by the hospital was 14% which is higher than the England average of 7.2%.

However,

- The ED's at both sites worked closely with local GP's to stream patients effectively, including back to their own GP. A joint information booklet for parents had been developed to educate them around treatment for common childhood illnesses and injuries.
- There were a number of specialist teams available, including a frail and older persons advice and liaison team which worked closely with the ED departments.
- People living with dementia received tailored care and treatment. Care of the elderly wards at the King George Hospital had been designed to be dementia friendly and the hospital used the butterfly scheme to help identify those living with dementia who may require extra help.
- Support for people with learning disabilities was available. There was a lead nurse available for support and advice. Staff made reasonable adjustments for patients with learning disabilities and there were easy read information leaflets available to explain treatments and support during their stay in hospital. There was a monthly safeguarding and learning disability operations group.
- A dedicated paediatric learning disability nurse had introduced support resources for patients, including a children's hospital passport and visual communication tools. This helped staff to build a relationship with patients who found it challenging to make themselves understood.
- Diagnostic waiting time indicators were met by the trust every month between May and August 2016.

**Planning and delivering services which meet people's needs**

- There were established links between the ED and with social care providers and local clinical commissioning groups (CCG).
- The trust had plans to go live on a child protection information sharing system by the end of October 2016. This was a national safeguarding database, which would help ensure better information sharing with the three local boroughs. Two of the local boroughs were already on the system and the trust were waiting for the final borough to go live before going live themselves.
- In recognition of the age profile of Havering being older than the London average, the trust had invested in the Frail and Older Persons Liaison Service (FOPAL), which regularly checked all patients 75 and above in the ED. The service did assessments on vulnerability using a frailty score and liaised with social services, family and local community services.

FOPAL initiated the Gold Standard framework assessment for patients who were through to benefit from the palliative care pathway. We saw one example of this and noted there had been discussion with the relatives.

- We found evidence of a local representatives panel. This was held bi-monthly, and included stakeholders such as Healthwatch and local councillors. Minutes indicated that service planning and delivery were a key component of the discussions within these meetings.
- There was a lack of bedside televisions or radios in the wards. Some patients without access to internet compatible devices told us that this made them feel isolated and bored.
- Work was in progress with the outpatients department to conduct a demand and capacity analysis in partnership with a private company that specialised in risk and trend analysis to develop a model whereby the hospital could assess and effectively manage the demands on the outpatients department. Managers told us the model would be used to inform how much extra capacity needed to be built into the system.

**Meeting people's individual needs**

- We found evidence in various areas where the trust had focused on developing services in response to patients' needs.
- Patients with a diagnosis of learning disability (LD) would be issued with a specific LD folder and were allocated an LD Link Nurse (a specialist nurse who supports people with a learning disability while they are in hospital, to make sure they get the care they need). Each patient would be issued with a hospital passport. Hospital passports were designed to give hospital staff helpful information, that was not only about illness and about health, but could also include a list of patient's likes and dislikes, favorite type of food and drink, as well as their interests.
- A dedicated paediatric learning disability nurse had introduced support resources for patients, including a children's hospital passport and visual communication tools. This helped staff to build a relationship with patients who found it challenging to make themselves understood.
- The trust hosted a 24/7 psychiatric liaison service (PLS). This team worked closely with ED staff to improve the quality of care experienced by those patients who presented to the department and had an associated mental health illness.
- At the King George Hospital we found the outpatient department had introduced new reception desks with a dip in

the desk, these made face to face interactions with reception staff accessible to wheelchair users. Separate waiting areas in the outpatients department had 'pods' to check patients into clinics on arrival.

- A multi-faith space was available to provide support in both hospitals. There was information for patients informing them how to access the multi-faith space if required.
- Within the catering menu there were many options to cater for those with different requirements. Menu items catered for those with food allergies and provided halal, kosher, vegetarian and vegan options.
- However, patient information leaflets were not standardly available in languages other than English. Face-to-face and telephone translation services were available, although staff awareness of this was variable.
- During the second unannounced inspection of Queen's Hospital ED we noted the waiting areas were very full and there were few chairs available for patients. Within the paediatric waiting area we saw a number of parents standing with their children due to a lack of seating space.

**Dementia**

- The trust had implemented the use of blue and white butterfly symbols on patient information boards to indicate whether a patient had a diagnosis of dementia or delirium respectively. Patients living with dementia were nursed according to a specially designed care pathway and were offered 1:1 nursing care from healthcare assistants with enhanced training, who provided stimulation and company.
- Family members and carers were encouraged to be involved in their care. 'This is me' booklets were produced to ensure staff were familiar with the best ways to approach caring for each patient. Red trays at meal times were used to alert nursing staff the patient may require extra help.
- Staff had received in-house training on caring for people living with dementia. All staff we spoke with were aware that these patients needed extra support and were able to describe how they would provide them with person-centred care. A specialist dementia team and dementia link nurses were available for support and advice.
- Staff used a cognitive assessment tool to identify patients with memory issues on admission. A joint delirium clinic with a psychiatrist from another trust also took place at the Queen's site to enable the rapid assessment of patients who had recently become confused.

- There were dementia carers and relatives coffee mornings, provided by the dementia team on a monthly basis. The purpose of these coffee mornings was to provide information and support to carers and relatives of patients living with dementia.

**Access and flow**

- Queen's Hospital March 2015 inspection report highlighted that in the past there been long waiting times for the majority of patients who attended the ED.
- Standards set by the government state that 95% of patients who attend the ED should be admitted or discharged within four hours. The percentage of patients seen within 4 hours at both hospitals had deteriorated over time rarely met the national standard.
- A 'streaming' process had been introduced (a process designed to fast track patients to the right places from reception, such as UCC, GPs or majors). The purpose of this was to prevent people waiting in the ED when it might not be required and minimise overcrowding.
- We saw the trust had developed ED escalation plans (full capacity protocols). These set out clear pathways and processes to be followed when there was a failure to deliver patient flow through the department as usual.
- We saw that failure to comply with the four hour standard was rated as extreme and was added to the corporate risk register in May 2016 and reviewed at each meeting. The recorded concern was that excessive waiting times and the resulting potential for delayed decision making impacted on patient care.
- The risk register in medicine highlighted that patients were experiencing extended lengths of stay at the hospital, due to delayed discharge from wards. This was causing poor patient experience, poor clinical outcomes, as well as poor patient flow throughout the division. The trust target of 40% of patients to be discharged between 8am and 12pm was not being achieved in the year September 2015 to August 2016.
- The trust did not submit any referral to treatment time (RTT) data to NHS England in the reporting period (Jun 2015 – May 2016). We were informed that this was due to the 52 week waiting times and the RTT Patient Tracking List (PLT) was undergoing a process of validation.
- In April 2016 the deputy chief operating officer (COO) had joined the hospital and had conducted an analysis of patients that had waited for an appointment for over 52 weeks. As a result

the hospital identified that a further 6000 appointments were required to provide these patients with care and treatment. An action plan and timescales were in place as a result of the analysis.

- The medical director told us the challenge for the trust in regards to RTT was patients waiting 18 to 52 weeks. The medical director said there had been a number of discussions with the COO in regards to patient safety whilst patients waited for an appointment and we were shown evidence that these had been assessed for clinical risk.
- The hospital had introduced initiatives to reduce patients RTT, including reviewing patients arriving in the emergency department (ED) to establish if the presenting problem was related to an outpatient's department appointment.
- In addition, the hospital was using a range of private providers to assist in clearing the backlog of appointments. The deputy COO told us the hospital looked daily at patients referred to a private provider and tracked and monitored their care and treatment. The hospital met with providers weekly and identified where patients were on their care and treatment journey. The hospital was also monitoring patient outcomes within private care provision.
- Senior managers told us the hospital was on-track to clear the backlog of patients waiting over 52 weeks for an appointment by the end of September 2016.
- The RTT performance pack dated 1 September 2016 recorded there had been an 88% reduction in the overall backlog of patients waiting over 52 weeks since May 2016. The trust had analysed the trajectory for these patients and were 387 appointments ahead of the planned target.
- In the trust's annual report 2015/16, they reported that 96.1% of patients with a diagnosis of cancer received their first treatment within 31 days of decision to treat (against a standard of 96%). In 2016, performance against the 31-day waiting time indicator continued to be good, achieving 100% for every month between March and July, apart from in April, when only 83.4% of patients were seen.
- In the same annual report, the trust reported that only 74% of patients were receiving their first treatment from the initial GP referral within 62 days (against a national standard of 85%). This continued to be an issue in 2016, with between only 25% and 80% of patients meeting the 62-day waiting time indicator between March and July. The trust was aware that it was failing to achieve this waiting time indicator and attributed this to

poor pathway management for specific tumour groups (urology, upper GI and colorectal), capacity and workforce issues, in addition to diagnostic tests occurring too late in the pathways.

- An action plan was devised to improve this, which included the engagement with partners via the London Cancer Vanguard programme to escalate issues and delays, regular review of capacity with additional clinics being run regularly and a recruitment plan being put into place. A cancer programme board monitored performance on a weekly basis and strengthened tracking of all patients on a 62-day pathway.
- The percentage of patients who did not attend (DNA) their appointment was 9.0%; this was above the England average of 6.8%. Managers said they recognised that the DNA rate was too high. The hospital had introduced an initiative whereby patients would not be discharged following their first missed appointment; they would instead be given three weeks' notice.

**Learning from complaints and concerns**

- We found that there was a culture of openness around complaints in the trust.
- Staff we spoke with confirmed awareness of the trust complaints procedure. However, not all were able to provide examples of complaints or concerns that resulted in change of practice or demonstrate how they learnt from it.
- Patient information on how to make a complaint or raise a concern with Patient Advice and Liaison Service (PALS) was available throughout the department.
- In most clinical areas that we visited, there was a 'good to talk' board, which included information on how to contact the patient advice and liaison service (PALS), language services, chaplaincy support and how to provide informal feedback. There were also boards on every ward that explained who different key staff were and included pictures of the different staff uniforms in use, explaining what role each one signified.
- Minutes from clinical quality review meetings indicated that PALS responses to complaints were sometimes not timely. Between April and June 2016, only 60% of complaints were replied to within the timescale agreed with the complainant, against a trust target of 85%.
- Complaints data was discussed monthly at both the clinical quality review meeting and the patient experience and engagement group. Any themes or learning were then shared with wider staff groups through the integrated quality and safety report, team meetings and divisional newsletters.

# Summary of findings

**Are services at this trust well-led?**

**Requires improvement**

We rated the well led domain as requires improvement. This was because:

- There was a lack of clarity on clinical strategy at a service level. We were told plans for the ED's were often changing and staff were not able to talk about local plans. Similarly in outpatient services staff were not able to articulate the future clinical strategy for services.
- We found inconsistency in the application of infection prevention and control policies and procedures.
- We found that whilst improvements had been made in regards to governance structures, this was not mature or embedded and there were a number of clinical policies and national guidelines which were out of date, or in some areas where we found multiple clinical guidelines available to staff.

However,

- Senior Leadership was visible and involved in clinical activity. Staff were positive about changes and were starting to feel more optimistic.
- Staff told us that the executive board frequently visited the various hospital departments interacting with staff and patients.
- Staff knew and understood the vision of the trust.
- Resources had been invested into improving clinical governance structures and risk management since the past inspection in March 2015. An external organisation had worked with the trust on strengthening their governance structures. The trust had rebranded clinical governance as 'quality and safety' and meetings took place on a monthly basis.
- It was evident that risk management was a priority at departmental level and local risk registers were more robust than during previous inspections.
- Quality improvement and research projects took place that drove innovation and improved the patient experience.

**Leadership of this trust**

- At the time of inspection, the senior leadership team comprised of substantive executives and non-executives. The Chair of the organisation Maureen Dalziel, had been in post since 2014 and the Chief Executive Officer Matthew Hopkins had been in post since April 2014.
- All non-executive director's had been in post for over two years. Whilst the executive director team including the chief operating office, the director of finance and investment, the director of people and organisational development and director of

strategy and planning in post from 2014. The medical director joined the organisation in 2015 and the most recent appointment the chief nurse had been in post since January 2016.

- The organisation operated across six clinical divisions: acute medicine, specialist medicine, surgery, anaesthetics, women and children's and cancer and clinical support. Each clinical division ran a divisional operational board, a divisional recruitment and retention group, a divisional quality and safety group. These were supported by speciality / service quality and safety groups and ward / team meetings. Each division consisting of a divisional leadership team, led by a clinical divisional director and supported by a divisional manager and a divisional nurse in a triumvirate model of management.

**Vision and strategy**

- In 2014 the organisation had developed the the trust values of Passion, Responsibility, Innovation, Drive and Empowerment (PRIDE). These values were discussed during the trust induction and staff were able to talk about these values during our inspection. We observed staff carrying a 'pocket-sized' booklet with the trust's values attached to their lanyards.
- The five strategic priorities for 2015/16 were:

1. Delivering high quality care
2. Running the hospitals efficiently
3. Becoming an employer of choice
4. Managing finances
5. Working in partnership

- The approach of continuous, incremental improvement was emphasised across all of these areas. The focus for all improvement work within the trust was the elimination of waste, the standardisation of work, mistake proofing and a methodology aimed primarily at reducing flow times and response times to patients. The goal of the trust was to become a learning organisation that engaged staff at every level. As such, this approach had been incorporated into the staff appraisal process.
- There was a five-year plan which had been developed in partnership with system leaders and organisations across north east London (with 2016/17 being the first year of the plan). This plan described how services would collectively work to deliver sustainable services to the local population, and was aligned to the emerging trust clinical services strategy. The plan involved working closely with commissioners to define and manage

clinical pathways. In December 2015, the trust had conducted a stakeholder audit to identify strengths and weaknesses and find a way of working together with other organisations to improve services.

**Governance, risk management and quality measurement**

- The trust had commissioned an external organisation to assist the set-up of governance systems and processes. There was a substantial drive across the organisation to improve quality of the service through a consistent clinical governance practices, however we found evidence that the pillars of governance were not fully matured and embedded at the time of our inspection.
- Each clinical division held a monthly quality and governance meetings which were used to ensure learning from incidents and complaints were embedded into the practice. We noted from minutes of these meetings that complaints, incidents and emerging risks were discussed, evaluated and monitored.
- Divisional board meetings and divisional quality and governance meetings fed into the trust-wide governance and quality structure for executive and non-executive review and sign-off, where appropriate.
- Structures to maintain risk management existed and divisional leaders understood these systems. We reviewed the risk registers for the divisions that we inspected. In the main these captured the majority of risks that we expected. However, we noted he organisation had recognised that further work was required to ensure the divisions were in control of their risks.
- There were several groups which aimed to improve governance and risk management across the trust. The clinical outcome and effectiveness group discussed topics such as national targets, audits, care pathways, medicine optimisation and NICE compliance. The patient safety group focused on topics such as incidents, infection prevention and control, medicines safety and safeguarding. The patient experience group discussed areas such as complaints, dementia, nutrition and volunteering. The people and culture committee examined issues such as staffing, training and equality and diversity. Discussions from these meetings all fed into the monthly quality assurance committee, which considered governance and risk management issues as a whole. However, some staff told us that this committee was often poorly attended.
- There were also regular senior nurses meetings, as well as divisional and ward meetings where risk and governance issues were discussed with a wider staff group. The frequency of these meetings varied across divisions, with some specialties or wards meeting every two weeks, and some every three months.

- The divisions had an audit calendar, which was used to monitor services and compliance against national and local standards. Nursing staff participated in local audits, and although some told us that this increased their workload, they could see how resulting information was shared amongst teams to promote improvement. There was an audit committee that met five times a year to oversee both external and internal audits.
- The hospital had introduced a 'performance pack' suite of reports that provided information on RTT performance. The deputy COO told us the reports provided the hospital with "clear visibility and accountability" with the aim of reducing the number of patients waiting for over 52 weeks for their care and treatment.
- The trust's medical director told us the trust had established harm panels which reviewed the admitted patients' pathway to assess degrees of patient harm. Three minor harms had been identified as a result of the review. The trust had also sampled 10% of non-admitted patients and identified no harm to patients with the longest waits. The assistant medical director had continued to review patients via 'dip checks.'
- There was some misalignment between the recorded risks on the risk register and what staff expressed was on their 'worry list'. For example in the ED at Queens Hospital nursing staffing levels was raised consistently by staff but this was not on the divisions risk register. However, we noted in some of the safety and quality minutes from April 2016 that "workforce vacancy impacting on patient safety – nursing" was recorded as an amber risk. However, we could not find this on the risk register provided by the trust.
- Trust policies were reviewed via the Policy Approval Group, however we were informed that this committee had been suspended and reinstated very recently. We found a number of out of date clinical policies during our inspection. We also found multiple versions of policies available on the trust intranet which could lead to staff confusion.

**Culture within the trust**

- Most staff that we spoke with talked openly about the culture within the trust. A number of staff told us they felt more positive and that morale was improving.
- Staff described the chief executive officer as having an open door policy allowing staff to make their thoughts and opinions known.

- Staff consistently told us of their commitment to provide person-centred care, and spoke positively about the care they delivered. Staff understood their responsibility in putting patients first and incorporating the trust's values into caring for patients.
- Most staff we spoke with commented on how supportive staff of all levels were, and how the trust had become a better organisation to work in.
- Nurses told us there had been a shift away from 'blame culture', towards learning from mistakes and 'near misses'. Most felt comfortable to raise concerns with local managers, but were also aware of formal whistleblowing procedures and policy. The independent guardian service was now into its third year and helped staff to openly raise their concerns in confidence.
- Staff commented on improvements in nursing morale and empowerment, making the wards more enjoyable to work on and reducing stress and sickness.

**Equalities and Diversity – including Workforce Race Equality Standard**

- The Workforce Race Equality Standard (WRES) became mandated in the NHS Standard Contract 2015/16 and commissioning contracts. As a result NHS bodies were required to publish a WRES baseline report by 1st July 2015, based on a set of WRES indicators at April 2015. There are nine WRES indicators (refer to Appendix 1) of which four relate to workforce data; another four are based on questions from the NHS staff survey questions and one indicator relates to improving the ethnic composition of NHS Boards, better to reflect the population served. NHS bodies are required to produce WRES reports annually and demonstrate progress against these indicators of workforce race equality.
- As part of our inspection we held one Black, Asian, and minority ethnic (BME) staff focus group at Queens Hospital and also an interview with the Head of Inclusion (the Trust Equality and Diversity Lead).
- Generally BME staff thought working for the Trust good, but some raised concerns that there was not much opportunity for progression and that there was a lack of BME role models at senior levels of the organisation.
- We found evidence of WRES reports being discussed at board level. We found that a BME network was recently created and that the network is engaging with the newly implemented Inclusion Steering Group.
- The trust now has a culture of openness and a willingness to engage with its BME staff, the BME workforce via its BME

network has expressed confidence in the trust and a willingness to work with the organisation to improve the experience of its minority staff. It was considered that the trust could engage with its BME workforce in a more meaningful way through assigning more specific goals to its' trust-wide action plan.

**Fit and Proper Persons**

- The trust had made preparations to meet the Fit and Proper Persons Requirement (FPPR) (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Regulation 5). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. The regulation came in to force in November 2014.
- The trust had a fit and proper persons policy in place. This was a policy covering arrangements for both recruitment and ongoing assurance. The Fit and Proper Person's criteria were linked to the annual appraisals of executive Board Directors, to ensure ongoing compliance.

**Public engagement**

- The trust had appointed a Director of communications and marketing to work with the Board, as well as holding responsibilities for external communications. The trust encouraged a number of initiatives to foster external engagement including: 'you said, we did' boards and developing ED twitter feeds.
- The trust had also introduced a patient experience and engagement group in 2015, which provided a forum for staff to engage with and receive feedback from key stakeholders including patients and carers. Listening events, held in conjunction with Healthwatch, focused on the highest number of Patient Advice and Liaison Service (PALS) enquiries and formal complaints, allowed patients the chance to ask senior management questions around issues raised. The trust produced leaflets that summarised concerns arising from these meetings and stated what had been done to address these.
- The trust included patient stories as part of the corporate trust induction. A patient story, based on real life experiences from the hospital, was presented each month at the board meetings so that leaders could hear first-hand about how patients felt about the care they had received.

**Staff engagement**

- The executive directors and non-executive directors carried out walk-arounds, during which they visit a range of clinical areas and receive staff feedback.

- Feedback from patients was obtained from the NHS Friends and Family test. We found evidence of other local surveys to obtain further feedback from staff. In the 2015 staff survey 2092 staff at Barking, Havering and Redbridge University Hospitals NHS Trust took part in the National NHS staff survey. This was a response rate of 37% which was below an overall average response rate of 41% for acute trusts in England, but represented an increased response of 4% on the 2014 staff survey.
- We looked at overall trust results of feedback from staff in the 2015 National NHS staff survey which was combined for King George hospital and Queen's hospital. The trust scored better than the national average for staff motivation at work, quality of non-mandatory training, percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months, percentage of staff reporting errors, near misses or incidents witnessed in the last month and effective use of patient feedback.
- However, the trust scored below the national average for percentage of staff believing that the organisation provides equal opportunities for career progression or promotion, percentage of staff satisfied with the opportunities for flexible working patterns, percentage of staff experiencing discrimination at work in last 12 months, percentage of staff suffering work related stress in last 12 months and percentage of staff working extra hours.
- The trust celebrated the achievements of staff by having a 'star of the month' which colleagues nominated. There were also annual staff award ceremonies, based around the trust values, which awarded staff in categories such as 'Hospital Hero', 'Working Together' and 'Pursuing Excellence'.
- A 'terrific ticket' initiative had been introduced across the trust, which rewarded staff members for good practice and for those who went over and beyond in their line of work
- The trust implemented a training programme for Health Care Assistants (HCAs), whereby staff work to achieve a Care Certificate. We were informed that 92% of HCAs had completed this course at the time of our inspection and that this was one area of focus in raising the profile of nursing within the organisation.

**Innovation, improvement and sustainability**

# Summary of findings

- The trust had been recognised with a number of awards over the twelve months prior to our inspection. The Healthy Workplace Charter was awarded in recognition of trust Health and Wellbeing Team and of the resources dedicated to ensuring a healthier workplace.
- The initiatives implemented include encouraging healthy eating and exercise, offering healthier food choices through catering at the hospitals, and encouraging attendance at various exercise or wellbeing classes on site.
- Two of our consultants were recognised for their commitment to helping junior colleagues in their training and development. One consultant was awarded the Outstanding Clinician Achievement award by the Essex Medical Society. Whilst another was the winner in the first Postgraduate Medical and Dental Education awards, in the Clinical Supervisor of the Year category.
- The action the trust had taken to reduce carbon emissions and tackle climate change had won a number of awards including: the Public Sector Sustainability Awards – Winner, Most Sustainable Public Sector Organisation. The Green Apple Awards – Winner, Environment Best Practice; and the Green Essex Awards – Winner, Greenest Large Business
- The trust was chosen as one of five trusts in the country to be mentored by the US system leader in sustainable change (the USA's 'Hospital of the Decade') as part of a five-year improvement programme. Clinicians and leaders from the institute were teaching staff about the principles and systems that they used. The trust values were a locally branded adaptation of their change methodology and formed the basis of their new change management approach.
- The trust engaged with the University of East London to develop a training pathway in health and social care for school leavers, as well as developing other innovative roles such as nursing associates to create openings for local recruitment in nursing.
- The organisation had encouraged a number of local innovations which have benefited patients including: the ehandover system. The trust is currently working with a private enterprise company to promote innovation, and will be holding regular events to encourage our staff in innovation.

# Overview of ratings

## Our ratings for Queens Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement |
| Medical care | Requires improvement | Good | Good | Requires improvement | Good | Requires improvement |
| Services for children and young people | Requires improvement | Good | Good | Good | Good | Good |
| Outpatients and diagnostic imaging | Good | N/A | Good | Requires improvement | Good | Good |

## Our ratings for The King George Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Requires improvement | Requires improvement | Good | Good | Requires improvement | Requires improvement |
| Medical care | Requires improvement | Requires improvement | Good | Requires improvement | Good | Requires improvement |
| Outpatients and diagnostic imaging | Requires improvement | N/A | Good | Requires improvement | Good | Requires improvement |

## Our ratings for Barking, Havering and Redbridge University Hospitals NHS Trust

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Overall | N/A | N/A | N/A | N/A | Requires improvement | Requires improvement |

# Outstanding practice and areas for improvement

## Outstanding practice

We saw several areas of outstanding practice including:

- The hospital provided tailored care to those patients living with dementia. The environment in which they were cared for was well considered and the staff were trained to deliver compassionate and thoughtful care to these individuals. Measures had been implemented to m ake their stay in hospital easier and reduce any emotional distress.
- The trust had awarded the neonatal and community teams for their work in providing babies with oxygen home therapy, which significantly improved the quality of life for families.
- A dedicated paediatric learning disability nurse had introduced support resources for patients, including a children's hospital passport and visual communication tools. This helped staff to build a relationship with patients who found it challenging to make themselves understood. This had been positively evaluated and received a high standard of feedback from parents and patients.
- Child to adult transition services were comprehensive and conducted with the full involvement of the patient and their parents. This included individualised stages of empowering the person to gradually increase their independence, the opportunity to spend time with paediatric and adult nurses together and facilities for parents to spend the night in adult wards when the young person first transitioned.

## Areas for improvement

**Action the trust MUST take to improve**

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure all patients attending the ED are seen by a clinician in am timely manner.
- Take action to improve levels of resuscitation training.
- Ensure there is oversight of all training done by locums, particularly around advanced life support training.
- Take action to improve levels of resuscitation training.
- Take action to improve the response to patients with suspected sepsis.
- Take action to address the poor levels of hand hygiene compliance.
- Ensure fire safety is maintained by ensuring fire doors are not forced to remain open.
- Ensure staff have a full understanding of local fire safety procedures, including the use of fire doors and location of emergency equipment
- Ensure hazardous waste, including sharps bins, is stored according to related national guidance and EU directives. This includes the consistent use of locked storage facilities.

In addition the trust should:

- Endeavour to recruit full time medical staff in an effort to reduce reliance on agency staff.
- Ensure there is sufficient number of nurses and doctors with adult and paediatric life support training in line with RCEM guidance on duty.
- Improve paediatric nursing capacity.
- Improve documentation of falls.
- Document skin inspection at care rounds.
- Document nutrition and hydration intake.
- Review arrangements for the consistent sharing of complaints and ensure that learning is always conveyed to staff.
- Make repairs to the departmental air cooling system.
- Ensure policies are up to date and reflect current evidence based guidance and improve access to guidelines and protocols for agency staff.
- Take action to improve the completion of early warning scores.
- Improve appraisal rates for nursing and medical staff.
- Regularise play specialist provision in the paediatric ED.
- Consider how to improve ambulance turn around to meet the national standard of 15 minutes.

# Outstanding practice and areas for improvement

- Ensure staff and public are kept informed about future plans for the ED.
- Restructure the submission of safety thermometer data to match the current divisional structure.
- Monitor both nursing and medical staffing levels. Follow actions detailed on corporate and divisional risk registers relating to this.
- Monitor and improve mandatory training compliance rates for medical staff. Improve completion rates for basic life support for nursing and medical staff.
- Review out-of-hours provision of services and consider how to more effectively provide a truly seven day service.
- Continue to work to improve endoscopy availability and service, as detailed on the corporate risk register.
- Make patient information leaflets readily available to those whose first language is not English.
- Ensure leaflets detailing how to make a formal complaint are available across all wards and departments.
- Ensure consent to care and treatment is always documented clearly.
- Ensure each inpatient has an adequate and documented nutrition and hydration assessment.
- Ensure there are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.
- Ensure there are appropriate processes and monitoring arrangements in place to improve the 31 and 62 day cancer waiting time indicator in line with national standards.
- Ensure the 18 week waiting time indicator is met in the outpatients department.
- Ensure the 52 week waiting time indicator is consistently met in the outpatients department.
- Ensure percentage of patients with an urgent cancer GP referral are seen by a specialist within two weeks consistently meets the England average.
- Ensure the number of patients that 'did not attend' (DNA) appointments are consistent with the England average.
- Ensure the number of hospital cancelled outpatient appointments reduce and are consistent with the England average.
- There is improved access for beds to clinical areas in diagnostic imaging.
- Address the risks associated with non-compliance in IR(ME)R and IRR99 regulations.
- Ensure the number of hospital cancelled outpatient appointments reduce and are consistent with the England average.
- Ensure diagnostic and imaging staff mandatory training meets the trust target of 85% compliance.
- Develop a departmental strategy in diagnostic imaging looking at capacity and demand and capital equipment needs.
- Improve staffing in radiology for sonographers.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>We had concerns around the governance of the emergency department including the handling of investigations of incidents, risk management, oversight of resuscitation training, and infection prevention and control management. The service must address this including:<br><br>1. Taking action to improve levels of resuscitation training.<br><br>2. Ensure there is oversight of the training competencies of locum doctors, particularly around advanced life support training.<br><br>3. Take action to improve the response to patients with suspected sepsis.<br><br>4. Take action to improve poor levels of hand hygiene compliance.<br><br>This was a breach of Regulation 17(2)(a) and 17(2)(b) |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Regulation 12 HSCA (RA) Regulations 2014 Safe care and<br><br>Treatment.<br><br>We saw that failure to comply with the four hour standard was rated as extreme and was added to the corporate risk register in May 2016 and reviewed at each meeting. The recorded concern was that excessive waiting times and the resulting potential for delayed |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br><br>There was inadequate compliance with fire safety standards and staff did not have sufficient understanding of local fire safety procedures. Environmental safety management was inconsistent for children's services. This included unsecured areas used to store items that could be dangerous to children, including sharps bins, chlorine tablets and clinical equipment. These concerns must be addressed, including:<br><br>1. Ensuring fire safety is maintained by ensuring fire doors are not forced to remain open and fire safety standards are appropriately implemented.<br><br>2. Ensure staff have a full understanding of local fire safety procedures, including the use of fire doors and location of emergency equipment.<br><br>3. Ensure hazardous waste, including sharps bins, is stored according to related national guidance and EU directives. This includes the consistent use of locked storage facilities.<br><br>This was a breach of Regulation 15(1)(a) and 15(1)(d) |

decision making impacted on patient care. The percentage of patients who left without being seen was also higher than the England average in all months between January 2016 and August 2016.

1. Ensure all patients attending the ED are seen more quickly by a clinician.

This was a breach of Regulation 12(2)(a).

# OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 18 APRIL 2017

| | |
|---|---|
| **Subject Heading:** | PMS Review and Primary Care Update |
| **Report Author and contact details:** | **Sarah Perman**<br>**North East London Commissioning Support Unit** |
| **Policy context:** | **The information presented will allow effective scrutiny of local primary care issues** |
| **Financial summary:** | **No impact of presenting of information itself which is for information/scrutiny only.** |

## SUMMARY

Information will be presented giving the latest position on the review of the Primary Medical Services (PMS) for GPs and on local primary issues generally.

## RECOMMENDATIONS

1. The Joint Committee to note the information presented and make any appropriate recommendations.

## REPORT DETAIL

Officers will present and summarise details of the position with renegotiation of the Primary Medical Services Contract with some local GPs. The Committee is asked to note the position and any other information re local primary care services that is presented.

## IMPLICATIONS AND RISKS

**Financial implications and risks:** None of this covering report.

**Legal implications and risks:** None of this covering report.

**Human Resources implications and risks:** None of this covering report.

**Equalities implications and risks:** None of this covering report.

## BACKGROUND PAPERS

None.

NHS
Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

# Personal Medical Services (PMS) Review and primary care update



## 18 April 2017

Sarah Perman, Primary Care Team, BHR CCGs

# Background - reminder

- In February 2014 NHS England (NHSE) issued national guidance that all PMS contracts must be reviewed

- PMS contracts allow GPs to receive extra payments for providing enhanced services to meet local needs (as opposed to General Medical Services [GMS] contracts) – BUT great variation in payments between practices and little evidence that they have improved outcomes for patients

- The review aims to move to a consistent, equitable approach, ensuring GPs are paid equally for providing the same services, and that PMS contracts are promoting innovation and improvement as originally intended.

# Background - reminder

- CCGs were asked to come up with “commissioning intentions”, to form the basis of their local PMS offer. This would be in addition to core contracts which would be consistent across the capital and were known as the “London offer”

- Contract negotiations paused in spring/summer 2016 while NHSE and Londonwide LMCs (LW-LMC) discussed the content of the London Offer in the context of the GP Forward View

- NHSE and LW-LMCs agreed a “one size fits all” approach will not work for London and wrote out to ask CCGs to progress the review at local level.

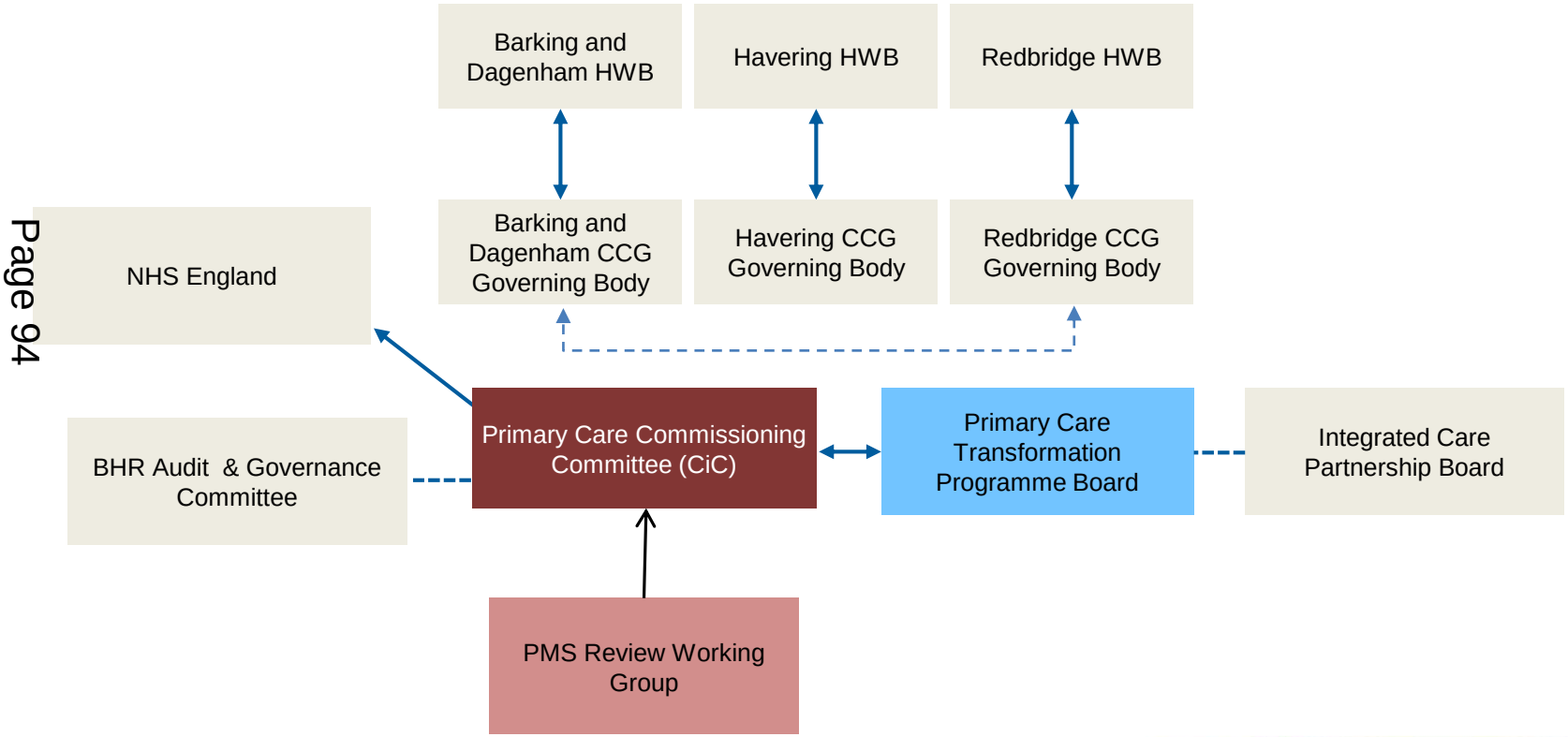
# Key principles: PMS review

- Will make system fairer by paying every practice in a borough the same basic amount per patient
- No reduction in level of GP funding in the CCG area: the review will give patients access to the same range of services regardless of what type of contract is held by the practice they are registered with
- We aim to ensure no GP practice is unfairly disadvantaged by the review, and we believe most will be better off
- We understand any practice whose basic income is seen to be reducing as a result of the review will be worried: putting in place a transition plan and will work closely with them to help manage this change
- This review is just part of a wider transformation plan, which will bring investment in new technologies and ways of working, and give GPs the opportunity to enhance their income through innovation and performance.

# Key principles: local negotiations

- NHS England and LW-LMC have asked individual CCGs to determine their own core GP contracts and PMS premium, so they can recognise and address local health needs
- BHR CCGs now working to draw up new core contracts, and decide which additional services should be provided by PMS practices and how much the new premium for providing those will be
- This will of course take time, but it gives us the opportunity to design a modern local GP offer, and specify the services all residents should have access to
- At the end of this process all patients will have access to the same range of services, reflecting the unique needs and challenges of their borough, and GPs will be paid equitably for providing the same services.

# Governance overview



# Local context in BHR - reminder

| CCG | Number PMS practices | Total premium value | Ranking of premium value in London | Min/Max premium (£pwp) |
|---|---|---|---|---|
| Barking and Dagenham | 11/38 | £2.4m | 2nd highest premium | £9.50 / £58.13 |
| Havering | 12/44 | £1.03m | 3rd lowest premium | £10.17 / £11.51 |
| Redbridge | 13/45 | £1.02m | 8th lowest premium | -£2.16 / £27.77 |

# Financial affordability: principles

- Over five years GMS/PMS increase of £7.3m (from £62.9m to £70.2m) across BHR – exceeding our funding increase
- STPs required to remain overall within their control totals during life of plan
- BHR CCGs must remain within overall affordability total – individual CCG agreements must account for this
- North East London STP seeking equity for providers across the region, BHR remain more challenged in terms of funding
- Each CCG area is in a different state regarding current funding to practices. Will be necessary to reflect this in different agreements, including phasing and transition timing
- A balance in timing must be achieved for equalising PMS and GMS contracts.

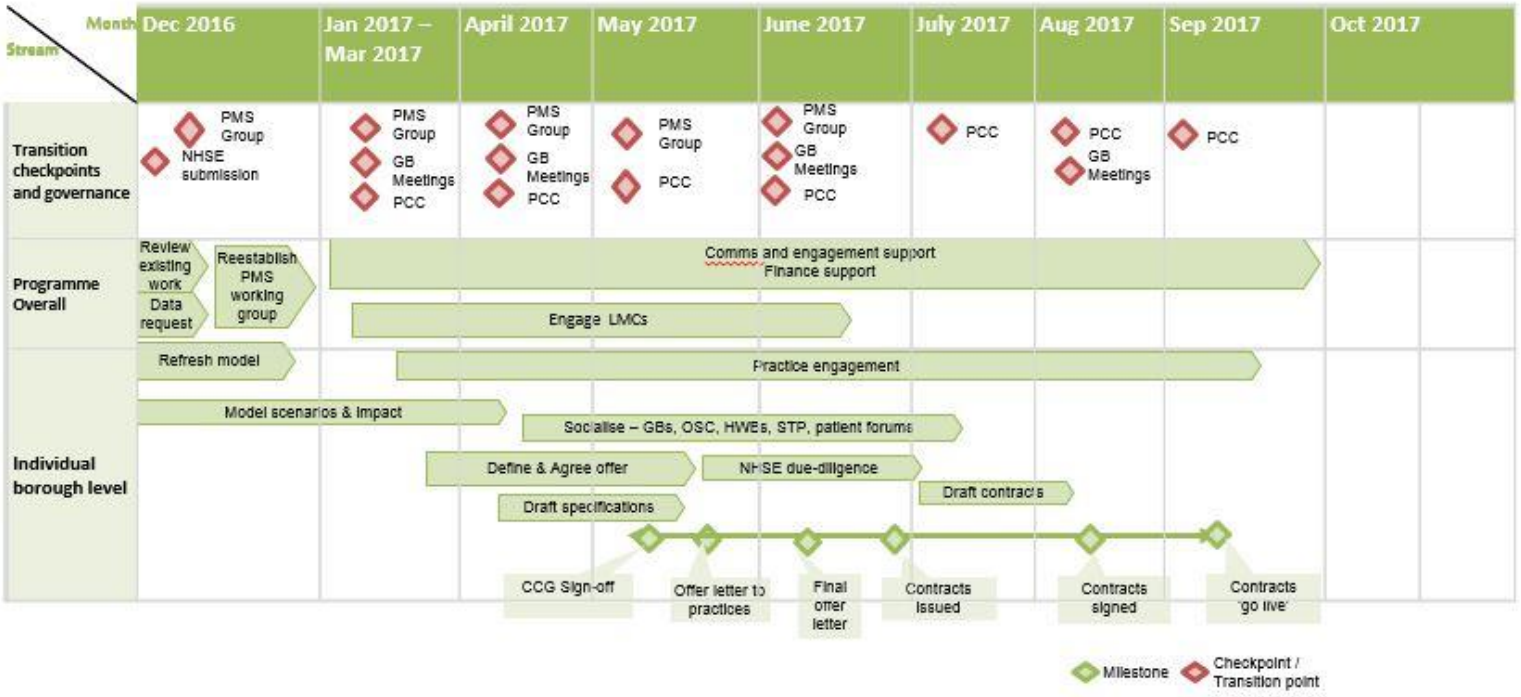
# Affordability: solutions to be explored

A number of options need to be explored to ensure contract expenditure remains within allocation.

This may include (but is not limited to) reviewing:

- current PMS offer assumptions
- premium transition costs
- phasing of GMS alignment
- current primary care investment funding
- GP Forward View initiatives (inc improved access)
- economy-wide solutions.

# Draft implementation plan



# CQC inspections update

| CCG | Total number of practices | Number of visits taken place with published reports | % of visits taken place with published reports | No. rated 'Inadequate' (special measures) | % rated 'inadequate' | Number rated 'requires improvement' | % rated 'requires Improvement' | Number rated 'Good' | % rated 'Good' |
|---|---|---|---|---|---|---|---|---|---|
| B&D | 38 | 30 | 78.95% | 3 | 10.00% | 7 | 23.33% | 20 | 66.67% |
| Havering | 44 | 35 | 79.55% | 1 | 2.86% | 14 | 40.00% | 20 | 57.14% |
| Redbridge | 45 | 28 | 62.22% | 2 | 7.14% | 9 | 32.14% | 17 | 60.71% |
| Total | 127 | 93 | 73.23% | 6 | 6.45% | 30 | 32.26% | 57 | 61.29% |



- CQC advise all visits have been completed – but 26.77% in BHR still to be published
- Barking and Dagenham CCG (and Havering) in bottom five nationally for highest percentage of practices rated ‘inadequate’ or ‘requires improvement’

# CQC: support offered to practices

- **Template policies and procedures emailed to practices** – include confidentiality, correspondence, dealing with medical device and safety alerts, repeat prescribing, recruitment, significant event review template and complaints procedure

- Access to **online training** resource sent to practices October 2016 – includes complaints handling, equality and diversity, fire safety, health and safety, infection control and manual handling

- **Face to face training and workshops** – include infection control (clinical and non clinical staff), safeguarding, fire safety, health and safety, chaperone training, CPR

- **Support programme for practices rated 'requires improvement'** – intending to provide support programme to these practices, to help them make improvements and achieve a good rating at re-inspection
  - All Havering practices that have been rated 'requires improvement' will be offered opportunity to voluntary participate in the programme.

# BHR GP networks

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

| Borough | Barking and Dagenham | Havering | Redbridge |
|---|---|---|---|
| **Networks** | Three networks established and meeting monthly. MOU agreed.<br><br>**North (Chadwell Heath)**<br>Leads: Dr Amit Sharma, Dr Narendra Teotia<br>**East (Dagenham)**<br>Leads: Dr Natalya Bila, Dr Simi Adedeji<br>**West (Barking – Thames)**<br>Leads: Dr J John, Dr Rajbir Randhawa | Three networks established and meeting regularly. Terms of reference proposed.<br><br>**North Network**<br>Leads: Dr Jwala Gupta, Dr S Symon<br>**Central Network**<br>Leads: Dr Aaron Patel, Dr Syed Pervez<br>**South Network**<br>Leads: Dr John O'Moore, Dr Nick Rao<br><br>**Overall lead:** Dr Ann Baldwin | Four networks established and meeting monthly. Terms of reference proposed.<br><br>**Fairlop**<br>Leads: Dr Imran Umrani, Dr Dave Sawh<br>**Wanstead & Woodford**<br>Leads: Dr Sangeetha Pazhanisami, Dr Tasneem Khan<br>**Cranbrook & Loxford**<br>Leads: Dr Altaf Baloch, Dr Shabnam Ali<br>**Seven Kings**<br>Leads: Dr Shabnam Quraishi, Dr Geeta Patel |
| **Network Leadership Group in place?** | Barking and Dagenham Network Council being established. Chairs to be agreed. Terms of reference to be agreed.<br>• Leadership development programme commissioned from UCLP – network leads being recruited to the programme. | Havering Partnership Network Board established. Chairs to be agreed. Terms of reference agreed.<br>• Leadership development programme commissioned from UCLP – network leads being recruited to the programme. | Redbridge Network Council being established. Terms of reference agreed.<br><br>• Leadership development programme commissioned from UCLP – network leads being recruited to the programme. |
| **Network priorities** | Diabetes<br>Primed supporting practices with diabetes LIS.<br>Social prescribing suggested as a focus. | Quality improvement programme (UCLP) to be rolled out across all three networks. Recruitment underway for six QI facilitators. Clinical Effectiveness Group supporting practices. | Quality improvement programme (UCLP) underway in all localities: focus on diabetes and atrial fibrillation. Eight QI facilitators recruited and being trained. Clinical Effectiveness Group supporting practices and networks. |
| **GP Federation** | Together First | Havering Health | Healthbridge Direct & Redbridge Alliance |
| **Integrated locality** | West (Barking – Thames) | To be confirmed | Fairlop |

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Dear stakeholder

**RE: PMS GP contract review**

We wrote to you last year to tell you about the review of GP contracts that Barking and Dagenham, Havering and Redbridge CCGs (BHR CCGs) were conducting in partnership with NHS England (NHSE). The aim of this review was to reduce inequalities between practices in terms of the amount paid for providing the same services, ensuring better value for money for the NHS and fairer and more equal access to care for patients.

It was intended that the basis for all GP contracts across London would be the same, with local CCGs then being able to choose any additional services that GP practices could provide in exchange for extra payments, and which would focus on tackling specific local health needs. NHSE was leading on developing that core “London offer”, with close involvement from London wide Local Medical Committees (LW-LMCs) who represent most GP practices in the capital.

You may recall that local work on the PMS Review paused over the summer, while NHSE and LW-LMCs negotiated the London offer. It has since been determined that a ‘one size fits all’ approach is difficult to achieve for a city as diverse as London, and all parties agree that making progress on the review is the most important priority. CCGs have therefore been given responsibility for agreeing the PMS contracts as well as agreeing which ‘extra’ services practices should provide, and how much they will be paid per patient for those services.

This does mean effectively starting the review from the beginning, but it gives us an opportunity to look at our current GP service to see how we can ensure it will be resilient in the light of challenges being faced by the whole health and care economy. Through this review, we can help ensure that everyone in BHR will have equal access to the same types of service, no matter what sort of contract their GP has. We can create a service that is targeted to the unique health challenges and needs of our area – while ensuring all GPs are paid fairly and equitably for the services they provide.

We still have work to do in deciding what this service will look like and what the payments to GP practices will be. This will take time, but it is crucial that we get it right, and that we do it in a way that will not destabilise local general practice or unfairly disadvantage individual GPs. We hope that our partners will bear with us while we work out the detail, and we will of course keep you informed when we have more specific detail to share. I enclose a short briefing document which explains more about how GP contracts work, the reasons for the review, and the next steps.

If you would like to discuss any of this in more detail, please do not hesitate to contact me.

**Sarah See, Director, Primary Care Transformation, BHR CCGs**

## Personal Medical Services (PMS) contract review

Barking and Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Groups, as delegated commissioners for primary medical services alongside NHS England, have been conducting a review of all GP practices operating on a Personal Medical Services (PMS) contract.

The review is based on the principle that all GP practices should receive the same core funding for providing the core services expected of them. In order to receive additional 'premium' funding, practices need to be able to demonstrate that this will result in improved services, better quality, or to meet the specific needs of a particular population.

**What is a PMS contract?**
These are locally-agreed contracts between NHS England and an individual GP practice. PMS is an alternative to the nationally agreed General Medical Services (GMS) contract and allows for local variation in the range of services the practice provides and how it is paid for those services.

Currently, practices on a PMS contract are likely to receive more money per patient than those operating under a GMS contract. The premium is paid per patient per year, and the amount that PMS GP practices receive varies widely – both from borough to borough and within individual boroughs – and there is little evidence that the premium results in improved care or outcomes.

Forty GP practices across BHR currently operate under a PMS contract:

| CCG | Number of PMS contracts | Total number of GP contracts |
|---|---|---|
| **Barking and Dagenham** | 11 | 38 |
| **Havering** | 12 | 44 |
| **Redbridge** | 13 | 45 |
| **Total** | 36 | 127 |

**Why carry out the review?**
The purpose of the review is to ensure that in future the NHS gets the best value for money from the 'premium' element of PMS funding. We need to ensure that where practices receive enhanced payments from the NHS, they are providing premium services to merit this, and that any money spent on a GP practice above the agreed contract level will:

- secure services or outcomes that go beyond what is expected of core general practice, or improve primary care premises
- help reduce health inequalities
- give equality of opportunity to all GP practices, irrespective of their contract (provided that they are able to satisfy the local-determined requirements)
- support fairer distribution of funding at locality level.

A local working group was established in October 2015 to take forward the review in BHR, and it will continue to do this under the new locally delegated arrangements for the review. It is chaired by Redbridge CCG's lay member for patient and public engagement, Khalil Ali, and members include the primary care clinical director lead for each CCG, as well as relevant CCG finance and primary care staff. Outside the CCG, the committee includes representatives from NHS England, as well as the Local Medical Committees (LMCs) to ensure input from general practice providers

**Engagement**

The CCGs have briefed all affected practices to inform them of the changes to how the review is being carried out, and we will continue to attend LMC meetings. To ensure the local authorities are kept informed, we will be attending local Health Scrutiny Committees and engaging with Health and Wellbeing Boards as soon as we have details of the proposed new contract arrangements. In terms of patient engagement, we will continue to provide updates to Healthwatch for each borough, and meet with the CCG Patient Engagement Forums when there is information to update on.

**Next steps**

Our PMS working group will continue to meet monthly. It will make recommendations to the BHR Primary Care Commissioning Committee (PCCC), which is responsible for decision-making for primary care commissioning. The PCCC will approve and sign-off the PMS contracts on behalf of the CCGs.

The indicative timeline for implementation is between 1 July and 31 October 2017, however BHR CCGs are working toward having the PMS review process completed locally by 1 July.

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# OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 18 APRIL 2017

| | |
|---|---|
| **Subject Heading:** | Spending NHS money wisely |
| **Report Author and contact details:** | **Louise Mitchell**<br>**Planned Care Transformation Programme Director**<br>**Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups**<br>**Tel: 020 3182 3044**<br>**email: Louisemitchell@nhs.net** |
| **Policy context:** | **The information presented will allow effective scrutiny of these proposals** |
| **Financial summary:** | **No impact of presenting of information itself which is for information/scrutiny only.** |

## SUMMARY

BHR CCGs are currently engaging on 'Spending NHS money wisely' to make savings locally of £55million. As part of this, they are looking at:

- stopping procedures that are purely cosmetic (so things such as breast augmentation, hair removal and removing cysts and moles)
- no longer prescribing some 'over the counter' medicines and products (including multi vitamins, gluten-free food, muscle rubs etc.)
- reducing the number of cycles of IVF funded locally
- introducing criteria for weight-loss surgery
- stopping funding male and female sterilisation

No decisions have been made.

## RECOMMENDATIONS

1. The Sub-Committee to review the information presented and make any appropriate recommendations.
2. The Sub-Committee to respond formally to the proposals.

## REPORT DETAIL

Clinicians will present and summarise details of the 'Spending NHS money' wisely programme. This is presented to the Committee for its information and the Committee is invited to make any recommendations on the issues that it considers appropriate.

## IMPLICATIONS AND RISKS

**Financial implications and risks:** None of this covering report.

**Legal implications and risks:** None of this covering report.

**Human Resources implications and risks:** None of this covering report.

**Equalities implications and risks:** None of this covering report.

## BACKGROUND PAPERS

http://www.barkingdagenhamccg.nhs.uk/Our-work/spending-nhs-money-wisely.htm
http://www.haveringccg.nhs.uk/Our-work/spending-nhs-money-wisely.htm
http://www.redbridgeccg.nhs.uk/Our-work/spending-nhs-money-wisely.htm

NHS
Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

# Spending NHS money wisely

**Proposals for:**

- IVF services
- Male and female sterilisation
- Prescribing
- Cosmetic procedures
- Weight-loss surgery

**Outer North East London Joint Health Overview and Scrutiny Committee**
**18 April 2017**

# The NHS Constitution

"The NHS is committed to providing best value for taxpayers' money.

"It is committed to providing the most effective, fair and sustainable use of finite resources.

"Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves."

# Our financial challenge

- Have to make savings of **£55 million** across BHR CCGs. Redbridge's share is **£17.7 million**
- Faced with some very difficult choices
- Must protect essential health services – cancer care, emergency care, life-threatening conditions and ensure parity of esteem for mental health
- Formally required by NHS England to find savings – have to act now to protect services.

# What we're already doing to save money

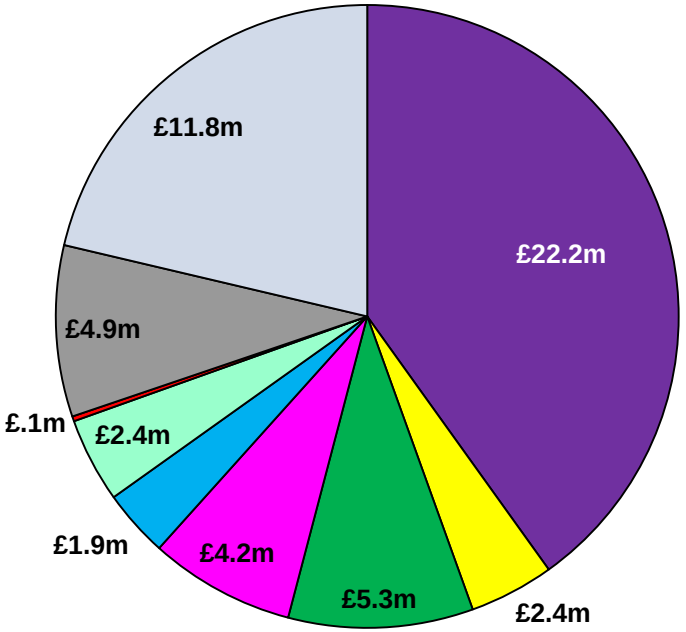
- working with providers to make sure patient pathways are delivered in the best possible way
- looking at contracts to make sure they are cost effective
- making better use of technology through e-clinics etc
- making sure we use buildings efficiently
- making sure everyone keeps to the policy on procedures of limited clinical effectiveness (POLCE) so only the patients who meet strict eligibility criteria can have treatment.

# We're also looking at:

- stopping procedures that are purely cosmetic (e.g. breast enlargement and removing moles)
- no longer prescribing some 'over the counter' medicines and products (including multi vitamins, gluten-free food, muscle rubs etc.)
- reducing the number of cycles of IVF that we will fund
- introducing criteria for weight-loss surgery
- stopping funding male and female sterilisation.

# Potential savings identified

**(all amounts in £millions)**




- Making hospital services more efficient and streamlined
- Making community and mental health services more efficient and streamlined
- Prescribing (£1.01m included in this consultation)
- Service cessation and/or restrictions (included in this consultation)
- Estates
- NHS continuing healthcare (CHC)
- Corporate
- Efficiencies from smaller contracts for various services
- To be identified

# IVF

We are considering whether the local NHS should continue to fund IVF, and, if so, how *many* embryo transfers we should fund.

We currently fund:

- a maximum of three cycles of ovarian stimulation leading to an embryo transfer for women aged 23-39
- a maximum of one cycle of ovarian stimulation leading to an embryo transfer for women aged 40 and 41.

***In a year around 800 women in BHR have IVF treatment paid for by the local NHS costing c£1.88 million.***

## NHS prescribing

There are a number of areas of NHS prescribing where we think we should make changes, because they do not have a demonstrable health benefit and/or they cost the NHS a lot to prescribe.



These are:

- Gluten-free food prescriptions
- Dental prescribing
- Over the counter prescribing
- Soya-based formula milk for babies and small children
- Travel vaccinations.

# Potential savings across BHR

| Prescribing area | Potential savings identified |
|---|---|
| Gluten-free food prescriptions | £210,000 |
| Dental prescribing | £96,000 |
| Over the counter prescribing | £485,000 |
| Soya-based formula milk | £13,500 |
| Travel vaccinations | £206,000 |

**These changes (if all implemented) could save the local NHS £1.01 million a year**

# Cosmetic procedures

**We are proposing that the local NHS no longer funds certain cosmetic procedures**



- We don't think that the NHS should pay for surgery or treatment that is needed only to improve someone's appearance. At the moment the NHS doesn't do this very often, but it does pay for some of these kinds of procedures if the patient meets some other specific criteria.
- We are now proposing that we stop funding these procedures altogether except in exceptional circumstances, like the patient has suffered from **major trauma, cancer or severe burns**.

# Spending NHS money wisely

- **No decisions have been made**
- E-copies of document and questionnaire sent to GP practices, trusts, councils, community and voluntary groups
- Working closely with Healthwatch and community and voluntary groups
- Drop-in sessions in each borough
- What else should we do?
- Engagement period ends **Thursday 18 May 2017**

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Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

# Spending NHS money wisely

***What do you think about our proposals for IVF, sterilisation, prescribing, cosmetic procedures and weight loss surgery?***

**Please tell us by 5pm on 18 May 2017**

# Contents

# Foreword from clinical leads

As GPs working in surgeries across Barking and Dagenham, Havering and Redbridge we know only too well the pressures that the NHS faces both here and across the country at the moment.

The care and treatment that we, along with our GP colleagues, provide every day for our patients is funded by taxpayers' money – your money. That's why we have a duty to spend it wisely, to make sure we get the best value we possibly can for every penny – especially when NHS funding is being severely squeezed and we are seeing more patients with more complex health issues than ever before.

That's why we are faced with some very difficult choices if we are to protect our most essential health services – things like cancer care, emergency care, life threatening conditions and mental health services – for the coming years.

To protect those services in our area we have to make savings locally of £55 million and to do that we must look at reducing spending now. That's why we need your help.

> "The NHS is committed to providing best value for taxpayers' money.
>
> "It is committed to providing the most effective, fair and sustainable use of finite resources.
>
> "Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves."
>
> ***NHS Constitution***

In this document, we talk about some of the things we think we can save money on and why. We want to know what you think. We haven't made any decisions yet and we won't until we have heard from you, our patients.

Unfortunately, doing nothing is not an option. We are family doctors, not politicians, but it's up to us – with your help – to get the local NHS onto a secure and sustainable footing to ensure that we can maintain those vital local services for you and your families, both now and in the future.

We'd welcome your comments (please read our questionnaire) and any suggestions you may have about how we can save money in other areas too.

| | | |
|---|---|---|
| **Dr Ravali Goriparthi** | **Dr Ashok Deshpande** | **Dr Anita Bhatia** |
| **Dr Anju Gupta** | **Dr Maurice Sanomi** | **Dr Sarah Heyes** |
| Barking and Dagenham CCG | Havering CCG | Redbridge CCG |

# About this document

This document explains how and why we want to change some of the things that we spend NHS money on in Barking and Dagenham, Havering and Redbridge (BHR). Clinical commissioning groups (CCGs) in these three boroughs are working together to look at how we can spend the money we have wisely.

We are looking at:

- In-vitro fertilisation (IVF)
- Male and female sterilisation
- NHS prescribing – including gluten-free food prescriptions, over the counter prescribing, soya-based formula milk and travel vaccinations
- Cosmetic procedures
- Weight loss surgery.

We have set out different options and explained why we've identified these. We want to know what you think and if there is anything else you want us to consider.

We'd like to hear from as many local people as possible about our proposals, so please tell your friends and family about this, and encourage them to respond. Comments from health professionals and our partners in the community and voluntary sector are also welcomed.

To tell us what you think, you can fill in the online questionnaire on our websites or print off the questionnaire at the back of this document, fill it in and send it back to **FREEPOST BHR CCGs**, free of charge.

**All responses must be received by 5pm on 18 May 2017.**

This document summarises our thinking. For more information visit our websites:

www.barkingdagenhamccg.nhs.uk/spending-wisely

www.haveringccg.nhs.uk/spending-wisely

www.redbridgeccg.nhs.uk/spending-wisely

# About clinical commissioning groups

Clinical commissioning groups (CCGs) plan and commission (buy) health care services for the residents of their local area. They are led by local GPs.

Commissioning is about deciding what services are needed, and making sure that they are provided, and getting the best possible health outcomes for local people by assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals.

Services CCGs commission include:

- urgent and emergency care (including GP out-of-hours)
- most planned hospital care
- most community health services such as health visitors and physiotherapy
- mental health and learning disability services.

All GP practices belong to a CCG. CCGs are regulated by NHS England.

In Barking and Dagenham, Havering and Redbridge, the three CCGs work together closely under one management structure, sharing resources.

# Introduction: our financial challenge

Nationally the NHS is facing a challenging time as demand for services continues to increase. A growing and ageing population and more people living with long term health conditions such as diabetes are placing further pressure on already stretched services and finances.

The population is growing

Compared to other boroughs in London, the three boroughs in BHR have population growth that is significantly higher than the London average and all three are in the top third of boroughs with the highest growth rates.

- **Redbridge**'s estimated population growth over the next five years is the highest in London
- **Barking and Dagenham** has the highest birth rate in London.

The population is aging

The greatest increases in population are expected in the 65+ age groups. Older patients generally have increased and more complex health and social care needs.

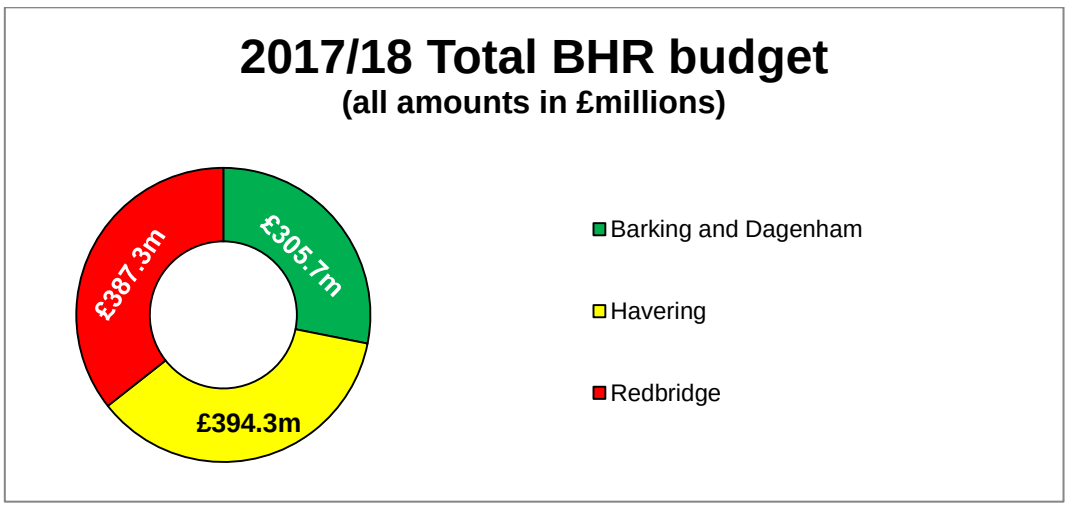
- **Havering** has the highest proportion of older people in London.

The population is changing

Some diseases are more common in specific ethnic groups, so the ethnic composition of the population influences what the population's health needs are.

There is rising local demand for NHS services and the cost and availability of treatments continues to increase, which means it is all the more essential that we spend our limited resources in the most effective way.

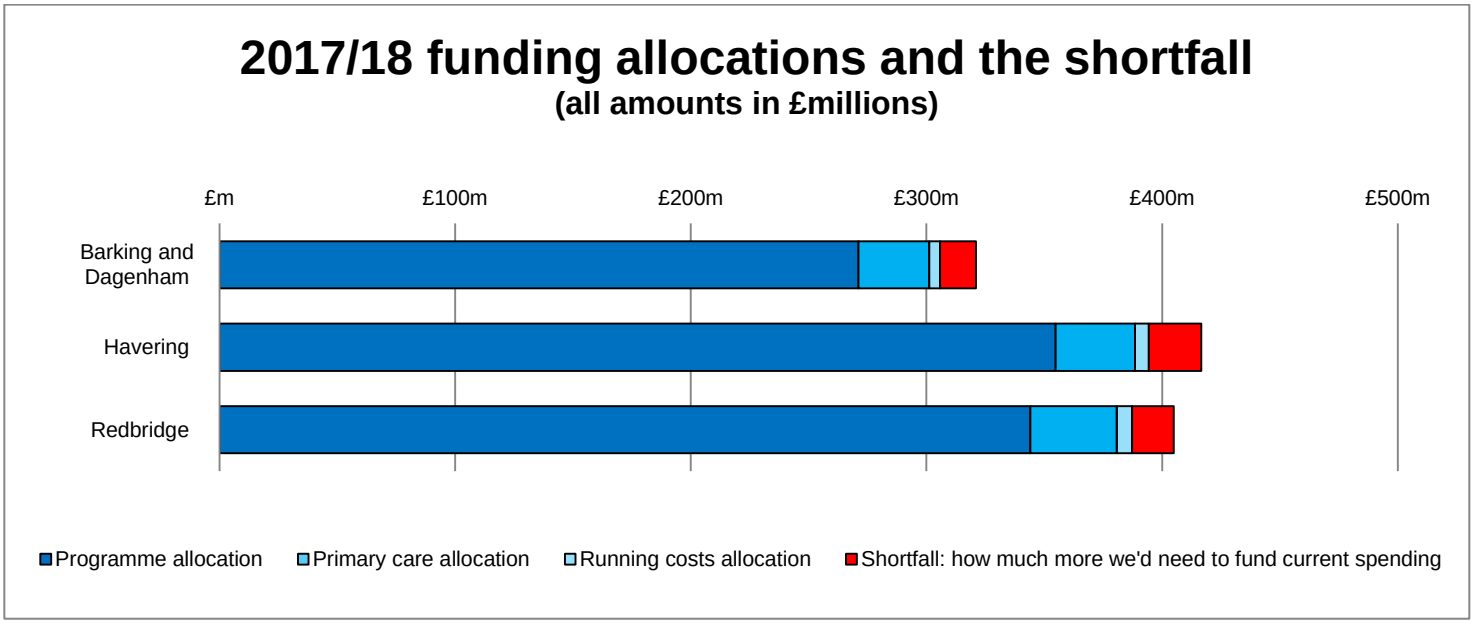
In terms of funding the amount of money allocated (funding allocation) to each CCG is decided by the Department of Health, based on the size of the population and local health needs. According to the formula used by the Department of Health, the BHR area is under-funded.



We have reached a point where we do not have enough money to continue buying all the services in the way we do now. We are in deficit and this has been caused by a number of factors, including our funding position and pressure from the continuing population changes.

For some time local patients have been waiting too long for treatment at our main local hospitals trust, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT). We have worked closely in partnership with them and other providers to tackle these long waiting lists and ensure that patients can receive the treatment they need within a reasonable time. Together we have achieved this change, which is positive for patients, but it has been at a cost.

We have a statutory responsibility to balance our budget. To achieve financial balance, BHR would need to deliver **£55 million** savings from the budget in the 2017/18 financial year. This is just over 5% of our total annual joint budget of just over **£1 billion** for the three boroughs.




To achieve this, we need to reduce our spending in some areas of our health budget. We have been looking closely at what we're spending money on, to ensure we are making the most effective use of public money to commission the most appropriate healthcare services for local people. We must maintain our investment in areas such as cancer treatment, mental health services, and accident and emergency care, so this means making decisions about what services and treatments we can fund and in some cases, no longer fund.

We are not alone in doing this. CCGs all over the country are looking at how they can use limited resources responsibly to make sure the NHS is able to help those most in need. They are reducing the services and treatments they will fund. We have managed to hold off longer than some others, but we cannot carry on without making changes.

**Note**

We are not looking at reducing the money we spend on primary care (care provided by GPs and their practice staff).

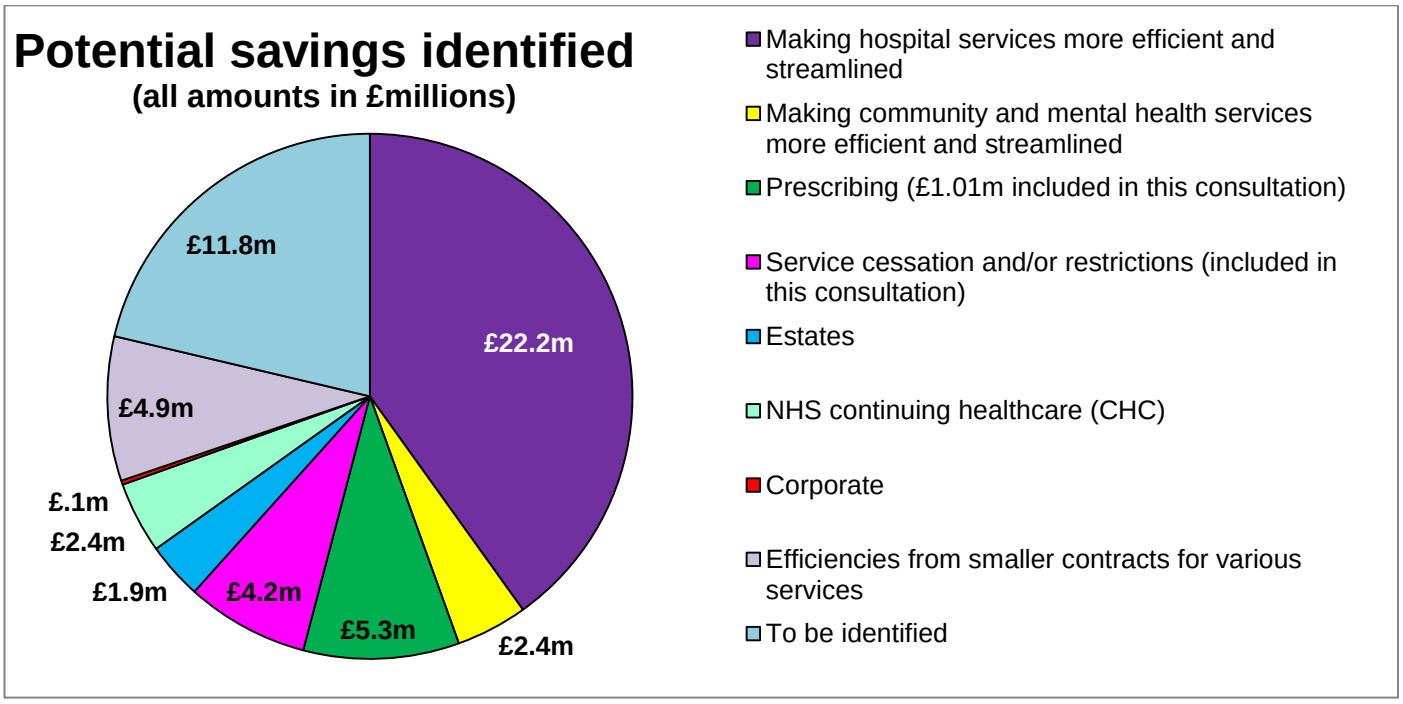
This is protected by NHS England and cannot be reduced.

Where we can, we will continue to make the case for additional funding for the Barking and Dagenham, Havering and Redbridge area, but that is unlikely to be granted (certainly in the next few years) given the current pressure on public spending. Waiting to see if our funding will be increased is not an option – we have to act now to protect services.

**Nothing has been decided. We want to know what local people think we should do.**

# What we're already doing to save money

BHR CCGs are small organisations with a single shared management structure, which is already a cost-effective way of operating, so there are limits to what administrative savings we can make. We have already reduced our limited interim staffing and general operating costs, but are looking at other ways to make the scale of the savings required and have developed a recovery plan to identify additional savings.




**To note**: these figures may change as further opportunities are identified and/or plans are refined.

We have a responsibility to balance our books and make efficiencies so we are:

- working with hospital and community providers to change patient pathways (the route a patient takes from their first contact with an NHS member of staff (usually their GP), through referral, to the end of their treatment) to eliminate any unnecessary steps
- looking at contracts with providers to make sure they are cost effective and identifying where savings could be made
- making better use of technology, for example introducing web-based 'e-clinics' to improve management of some conditions in primary care
- reviewing continuing healthcare (the name given to a package of care that is arranged and funded solely by the NHS for people outside of hospital who have ongoing healthcare needs) to ensure the most consistent and effective commissioning of services and appropriate funding
- working with property owners to make sure we are using buildings efficiently and not paying for space we don't need
- basing clinical practice on scientific evidence (adhering to evidence-based medicine) by making sure everyone sticks to the policy on procedures of limited clinical effectiveness (POLCE) (see box on the next page) which means that only the patients who meet the strict eligibility criteria can have the treatment.

**Procedures of Limited Clinical Effectiveness (POLCE)**

These are procedures that doctors have identified are usually unnecessary and don't generally benefit someone's health - such as taking children's tonsils out, which used to happen a lot. As children get older they generally grow out of tonsillitis, which doctors think is better for them than operating on them (because there are always risks associated with operations).

Doctors have set criteria in the POLCE guidelines for when they think these procedures *should* be carried out. For example, a child would be eligible for a tonsillectomy if it could be shown that they had severe tonsillitis seven or more times in the past year.

Put simply, the NHS should only be funding procedures to deal with medical conditions and symptoms. The aim is to make sure that only those who will benefit clinically from the treatment receive it. This means that people won't have unnecessary treatment and the NHS won't waste money.

In 2016/17 we spent more than **£17 million** on POLCE procedures. We estimate that tightening this up will save us around **£2.4 million** in the next year.

Read our POLCE policy on our websites:

www.barkingdagenhamccg.nhs.uk/spending-wisely

www.haveringccg.nhs.uk/spending-wisely

www.redbridgeccg.nhs.uk/spending-wisely

# We need to do more

We want to make sure that local people will always be able to get treatment for conditions like cancer, heart disease, stroke and serious mental illness. To do this we have identified some other areas of NHS spending where we think could make further savings of up to about £5.21 million each year.

This involves making some difficult decisions about other things that the NHS spends money on at the moment. These are:

- In-vitro fertilisation (IVF)
- Male and female sterilisation
- NHS prescribing
- Cosmetic procedures
- Weight-loss surgery.

In the next section we explain what these are and our proposals.

# IVF

**We are considering whether the local NHS should continue to fund IVF, and, if so, how *many* embryo transfers we should fund.**

In-vitro fertilisation (IVF) is a technique to help people with fertility problems have a baby.

During IVF, an egg is removed from the woman's ovaries (known as ovarian stimulation) and fertilised with sperm in a laboratory culture dish. Fertilisation takes place in this dish, 'in vitro', which means in glass. The fertilised egg, called an embryo, is then returned to the woman's womb to grow and develop.

Currently, we fund:

- a maximum of three embryo transfers for women aged 23-39
- one embryo transfer for women aged 40 and 41.

Women aged 42 and over are not eligible for NHS-funded IVF because it has a very low chance of success.

We are considering whether the local NHS should continue to fund IVF, and if so, how many embryo transfers we should fund. We are thinking about reducing the number of embryo transfers women have but keeping the other criteria the same.

This could mean:

**IVF eligibility**

To be eligible for NHS-funded IVF locally:

- The woman must not be too over- or under-weight (her BMI should be between 19 and 30) before treatment can begin.
- Women must be non-smokers and continue to be non-smokers throughout treatment.
- Couples cannot already have a child together
- Single applicants cannot already have a child.

Read our IVF policy:

www.barkingdagenhamccg.nhs.uk/spending-wisely

www.haveringccg.nhs.uk/spending-wisely

www.redbridgeccg.nhs.uk/spending-wisely

| For women aged 23-39 | For women aged 40-41 | Estimated saving |
|---|---|---|
| Funding three embryo transfers (what we do at the moment) | Funding one embryo transfer (what we do at the moment) | **No saving**<br>(Doing this would cost us approximately £1.88m a year) |
| Funding two embryo transfers | Stop funding IVF | **£298,249 a year** |
| Funding one embryo transfer | Stop funding IVF | **£1.07 million a year** |
| Stop funding IVF | Stop funding IVF | **£1.88 million a year** |

**IVF success rates**

The success rate of IVF depends on the age of the woman having treatment, as well as the cause of the infertility (if it's known).

According to the NHS Choices website (www.nhs.uk), the percentage of IVF treatments in 2010 that resulted in a live birth was:

- 32.2% for women under 35
- 27.7% for women aged 35-37
- 20.8% for women aged 38-39
- 13.6% for women aged 40-42

If we did decide to stop funding IVF, aside from exceptional cases only those people already receiving IVF or who were about to have treatment would get NHS IVF treatment. Local people would need to pay for their IVF treatment privately if they wanted to and were able to afford it.

Stopping NHS funding for IVF treatment does not mean stopping all NHS fertility treatment. People experiencing fertility problems could still see their GP, who would be able to refer them for further investigation and other medical or surgical treatments, as appropriate. This would still be funded by the NHS.

***We estimate that in a year around 800 women have IVF treatment paid for by the local NHS at an approximate cost of £1.88 million.***

## Note

**Exceptional cases**

Whatever decision is made, we intend to continue to fund IVF for the following people:

- Patients undergoing cancer treatment or who have a disease or condition requiring medical or surgical treatment that has a significant likelihood of making them infertile.
- Couples where the male partner has a chronic viral infection such as HIV that could be transmitted to the female partner and potentially any unborn child.

# Male and female sterilisation

**We are considering if the local NHS should continue to fund male and female sterilisation.**

Sterilisation is surgery so a person is permanently not able to have children. There are different forms of sterilisation for men and women.

For men this is a vasectomy. This works by stopping sperm from getting into a man's semen. It means that when a man ejaculates, the semen has no sperm.

Female sterilisation is sometimes known as 'having your tubes tied'. This is surgery to block the fallopian tubes to prevent the woman's eggs from reaching sperm and becoming fertilised.

A sterilisation operation is difficult to reverse and so you should only be sterilised if you are certain that you do not want to have any (or any more) children.

If we made this change, we would instead encourage women to have a long-acting reversible contraceptive (LARC), such as an IUD (intrauterine device), or 'the coil'. These work for up to ten years, so once they are in place, you don't have to think about it. If implanted correctly in a woman, LARCs are more than 99% effective. There are no LARCs for men.

***We estimate that in a year around 70 women undergo a sterilisation procedure paid for by the local NHS at an approximate cost of £79,000.***

***We estimate that in a year around 200 men have a vasectomy paid for by the local NHS at an approximate cost of £87,000.***

# NHS prescribing

We have identified a number of areas of NHS prescribing where we think we should make changes. This is because they do not have a demonstrable health benefit and/or they cost the NHS a lot to prescribe (particularly when you take into account the GP consultation time as well).

These are:

- Gluten-free food prescriptions
- Dental prescribing
- Over the counter prescribing
- Soya-based formula milk for babies and small children
- Travel vaccinations.

We have explained our thinking about these in the following pages.

## Gluten-free food prescriptions

**We are proposing to stop prescribing gluten-free products.**

The NHS began providing gluten-free foods on prescription to patients with coeliac disease (a common autoimmune digestive condition caused by an adverse reaction to gluten, which is found in wheat, barley and rye) because gluten-free food was hard to find and was often very expensive.

Fortunately this is no longer the case and all major supermarkets and many other retailers, commonly stock gluten-free foods as well as other special diet alternatives, at a reasonable price.

People can eat a healthy, balanced, gluten-free diet without the need for any specialist dietary foods at all, because other naturally gluten-free foods such as rice and potatoes are widely and cheaply available.

Improved food labelling now means people are able to see whether ordinary food products are free from gluten and can be safely eaten.

**The cost of a loaf of gluten-free bread**

Supermarket gluten-free loaf:

£1.50 - £3.50

Average cost to the local NHS of a gluten-free loaf on prescription:

£8.16

***We estimate that in a year 13,900 prescriptions are issued by local GPs for gluten-free food at an approximate cost of £210,000.***

## Dental prescribing

**We are proposing that GPs don't prescribe medicines for dental conditions.**

Prescribed medicines can be part of many dental treatment plans, for example fluoride toothpaste/mouthwashes, teething gel and treatments for dry mouth.

People can buy most dental products over the counter, without the need for a prescription.

Dentists can and should prescribe medicines for dental conditions, where appropriate. Involving GPs in prescribing medicines for dental conditions is usually unnecessary, and uses valuable appointments and GPs' time.

If this change were to go ahead, GPs would still be able to prescribe dental products where it was an important part of the care they were providing for a patient.

***We estimate that in a year over 20,000 prescriptions are issued by local GPs for dental products at an approximate cost of £96,000.***

## Over the counter prescribing

At the moment many people visit their GP to get prescriptions for medication that can be cheaply and easily bought on the high street. This is often quite expensive for the NHS, especially when taking into account the cost of GP appointment times and pharmacist fees.

**We are proposing that GPs should no longer issue prescriptions for the treatments listed in the table below.**

| Type of medication | Why we want to stop funding this | Cost of product on the high street | Number of prescriptions issued last year | How much these prescriptions cost the local NHS last year |
|---|---|---|---|---|
| **Head lice and scabies medication** | Treatments for head lice and scabies can be bought from a pharmacy, who can advise how to use them. | Tesco Head Lice Treatment, 100ml, £4.25 (Tesco online)<br>Hedrin Once Spray Gel (for head lice), 60ml, £5.99 (Boots online) | 2,981 prescriptions | £38,500 |
| **Rubefacient creams and gels such as 'Deep Heat' and 'Tiger Balm'** | These are used to treat minor aches and pains of the muscles but there is limited evidence about how well these creams and gels work.<br>Evidence does not support the use of these in acute or chronic musculoskeletal pain or to treat osteoarthritis. | Deep Heat – Heat Rub, 42g, £2.49<br>Tiger Balm Ointment, 19g, £4.39<br>(Boots online) | 11,463 prescriptions | £68,000 |

| Type of medication | Why we want to stop funding this | Cost of product on the high street | Number of prescriptions issued last year | How much these prescriptions cost the local NHS last year |
|---|---|---|---|---|
| **Omega-3 and other fish oil supplements** | NICE does not recommend the routine prescribing of fish oil supplements to prevent heart disease.<br>If people want to take these, they are widely available at reasonable cost at supermarkets, pharmacies and other retailers. | Boots Omega 3 Fish Oil 300mg, 30 capsules, £0.99 (Boots online)<br>Tesco Cod Liver Oil 1000mg, 30 capsules, £1.50 (Tesco online)<br>Seven Seas Simply Timeless Cod Liver Oil One-a-Day, 60 capsules, £5.79 (Boots online) | 2,774 prescriptions | £86,000 |
| **Multivitamin supplements** | Vitamins should be obtained through food rather than pills.<br>If people want to take supplements to support a balanced diet, they are widely available at reasonable cost at supermarkets, pharmacies and other retailers. | Tesco Everyday Value Multivitamins, 30 tablets, £0.50 (Tesco online)<br>Boots Multivitamins, 30 tablets, £0.99 (Boots online)<br>Boots Multivitamin with Probiotics, 30 capsules, £3.49 (Boots online) | 30,612 prescriptions | £168,000 |
| **Eye vitamin supplements** | There is no evidence that eye vitamin supplements are beneficial for eye health.<br>They are classed as food supplements and not licenced medicines.<br>They are widely available at reasonable cost at supermarkets, pharmacies and other retailers. | Boots Vision Aid, 30 tablets, £7.19 (Boots online) | 7,683 prescriptions | £66,000 |

| Type of medication | Why we want to stop funding this | Cost of product on the high street | Number of prescriptions issued last year | How much these prescriptions cost the local NHS last year |
|---|---|---|---|---|
| **Colic remedies for babies** | Colic eventually improves on its own, so medical treatment isn't usually recommended.<br>There isn't much evidence that these treatments actually work, although some parents find them helpful.<br>They are classed as food supplements and not licenced medicines.<br>They are widely available at reasonable cost at supermarkets, pharmacies and other retailers. | Boots Gripe Water 1 month plus, 150ml, £2.49 (Boots online)<br>Woodwards Gripe Water, 150ml £3.59 (Boots online)<br>Dentinox Infant Colic Drops, 100ml, £2.50 (Tesco online)<br>Infacol, 50ml, £3.19 (Boots online) | 1,644 prescriptions | £11,000 |
| **Cough and cold remedies** | Coughs and colds usually improve on their own and have no long-term harmful effect on a person's health.<br>They are widely available at reasonable cost at supermarkets, pharmacies and other retailers. | Tesco Mentholated Bronchial Balsam, 200ml, £1.20 (Tesco online)<br>Boots pharmaceutical cough syrup 3 months plus 100ml, £2.29 (Boots online)<br>ASDA cold relief capsules (16) £0.60 | 17,919 prescriptions | £28,500 |

| Type of medication | Why we want to stop funding this | Cost of product on the high street | Number of prescriptions issued last year | How much these prescriptions cost the local NHS last year |
|---|---|---|---|---|
| **Painkillers such as paracetamol and ibuprofen** | Painkillers like paracetamol and ibuprofen can help treat pain and reduce a high temperature (fever). They are typically used to relieve mild or moderate pain, such as headaches, toothache or sprains, and reduce fevers caused by illnesses such as colds and flu.<br>These symptoms usually improve on their own and have no long-term harmful effect on a person's health.<br>They are widely available at low cost at supermarkets, pharmacies and other retailers. | Value Health Paracetamol 500mg, 16 tablets, £0.20 (Boots online)<br>Value Health Ibuprofen 200mg, 16 tablets, £0.35 (Boots online) | 15,275 prescriptions | £19,000 |

***We estimate that in a year around 90,000 prescriptions are issued for the medicines listed above costing the local NHS approximately £485,000***.

## Note

If you are a patient who needs these painkillers like paracetamol and ibuprofen in regular large quantities for long-term pain, don't worry – you would continue to get them on repeat prescription.

We also intend to continue to prescribe these painkillers for children when needed.

## Soya-based formula milk for babies and small children

**We are proposing that GPs should no longer prescribe soya-based formula milk.**

Where possible, we want to encourage women to breastfeed, as this is the safest, most nutritionally beneficial form of feeding for most babies.

Historically it was difficult to buy alternative formula such as soya-based formula. This is no longer the case and soya-based formula is available at most major pharmacies, supermarkets and online. The cost is similar to standard infant formula.

***We estimate that in a year around 500 prescriptions for soya-based formula milk are issued costing the local NHS approximately £13,500.***

### Note

We think that GPs should continue to prescribe suitable specialised hypoallergenic formula milk for children with confirmed milk intolerance or conditions such as: cow's milk protein allergy (CMPA), faltering growth, premature birth, and specific medical conditions such as renal or liver disease.

## Travel vaccinations

**We are proposing that the NHS should no longer fund some travel vaccinations.**

You don't always need vaccinations to travel abroad. If you do, the recommended vaccinations will vary, depending on a range of factors, such as:

- which country you're visiting and, in some cases, which part of the country
- the season or time of year when you'll be travelling (for example, the rainy season)
- whether you'll be staying in a rural area, or an urban or developed area
- what you'll be doing during your stay, such as working in or visiting rural areas
- how long you'll be staying
- your age and health.

Some vaccinations are currently free on the NHS because they protect against diseases which are considered to be the greatest risk to public health if they were brought into the country. We think these diseases (in the list below) should continue to be free on the NHS:

- Cholera
- Diphtheria, polio and tetanus booster
- Hepatitis A
- Typhoid.

There are a number of other travel vaccinations for the diseases listed below which we are proposing people should pay for:

- Hepatitis A and B combined
- Hepatitis B
- Meningococcal meningitis
- Japanese encephalitis
- Rabies
- Tick-borne encephalitis
- Tuberculosis
- Yellow fever.

We think travellers should include the cost of vaccines for these in their holiday budgeting, just like they have to include the cost of flights, accommodation and insurance.

***We estimate that in a year 9,054 prescriptions are issued for the travel vaccinations listed above, costing the local NHS approximately £206,000.***

## Potential savings from changes to NHS prescribing

| **Prescribing area** | **Potential savings identified** |
|---|---|
| Gluten-free food prescriptions | £210,000 |
| Dental prescribing | £96,000 |
| Over the counter prescribing | £485,000 |
| Soya-based formula milk for babies and small children | £13,500 |
| Travel vaccinations | £206,000 |

***If they were all implemented, these changes could save the local NHS approximately £1.01 million a year.***

# Cosmetic procedures

We are proposing that the local NHS no longer funds certain cosmetic procedures.

We don't think that the NHS should pay for surgery or treatment that is needed only for cosmetic reasons (to improve someone's appearance). At the moment the NHS doesn't do this very often, but it does pay for some of these kinds of procedures if the patient meets some other specific criteria.

**We are now proposing that we stop funding these procedures altogether except in exceptional circumstances, like the patient has suffered from major trauma, cancer or severe burns (when an individual funding request application would have to be made).**

**What is an individual funding request?**

An individual funding request can be made for a treatment that is not routinely offered by the NHS if the doctor believes that their patient is clearly different to other patients with the same condition or where their patient might significantly benefit from the treatment in a different way to an average patient with the same condition.

This is known as "clinical exceptionality" and evidence must be provided about why the patient should have this treatment, which is considered by a panel of clinicians who decide if funding should be granted.

We have listed the procedures we are proposing should no longer be funded by the local NHS in the table on the following pages.

## Cosmetic procedures we propose should no longer be funded by the NHS

| Name of procedure | What does it involve? | When does the NHS fund this procedure at the moment? | What change is being proposed? | Number of procedures funded by the local NHS in the last three years | Average cost per procedure |
|---|---|---|---|---|---|
| **Surgery to the outside of the ear** | Surgery to change the size or shape of the ears, or pin them back if they stick out. | For children aged 5-18 with very significant ear deformity or asymmetry | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. | 61 procedures | £1,433 |
| **Facelift or browlift**<br><br>**(Rhytidectomy)** | Surgery to lift up and pull back the skin to make the face tighter and smoother. | When a person's skin droops so they could have difficulty seeing | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. | 171 procedures | £1,075 |
| **Surgical removal of moles, scars, cysts and birthmarks**<br><br>**(lesions on and under the skin)** | Surgical removal of moles, scars, cysts, and birthmarks. | • If the lesion is regularly damaged and becomes infected, meaning two or more courses of antibiotics are needed in a year<br>• If the lesion is obstructing an orifice or making it hard for the person to see<br>• If the lesion is making it hard for the person to move their limbs more than 20 degrees | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. | Five procedures | £1,999 |

| Name of procedure | What does it involve? | When does the NHS fund this procedure at the moment? | What change is being proposed? | Number of procedures funded by the local NHS in the last three years | Average cost per procedure |
|---|---|---|---|---|---|
| **Surgical removal of vascular lesions** | Surgical removal of lesions such as spider veins, broken veins and port wine stains. | Only when there is evidence of significant facial disfigurement. | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. | 3,440 procedures | £711 |
| **Hair removal** | Long term removal of excessive hair growth in certain areas of the body. | • When reconstructive surgery means that the patient has skin with hair in an area (not covered by normal clothing) that normally would not have hair.<br>• When a person is having treatment for pilonidal sinuses, a small hole or 'tunnel' in the skin, usually in the cleft of the buttocks at the top of the bottom area, which is thought to be caused by loose hair piercing the skin.<br>The NHS funds a maximum of six hair removal treatments. | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. | Five procedures/ courses of treatment | £1,132 |

| Name of procedure | What does it involve? | When does the NHS fund this procedure at the moment? | What change is being proposed? | Number of procedures funded by the local NHS in the last three years | Average cost per procedure |
|---|---|---|---|---|---|
| **Breast enlargement**<br><br>**(Augmentation mammoplasty)** | Surgery to increase the size of breasts. This usually involves breast implants. | When one breast is two or more cup sizes smaller than the other. | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved.<br>**See note 1 at the end of this table.** | 20 procedures | £2,455 |
| **Revising breast enlargement**<br><br>**(Breast augmentation revision)** | Redoing a breast enlargement | When:<br>• A woman has breast disease<br>• Implants are complicated by recurrent infections<br>• Implants have resulted in scar tissue which is causing severe pain or making it hard for to have mammograms<br>• Implants have ruptured | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved.<br>**See note 2 at the end of this table.** | 39 procedures | £2,220 |

| Name of procedure | What does it involve? | When does the NHS fund this procedure at the moment? | What change is being proposed? | Number of procedures funded by the local NHS in the last three years | Average cost per procedure |
|---|---|---|---|---|---|
| **Breast reduction** | Reducing the size of breasts | • When a woman has cup size H breasts or larger *and*<br>• The surgery should result in a reduction of at least three cup sizes/500 grams in each breast *and*<br>• The patient's BMI has been below 27kg/m2 for at least 24 months *and*<br>• They can show that they have suffered from at least two of the following conditions for at least 12 months:<br>  • Neck pain<br>  • Upper back pain<br>  • Shoulder pain<br>  • Curvature of the spine (x-ray evidence needed)<br>  • Pain or discomfort from bra straps cutting into shoulders<br>*and*<br>• They can prove pain persists after a six month trial of non-surgical measures such as a properly fitted bra, painkillers and physical therapy *and*<br>• There is significant musculoskeletal pain or the symptoms make it hard to go about everyday life and the doctor thinks surgery will fix this. | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. | 91 procedures | £2,288 |

| Name of procedure | What does it involve? | When does the NHS fund this procedure at the moment? | What change is being proposed? | Number of procedures funded by the local NHS in the last three years | Average cost per procedure |
|---|---|---|---|---|---|
| **Surgery for 'man boobs'**<br><br>**(Gynaecomastia)** | Surgery to remove male breast tissue | • When it is clear the condition is not as a result of drug use (e.g. steroids and growth hormone) *and*<br>• the man has had the condition for at least 18 months *and*<br>• has a BMI of less than 27kg/m2 *and*<br>• a surgeon has confirmed that the condition is severe (significant breast enlargement with loose, drooping skin) *and*<br>• surgery would remove more than 100 grams of tissue from each side *and*<br>• the man is aged 25 or over. | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. | 13 procedures | £2,831 |

| Name of procedure | What does it involve? | When does the NHS fund this procedure at the moment? | What change is being proposed? | Number of procedures funded by the local NHS in the last three years | Average cost per procedure |
|---|---|---|---|---|---|
| **Surgery to reduce excessive sweating**<br><br>**(Hyperhidrosis)** | Surgery to cut the nerves in an attempt to reduce excessive sweating.<br>(This surgery carries a risk of serious complications, is not always successful and can sometimes make sweating worse.) | When the person has significant sweating in a particular area and has undergone treatment supervised by a GP without success, and all of the following non-surgical treatments have been tried without success:<br>• Treatment for anxiety (if a factor)<br>• Dermatologist-prescribed skin cream<br>• Drugs prescribed to block the effect of the nerves that stimulate the sweat glands<br>• treating affected areas of skin with a weak electric current which is thought to help block the sweat glands<br>• Botox injections in the armpit. | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. | 46 procedures | £868 |

| Name of procedure | What does it involve? | When does the NHS fund this procedure at the moment? | What change is being proposed? | Number of procedures funded by the local NHS in the last three years | Average cost per procedure |
|---|---|---|---|---|---|
| **Tummy tuck surgery**<br><br>**(Abdominoplasty)** | Surgery to make the abdomen thinner and more firm by removing excess skin and fat. | The person must have a stable BMI of less than 27kg/m2 for at least 24 months<br>*and*<br>have had weight loss surgery at least 24 months ago (if applicable)<br>*and*<br>be suffering from associated health problems due to excess skin such as:<br>• severe difficulties performing everyday tasks and proof that surgery will resolve this<br>• proof that excess skin is causing infections that require four or more courses of antibiotics in 24 months of being at a stable weight<br>• Where overhanging skin makes it impossible to care for a stoma. | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. | 11 procedures | £3,006 |

| Name of procedure | What does it involve? | When does the NHS fund this procedure at the moment? | What change is being proposed? | Number of procedures funded by the local NHS in the last three years | Average cost per procedure |
|---|---|---|---|---|---|
| **Trigger finger surgery** | A condition that affects one or more of the hand's tendons, making it difficult to bend that finger or thumb. | Only if the patient doesn't respond to non-invasive treatment<br>*and*<br>doesn't respond to at least one corticosteroid injection<br>*or*<br>can't fully straighten their finger or thumb<br>*or*<br>is allergic to corticosteroid injection. | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. | 399 procedures | £1,041 |
| **Scrotum swellings**<br><br>**(Varicocoele)** | Non-cancerous swellings in the scrotum caused by swollen and enlarged veins. | Only if a man experiences continuing discomfort despite management of the problem. | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. | 30 procedures | £1,064 |

| Name of procedure | What does it involve? | When does the NHS fund this procedure at the moment? | What change is being proposed? | Number of procedures funded by the local NHS in the last three years | Average cost per procedure |
|---|---|---|---|---|---|
| **Labiaplasty** | A procedure for altering the labia (the folds of skin that surround the vulva) | Only when a woman is born with malformed labia. | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved.<br>**See note 3 at the end of this table.** | 30 procedures | £1,574 |
| **Surgery for varicose veins** | Varicose veins are swollen and enlarged veins – usually blue or dark purple – on the legs. They may also be lumpy, bulging or twisted in appearance. | Only after:<br>• discomfort continues despite six months of non-surgical management such as exercise and keeping the legs up<br>• lower leg skin changes such as eczema thought to be caused by veins not working properly<br>• blood clots in veins<br>• a venous leg ulcer (that has healed, or has not healed within two weeks) | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. | 1,017 procedures | £1,257 |



***If all these procedures were no longer funded, this could save the local NHS up to approximately £1.93 million a year (depending on the number of cases with exceptional circumstances).***

## Notes

**1. Breast enlargement**

We intend to continue to fund this procedure for women who have suffered from cancer.

**2. Revising breast enlargement**

We intend to continue to fund this procedure for women who have suffered from cancer.

**3. Labiaplasty**

This is not treatment for female genital mutilation (FGM). Treatment for FGM involves opening up the vagina and is known as deinfibulation. We currently fund this treatment and we intend to continue to fund it.

# Weight loss surgery

**We are proposing to tighten up who can have NHS-funded weight loss surgery (also called bariatric surgery).**

We want to introduce new eligibility criteria, which would mean the local NHS would only fund weight loss surgery if a person:

- has a Body Mass Index (BMI) of 35 or above, which means they are defined as obese (very overweight with a lot of body fat)

  and

- has type 2 diabetes

The reason for this is that this group of people are more likely to develop complex health conditions if they don't have the surgery and they are also most likely to benefit from surgery.

We estimate that in a year just over 50 people have weight loss surgery which is funded by the NHS, at a cost of approximately £370,000.

If we only funded surgery for patients who met these new eligibility criteria, around 18 people a year would have weight loss surgery funded by the local NHS, at a cost of approximately £123,000.

***Introducing new eligibility criteria for weight loss surgery could save the local NHS approximately £247,000 a year.***

# How we are engaging with local people

We know that if we carry out the proposals in this document some people's lives could be significantly affected.

We want to hear from as many people as possible so we can make the best possible decision. We are providing the opportunity for everyone to have their say.

We are also working with GPs, patient groups, local Healthwatch organisations and community and voluntary organisations to make sure we reach as many local people as possible. If you would like us to come and talk to your group about these proposals please get in touch.

**No decisions have been made**.

Over the next eight weeks (until 18 May 2017) we are engaging with local people in order to explain our financial position and the reasons for developing these proposals, outline how people might be affected and encourage them to respond.

All responses will form a report, which will go to our governing bodies to consider and make a decision. We will put that report and details of whatever decisions are made on our websites:

www.barkingdagenhamccg.nhs.uk/spending-wisely

www.haveringccg.nhs.uk/spending-wisely

www.redbridgeccg.nhs.uk/spending-wisely

**We want to know what you think.**

- How might these proposals affect you or your family?
- How could we limit the effects of these proposals?
- Could we do things differently?
- Are there are any exemptions we should consider?
- Are there any circumstances where these proposed changes should not apply?

**Please fill out our questionnaire by 5pm on 18 May 2017.**

# Impact on people's mental health

Mental health is often a factor in patients seeking cosmetic treatment or surgery. There are no universally accepted and objective measures of psychological distress, so it is difficult to include such factors when setting clinical thresholds for agreeing when a particular treatment is effective or needed.

Couples facing infertility are also more likely to have various mental health concerns, such as increased anxiety, depression, and mood disorders. Having IVF can be extremely stressful, particularly when it is not successful.

We believe it is generally better to provide support, such as therapy, to treat the mental health need, but if a clinician thought there were exceptional mental health reasons why a patient needed treatment, they could apply through the individual funding request process explaining why this is an exceptional case. This is not guaranteed to be approved.

**Mental health support: Talking Therapies**

Talking Therapies is a free and confidential NHS service that provides support from an expert team who understand what people are going through, and who work with people to help them feel better. The highly professional team will introduce people to effective, practical techniques specific to their needs that are proven to work. The national programme is based on evidence and all the tools and techniques used are recommended by local GPs.

The programme has already helped thousands of local people to feel better.

To find out more: www.mytalkingtherapies.org.uk or call 0300 300 1554

# Equality impact assessment

An equality impact assessment (EIA) is a process to make sure that a policy, project or proposal does not discriminate or disadvantage against the following characteristics:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

As part of this work, we will carry out an initial EIA and publish a draft on our websites. We will take into account people's responses to our proposals and this will inform a more detailed final EIA, which will go to our governing bodies to consider before any decision is made about these proposals.

# Questionnaire

Please complete this questionnaire on our website:

www.barkingdagenhamccg.nhs.uk/spending-wisely
www.haveringccg.nhs.uk/spending-wisely
www.redbridgeccg.nhs.uk/spending-wisely

Or you can fill it in and post it to **FREEPOST BHR CCGs** (no stamp needed). Please make sure we receive your response before 5pm on 18 May 2017.

## Tell us about you

We want to see what sorts of people are responding to our proposals. This helps us to understand if our proposals might have more of an impact on some groups of people than others. **These questions are optional – you don't have to answer them if you don't want to.**

# Please tick as appropriate

**1. Are you?**

- ☐ Male
- ☐ Female
- ☐ Other
- ☐ Prefer not to say

**2. How old are you?**

- ☐ Under 18 years
- ☐ 18 to 24 years
- ☐ 25 to 34 years
- ☐ 35 to 44 years
- ☐ 45 to 54 years
- ☐ 55 to 64 years
- ☐ 65 to 74 years
- ☐ 75 years or older
- ☐ Prefer not to say

**3. Do you consider yourself to have a disability?**

- ☐ Yes
- ☐ No

**4. Which borough do you live in?**

- ☐ Barking and Dagenham
- ☐ Havering
- ☐ Redbridge
- ☐ Other (please tell us which borough)

**5. What is your ethnicity?**

This is not about place of birth or citizenship. It is about the group you think you belong to in terms of culture, nationality or race.

- ☐ Any white background
- ☐ Any mixed ethnic background
- ☐ Any Asian background
- ☐ Any black background
- ☐ Any other ethnic group (please tell us what it is)
- ☐ Prefer not to say

**6. Are you responding as: (choose as many as apply)**

- ☐ A local resident
- ☐ A representative of an organisation or group (please tell us which)
- ☐ A clinician, commissioner or other healthcare professional
- ☐ Someone who would be personally affected by these proposals
- ☐ Other (please tell us why)

# What do you think about our proposals?

We want to understand your views on possible changes in these five different areas of healthcare:

- In-vitro fertilisation (IVF)
- Male and female sterilisation
- NHS prescribing
- Cosmetic procedures
- Weight loss surgery

We also want to know what you think about what we're proposing to do more generally.

**You don't have to answer the whole questionnaire if you don't want to.**

# IVF

### We are proposing to reduce the number of IVF embryo transfers we fund.

1. How many IVF embryo transfers do you think we should fund for eligible **women aged 23-39**?

   ☐ No change to the existing service (fund three IVF embryo transfers)
   ☐ Fund two embryo transfers
   ☐ Fund one embryo transfer
   ☐ Do not fund IVF

2. How many IVF embryo transfers do you think we should fund for eligible **women aged 40-41**?

   ☐ No change to the existing service (fund one embryo transfer)
   ☐ Do not fund IVF

3. Is there anything else you want to tell us, or think we should consider, before making a decision about funding IVF?

# Male and female sterilisation

**We are proposing that the local NHS should stop funding male and female sterilisation.**

4. Please tell us what you think by ticking the statement that best matches your views:

| | I strongly support this proposal | I support this proposal | I am neutral about this proposal | I am against this proposal | I am strongly against this proposal |
|---|---|---|---|---|---|
| The local NHS should stop funding male sterilisation (vasectomy) | | | | | |
| The local NHS should stop funding female sterilisation | | | | | |

5. Is there anything else you want to tell us, or think we should consider, before making a decision about sterilisation?

| |
|---|
| |

# NHS prescribing

There are a number of areas of local NHS prescribing where we think we should make changes. This is because these products do not have a demonstrable health benefit and are quite expensive for the NHS, when you take into account GP appointment times and pharmacist dispensing fees.

## Gluten-free prescribing

### We are proposing to stop prescribing gluten-free products.

The NHS began providing gluten-free foods on prescription to patients with coeliac disease because gluten-free food was hard to find and was often very expensive.

Fortunately this is no longer the case and all major supermarkets and many other retailers, commonly stock gluten-free foods as well as other special diet alternatives, at a reasonable price.

6. Please tell us what you think by ticking the statement that best matches your views:

| | **I strongly support this proposal** | **I support this proposal** | **I am neutral about this proposal** | **I am against this proposal** | **I am strongly against this proposal** |
|---|---|---|---|---|---|
| The local NHS should stop prescribing gluten-free products. | | | | | |

7. Is there anything else you want to tell us, or think we should consider, before making a decision about gluten-free prescribing?

## Dental prescribing

### We are proposing that GPs don't prescribe medicines for dental conditions.

Involving GPs in prescribing medicines for dental conditions is usually unnecessary, and uses valuable appointments and GPs' time. Dentists can and should prescribe acute and repeat medicines for dental conditions, where appropriate. They can also suggest that a patient can buy a product without needing a prescription.

8. Please tell us what you think by ticking the statement that best matches your views:

| | I strongly support this proposal | I support this proposal | I am neutral about this proposal | I am against this proposal | I am strongly against this proposal |
|---|---|---|---|---|---|
| The local NHS should stop prescribing medicines for dental conditions | | | | | |

9. Is there anything else you want to tell us, or think we should consider, before making a decision about prescribing for dental conditions?

## Over the counter prescribing

### There are a number of treatments that we propose GPs should no longer issue prescriptions for.

At the moment many people visit their GP to get prescriptions for medication that can be cheaply bought over the counter from a pharmacy or supermarket. This is often expensive for the NHS, especially when GP appointment time and pharmacist dispensing fees are taken into account.

10. Please tell us what you think about our proposal to no longer prescribe certain types of medication by ticking the statement that best matches your views for each:

| | **I strongly support this proposal** | **I support this proposal** | **I am neutral about this proposal** | **I am against this proposal** | **I am strongly against this proposal** |
|---|---|---|---|---|---|
| Head lice medication (for nits and scabies) | | | | | |
| Rubefacient creams and gels such as 'Deep Heat' and 'Tiger Balm' | | | | | |
| Omega-3 and other fish oil supplements | | | | | |
| Multivitamin supplements | | | | | |
| Eye vitamin supplements | | | | | |
| Colic treatments for babies | | | | | |
| Cough and cold remedies | | | | | |
| Painkillers such as paracetamol and ibuprofen | | | | | |

11. Is there anything else you want to tell us, or think we should consider, before making a decision about prescribing certain types of medication?

## Soya-based formula milk for babies and small children

### We are proposing that GPs should no longer prescribe soya-based formula milk.

Formula should only be prescribed by the NHS where there is a medical need. In the past it was difficult to buy alternative infant formula for babies. This is no longer the case and soya-based formula is available at most major pharmacies and supermarkets and online. The cost is similar to standard infant formula.

12. Please tell us what you think by ticking the statement that best matches your views:

| | I strongly support this proposal | I support this proposal | I am neutral about this proposal | I am against this proposal | I am strongly against this proposal |
|---|---|---|---|---|---|
| The local NHS should stop prescribing soya-based formula milk | | | | | |

13. Is there anything else you want to tell us, or think we should consider, before making a decision about stopping prescribing soya-based formula milk?

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| |

## Travel vaccinations

**We are proposing that the NHS should no longer fund some travel vaccinations.**

We think that travellers should include the cost of vaccinations in their holiday budgeting, just like they have to include the cost of flights, accommodation and insurance.

14. Please tell us what you think by ticking the box that best matches your views:

| | I strongly support this proposal | I support this proposal | I am neutral about this proposal | I am against this proposal | I am strongly against this proposal |
|---|---|---|---|---|---|
| The local NHS should stop paying for some travel vaccinations | | | | | |

15. Is there anything else you want to tell us, or think we should consider, before making a decision about stopping funding some travel vaccinations?

# Cosmetic procedures

We don't think that the NHS should pay for surgery or treatment that is needed only for cosmetic reasons (this means to improve someone's appearance). Locally the NHS does not do this very often, but it does pay for some of these kinds of procedures **if** the patient meets some other specific criteria. This means it doesn't happen very often.

**We are proposing that we stop funding these altogether unless there are exceptional circumstances. This might be that the patient has suffered major trauma, cancer or severe burns.**

16. Please tell us what you think about our proposal to no longer fund the cosmetic procedures we've identified by ticking the statement that best matches your views for each:

| The local NHS should stop funding: | I strongly support this proposal | I support this proposal | I am neutral about this proposal | I am against this proposal | I am strongly against this proposal |
|---|---|---|---|---|---|
| Surgery to the outside of the ear | | | | | |
| Facelift/browlift | | | | | |
| Removal of skin and under the skin lesions | | | | | |
| Vascular lesions | | | | | |
| Hair removal | | | | | |
| Breast enlargement | | | | | |
| Redoing breast enlargement | | | | | |
| Breast reduction | | | | | |
| Surgery for 'man boobs' | | | | | |
| Surgery for excessive sweating | | | | | |
| Tummy tuck | | | | | |
| Trigger finger | | | | | |
| Swelling in the testicles | | | | | |
| Surgery to alter the labia | | | | | |
| Varicose vein surgery | | | | | |

17. Is there anything else you want to tell us, or think we should consider, before making a decision about stopping funding cosmetic procedures except in exceptional circumstances?

## Weight loss surgery

**We are proposing to allow only people with a BMI of 35 or over and type 2 diabetes to receive NHS-funded weight loss surgery.**

18. Please tell us what you think about our proposal by ticking the statement that best matches your views:

| | I strongly support this proposal | I support this proposal | I am neutral about this proposal | I am against this proposal | I am strongly against this proposal |
|---|---|---|---|---|---|
| The local NHS should only allow people with a BMI of 35 or over and type 2 diabetes to receive NHS-funded weight loss surgery | | | | | |

19. Is there anything else you want to tell us, or think we should consider, before making a decision about introducing criteria for weight loss surgery?

# General comments

20. If we made these changes, would you be affected by any of them? Please tell us which.

| | Yes | No |
|---|---|---|
| IVF | | |
| Sterilisation | | |
| Gluten-free food prescriptions | | |
| Dental prescriptions | | |
| Over the counter prescriptions | | |
| Soya-based formula milk prescriptions | | |
| Travel vaccinations | | |
| Cosmetic procedures | | |
| Weight loss surgery | | |

21. Is there anything you would like to tell us about the impact it might have on you?

| |
|---|
| |

22. Do you have any other comments about our proposals that you'd like to make?

23. Are there any other services or treatments you think the NHS should stop funding? If so, please tell us what they are.

24. Do you have any suggestions about how the local NHS can save money?

25. If you would like us to tell you what decisions we reach regarding these proposals, please write your name and email address in the box below. We will keep your details safe and won't share them.

## Thank you for taking the time to let us know what you think.

If you're not completing this questionnaire online, please make sure you send it back to **FREEPOST BHR CCGs**.

All comments must be received by 5pm on 18 May 2017.

# Glossary

| Term | Meaning |
|---|---|
| **Abdominoplasty** | Tummy tuck surgery |
| **Acute** | In need of urgent care |
| **Augmentation mammoplasty** | Breast enlargement |
| **Autoimmune disease** | This refers to problems with the way the immune system reacts to things |
| **Bariatric surgery** | Weight loss surgery |
| **BMI** | Body Mass Index - a measure of body fat based on height and weight that applies to adult men and women |
| **Carbohydrate** | Starchy foods such as potatoes, bread, rice, pasta and cereals |
| **CCG** | Clinical commissioning group |
| **Chronic** | Ongoing |
| **Coeliac** | Relating to the abdomen (stomach) |
| **Colic** | Excessive, frequent crying in a baby who appears to be otherwise healthy |
| **Congenital** | A condition existing at or before birth |
| **Continuing healthcare** | A package of care that is arranged and funded solely by the NHS for people who are not in hospital and have been assessed as having a 'primary health need' |
| **Corticosteroid** | Medicine used to reduce inflammation and suppress the immune system |
| **Eligible** | Whether someone qualifies. In this case, the minimum criteria to access a procedure |
| **Exceptional circumstances** | A patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients, with the same medical condition and at the same stage of progression as the patient. |

| | |
|---|---|
| **GP** | General practitioner |
| **Gluten** | A protein found in wheat, rye and barley |
| **Gynaecomastia** | A common condition that causes boys' and men's breasts to swell and become larger than normal |
| **Hyperhidrosis** | A condition in which a person sweats excessively |
| **Individual Funding Request (IFR)** | A request received from a provider or a patient with clear support from a clinician, which seeks funding for a single identified patient for a specific treatment. |
| **IVF** | In-vitro fertilisation |
| **Labia** | The folds of skin that surround the vulva |
| **Labiaplasty** | A procedure for altering the labia |
| **Lesions** | An area of abnormal tissue change |
| **Musculoskeletal** | The nerves, tendons, muscles and supporting structures, such as the discs in your back |
| **NICE** | National Institute for Health and Care Excellence |
| **Omega-3** | A type of fatty acids that are good for you |
| **Orifice** | An opening in the body such as a nostril or the anus |
| **Pharmacist dispensing fee** | Pharmacists receive a professional fee for every item dispensed. This fee is currently 90p per item. |
| **Recurrent** | Occurring often or repeatedly |
| **Rubefacient** | Cream or gel used to treat minor aches and muscle pains |
| **Rhytidectomy** | Facelift or browlift |
| **Scabies** | A contagious skin condition caused by tiny mites that burrow into the skin |
| **Stoma** | An opening on the surface of the stomach surgically created to divert the flow of faeces or urine |

| | |
|---|---|
| **Subcutaneous** | Under the skin |
| **Varicocoele** | Non-harmful swellings within the scrotum caused by swollen and enlarged veins |
| **Vascular** | Relating to blood vessels |
| **Vasectomy** | Procedure to sterilise a man, where the tubes that carry sperm from a man's testicles to the penis are cut, blocked or sealed. |
| **Venous** | Relating to the veins |

# Other formats

This document is about changes we want to make to some health services in Barking and Dagenham, Havering and Redbridge. We want to know what you think about this.

If you would like to know more, please email haveyoursay.bhr@nhs.net or call 020 3688 1615 and tell us what help you need. Let us know if you need this in large print, easy read or a different format or language.

**Bengali**

বার্কিং ও দাগনেহাম, হ্যাভরেিং ও রডেব্রজিে কছিু স্বাস্থ্য পরষিবোয় আমরা যে পরবির্তনগুলে োকরতে চাই এই ডকুমন্টেটি সে সম্পর্কতি। আপনি এ সম্পর্কে কী ভাবছনে আমরা সে বষিয়ে জানতে চাই। যদি আপনি আরো জানতে চান, তাহলে অনুগ্রহ করে haveyoursay.bhr@nhs.net ইমইেল ঠকিানায় বা 020 3688 1615 নম্বরে আমাদরে সাথে যোগাযোগ করুন এবং আপনার কী সাহায্য প্রয়োজন তা আমাদরেকে জানান। যদি আপনি এটি বড় ছাপার অক্ষরে, সহজে পাঠযোগ্যভাবে বা ভন্নি কোনো ফরম্যাটে বা ভাষায় পতেে চান তাহলে আমাদরেকে জানান।

**Lithuanian**

Šis dokumentas yra apie pokyčius, kuriuos norime įgyvendinti sveikatos priežiūros srityje Barking ir Dagenham, Havering ir Redbridge vietovėse. Norėtume sužinoti jūsų nuomonę apie tai. Jei turite klausimų ar norite sužinoti apie tai daugiau, kreipkitės į mus haveyoursay.bhr@nhs.net arba tel. 020 3688 1615. Praneškite, jei šią informaciją norėtumėte gauti stambiu šriftu, lengviau įskaitomą, kita forma ar kalba.

**Portuguese**

Este documento é sobre as alterações que pretendemos implementar em alguns serviços de Saúde em Barking e Dagenham, Havering e Redbridge. Gostaríamos de saber a sua opinião. Caso pretenda obter mais informações, contacte-nos através do e-mail haveyoursay.bhr@nhs.net ou do número de telefone 020 3688 1615 e diga-nos que tipo de ajuda precisa. Indique-nos se precisa deste texto em letra grande, leitura fácil ou num formato ou idioma diferentes.

**Punjabi**

ਇਹ ਦਸਤਾਵੇਜ਼ ਉਨ੍ਹਾਂ ਬਦਲਾਵਾਂ ਬਾਰੇ ਹੈ ਜੋ ਅਸੀਂ ਬਾਰਕਿੰਗ ਐਂਡ ਡੈਗਨਹੈਮ, ਹੈਵਰਿੰਗ ਐਂਡ ਰੇਡਬ੍ਰਿਜ ਦੀਆਂ ਕੁਝ ਸਿਹਤ ਸੇਵਾਵਾਂ ਵਿੱਚ ਕਰਨਾ ਚਾਹੁੰਦੇ ਹਾਂ। ਅਸੀਂ ਜਾਣਨਾ ਚਾਹੁੰਦੇ ਹਾਂ ਕਿ ਤੁਹਾਡੇ ਇਸ ਬਾਰੇ ਕੀ ਵਿਚਾਰ ਹਨ। ਜੇ ਤੁਸੀਂ ਹੋਰ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨਾ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ haveyoursay.bhr@nhs.net ਜਾਂ 020 3688 1615 ਤੇ ਸੰਪਰਕ ਕਰੋ ਅਤੇ ਸਾਨੂੰ ਦੱਸੋ ਕਿ ਤੁਹਾਨੂੰ ਕਿਸ ਤਰ੍ਹਾਂ ਦੀ ਮਦਦ ਦਾ ਲੋੜ ਹੈ। ਸਾਨੂੰ ਦੱਸੋ ਜੇ ਤੁਸੀਂ ਇਸਨੂੰ ਵੱਡੇ ਛਾਪੇ, ਆਸਾਨੀ ਨਾਲ ਪੜ੍ਹੇ ਜਾਣ ਵਾਲੇ ਜਾਂ ਕਿਸੇ ਵੱਖਰੇ ਫਾਰਮੇਟ ਜਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਚਾਹੁੰਦੇ ਹੋ।

**Romanian**

Acest document se referă la schimbările pe care dorim să le facem în cadrul unor servicii medicale din Barking și Dagenham, Havering și Redbridge. Am dori să aflăm care este părerea dvs. despre acest lucru. Dacă doriți mai multe informații, vă rugăm să ne contactați la haveyoursay.bhr@nhs.net sau la 020 3688 1615 și să ne spuneți cu ce vă putem ajuta. Spuneți-ne dacă aveți nevoie de aceste informații scrise cu caractere mari, ușor de citit sau într-un alt format ori într-o altă limbă.

**Tamil**

*Barking மற்றும் Dagenham, Havering மற்றும் Redbridge-இல் உள்ள சில சுகாதாரச் சேவைகளில் நாங்கள் மேற்கொள்ள விரும்பும் மாற்றங்கள் குறித்து இந்த ஆவணம் விளக்குகிறது. இது குறித்து நீங்கள் என்ன கருதுகிறீர்கள் என்பதை நாங்கள் தெரிந்துகொள்ள விரும்புகிறோம். நீங்கள் மேலும் தகவல்கள் பெற விரும்பினால், haveyoursay.bhr@nhs.net என்ற மின்னஞ்சல் அல்லது 020 3688 1615 என்ற எண்ணில் எங்களைத் தொடர்புகொண்டு, உங்களுக்கு எந்த விதமான உதவி தேவை என்பதை எங்களிடம் கூறுங்கள். இந்த ஆவணத்தின் பெரிய அச்சு, எளிதில் வாசிக்கக்கூடிய பிரதி அல்லது வேறொரு வடிவம் அல்லது மொழியில் உங்களுக்குத் தேவைப்பட்டால், எங்களுக்கு தெரியப்படுத்துங்கள்.*

Urdu

یہ دستاویز ان تبدیلیوں کے متعلق ہے جو ہم بارکنگ اور ڈیگنہم، ہیورنگ اور ریڈبرج (Barking اور Havering ،Dagenham اور Redbridge) میں خدمات صحت میں ہم کرنا چاہتے ہیں۔ ہم جاننا چاہتے ہیں کہ اس کے متعلق آپ کیا سوچتے ہیں۔ اگر آپ مزید جاننا چاہیں گے، تو براہ کرم ہم سے haveyoursay.bhr@nhs.net یا 020 3688 1615 پر رابطہ کریں اور ہمیں بتائیں کہ آپ کو کس مدد کی ضرورت ہے۔ ہمیں بتائیں اگر آپ کو بڑے پرنٹ، آسان پڑھائی یا کسی مختلف شکل یا زبان میں اس کی ضرورت ہے۔