Public Document Pack

# OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

| 4.00 pm | Tuesday<br>10 October 2017 | Redbridge Town Hall,<br>Council Chamber |
|---|---|---|

**COUNCILLORS:**

**LONDON BOROUGH OF BARKING & DAGENHAM**

**Councillor Agegboyega Oluwole**
**Councillor Peter Chand**
**Councillor Jane Jones**

**LONDON BOROUGH OF WALTHAM FOREST**

**Councillor Mark Rusling**
**Councillor Richard Sweden**
**Councillor Geoff Walker**

**LONDON BOROUGH OF HAVERING**

**Councillor Dilip Patel**
**Councillor Michael White**
**Councillor Nic Dodin**

**ESSEX COUNTY COUNCIL**

**Councillor Chris Pond**

**LONDON BOROUGH OF REDBRIDGE**

**Councillor Stuart Bellwood**
**Councillor Suzanne Nolan/ Councillor Hugh Cleaver**
**Councillor Neil Zammett (Chaitman)**

**EPPING FOREST DISTRICT COUNCIL**

**Councillor Aniket Patel (Observer Member)**

**CO-OPTED MEMBERS:**

**Ian Buckmaster, Healthwatch Havering**
**Mike New, Healthwatch Redbridge**
**Richard Vann, Healthwatch Barking & Dagenham**
**Vacant, 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** (Pages 1 - 2)

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. Details of venue location etc are attached.

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

Apologies have been received from Councillors Dilip Patel (Havering) and Chris Pond (Essex).

**3 DISCLOSURE OF INTERESTS**

Members are invited to disclose 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 3 - 10)

To agree as a correct record the minutes of the meeting of the Joint Committee held on 18 July 2017 (attached) and to authorise the Chairman to sign these as a correct record.

**5 WHIPPS CROSS CARE FOR PATIENTS WITH DEMENTIA** (Pages 11 - 24)

Report and presentation attached.

**6 SPENDING NHS MONEY WISELY 2 CONSULTATION** (Pages 25 - 84)

Report and consultation document attached.

**7 BHRUT IMPROVEMENT UPDATE** (Pages 85 - 100)

Report and presentation attached.

**8 EAST LONDON HEALTH AND CARE PARTNERSHIP UPDATE** (Pages 101 - 138)

Report attached.

**9 HEALTHWATCH REDBRIDGE REPORTS ON DISCHARGE PATHWAY** (Pages 139 - 184)

Reports attached.

## 10 NEXT MEETING

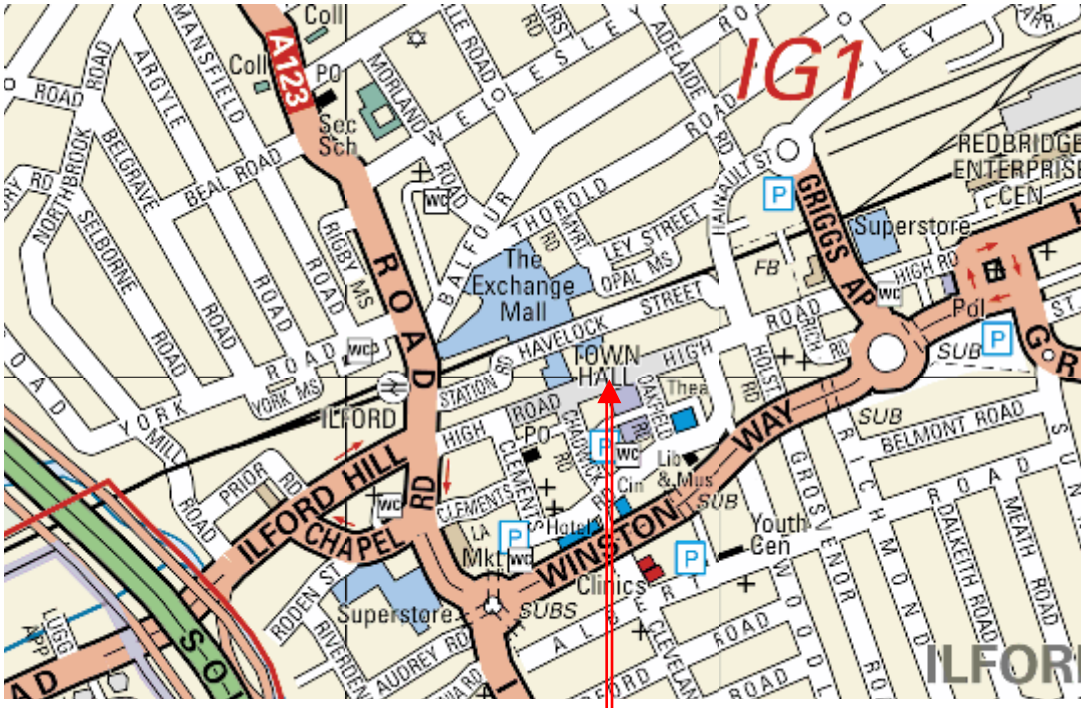
To note that the next meeting of the Joint Committee will be on Tuesday 16 January 2018 at 4 pm at Havering Town Hall, Romford.

## 11 URGENT BUSINESS

To consider any items, 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**

**Map showing LB Redbridge Town Hall**
128-142 High Road Ilford, Essex IG1 2DD




Please report to reception – the front reception (High Road) is open from 9-5pm and the side reception (Oakfield Road) is open before 9am and after 5pm.

Current meetings will be displayed on the electronic board.

The Council Chamber and Committee Rooms 1 & 2 are on the 1st Floor
Rooms 43 and 49 are on the 2nd Floor

**Travel directions**

**Public transport**
The Town Hall is served by a number of buses and is a 5 minute walk away from Ilford Station, which is in zone 4. For more information see the Transport for London website: www.tfl.gov.uk.

**Driving**
The nearest motorways are the A12 (alight at Gants Hill for Cranbrook Road and proceed toward Winston Way) or the A406 (alight at Ilford for Winston Way). For information about public car parks which operate a pay and display system see the Council website: https://www.redbridge.gov.uk/parking/car-parks-in-redbridge/

If using the Chadwick Road (Ilford) car park take the first left at the Winston Way roundabout and proceed straight ahead for Chadwick Road – **please do not turn right towards the library, as only buses can turn right and you may incur a penalty charge notice (PCN) - the Council will not be held responsible for any issued PCNs.**

Alternative parking is found in the Clements Road Car Park or in The Exchange Mall (Station Road).

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**MINUTES OF A MEETING OF THE**
**JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE**
**Barking Town Hall**
**18 July 2017 (4.00 pm - 6.14 pm)**

**Present:**

**COUNCILLORS**

| | |
|---|---|
| **London Borough of Barking & Dagenham** | Abegboyega Oluwole and Peter Chand (Chairman) |
| **London Borough of Havering** | Nic Dodin and Michael White |
| **London Borough of Redbridge** | Stuart Bellwood and Neil Zammett |
| **London Borough of Waltham Forest** | Peter Herrington and Richard Sweden |
| **Essex County Council** | Chris Pond |
| **Epping Forest District Councillor** | Aniket Patel |
| **Co-opted Members** | Mike New (Healthwatch Redbridge)<br>Anne-Marie Dean (Healthwatch Havering) |

**Also present:**

Sue Boon, Integrated Care Director, NELFT
Kathryn Halford, Chief Nurse, BHRUT

Masuma Ahmed, Barking & Dagenham
Anthony Clements, Havering
Jilly Szymanski, Redbridge
Tudur Williams, Barking & Dagenham

All decisions were taken with no votes against.

## 1 CHAIRMAN'S ANNOUNCEMENTS

The Chairman gave details of the arrangements in case of fire or other event that should require the evacuation of the meeting room or building.

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

Apologies for absence were received from Councillor Jane Jones (Barking & Dagenham) Councillor Dilip Patel (Havering) Councillor Suzanne Nolan (Redbridge) Councillor Mark Rusling (Waltham Forest) and Councillor Geoff Walker (Waltham Forest, Councillor Peter Herrington substituting).

Apologies were also received from Richard Vann (Healthwatch Barking & Dagenham) and Ian Buckmaster (Healthwatch Havering, Anne-Marie Dean substituting).

## 3 DISCLOSURE OF INTERESTS

Councillor Sweden declared an interest in item 6 (NELFT future plans) as he was managed, though not employed by, the North East London NHS Foundation Trust.

## 4 MINUTES OF PREVIOUS MEETING

The minutes of the meeting of the Joint Committee held on 18 April 2017 were agreed as a correct record and signed by the Chairman.

## 5 BHRUT - UPDATE ON SAFETY OF SERVICES

The Chief Nurse at BHRUT advised that the Trust was now above the national average for incident reporting – an indication of a healthy organisation. Few of the reported incidents were serious or harmful in nature. The most common categories of incidents reported included pressure ulcers (which the Trust had done a lot of work to reduce the occurrence of) delays to treatment, falls within the hospital, medication errors (these were mainly of no harm/near miss incidents) and maternity services. The number of serious incidents reported had reduced.

Learning was undertaken from serious incidents with the Trust identifying root cause analysis and providing families with copies of reports at the conclusion of an investigation. Meetings were also held with local CCGs in order to discuss learning points from incidents.

All complaint responses were reviewed by the Chief Nurse. Complaints were now more focussed on the whole on specific issues and the Trust welcomed the chance to meet face to face with complainants. The Trust had recently received its first Regulation 28 report from a coroner in 18 months concerning a patient who had died following a liver biopsy.

Data could be circulated by the Trust giving comparisons of incident reporting against national averages. One maternal death had recently been reported by the Trust, the first such occurrence for two years although two terminally ill mothers who had given birth were also required to be included in the statistics.

The Trust had not received any reports of theatre equipment being used for anything other than medical use. There was a two hour window for the dispensing of prescriptions but these were still reported as near misses if not dispensed at the target time. Staff would be disciplined if necessary but only if incidents were sufficiently serious in nature.

The Trust Chief Nurse agreed that it was unacceptable that patients should develop pressure ulcers and investigated each such case with the appropriate team. It was aimed to improve such matters where possible via education, training and support to staff. It was clarified that the statistics covered formal complaints or incidents reported at all the Trust's hospitals and satellite clinics. Cases dealt with by the Trust Patient Advice and Liaison Service were not included. An initial response would be sent to a complainant within three days which sought to agree a timescale for the completion of the full investigation and response.

It was noted that Barking & Dagenham had not received the Trust's Quality Account and the Trust would aim to ensure the draft was sent to partners earlier in future years.

The Committee noted the position.

## 6 NELFT FUTURE PLANS

The NELFT Integrated Care Director confirmed that each borough Health Overview and Scrutiny Committee had scrutinised the outcome of the Trust's inspection by the Care Quality Commission (CQC) that had taken place in early 2016. The Brookside unit for young people had been rated as inadequate and other concerns had been raised over care planning and risk assessment on mental health inpatient wards.

The Brookside unit had been closed for a period in response and the model of care employed there had been fundamentally changed. A new model of service had now been agreed with commissioners – NHS England. The CQC had revisited the refurbished unit in October 2016 and was now happy with the services at Brookside although the unit was still closely monitored. It was clarified that the unit accommodated people aged 12-18 years and covered all four Outer North East London boroughs. The unit was based at Goodmayes Hospital. A shortage of adolescent mental health beds

nationally meant there had been pressure on the unit to admit patients from elsewhere. This had improved however and patients were mainly from the Outer North East London boroughs. Councillor Sweden congratulated the NELFT officer on the improvements at Brookside.

Most CQC recommendations had now been implemented by NELFT with the remainder in the process of being completed. Quality improvement work was under way to address the CQC findings around care planning and risk assessments. Work to eliminate ligature risks in the in-patient mental health unit would be completed by spring 2018 and the unit would be closed while this work was carried out.

The CQC would carry put a further inspection on the 'well led' domain in October 2017 when some other areas would also be assessed that had previously been found to need improvement.

It was hoped that the changes made would also improve corporate governance and vacancy rates at the Trust had been addressed. The exact position re the registration of non-executive directors at the Trust in relation to the Fit and Proper Person Test would be confirmed by officers.

A ward at Goodmayes that catered for patients with learning disabilities had originally been closed due to the presence of a very challenging patient on the ward, leading to safety issues for other patients. The unit was now open to admissions but a written response would be provided.

Officers agreed that earlier intervention in mental health conditions was usually better for patients. The Trust's Early Intervention in Psychosis service had a target of establishing a care package for psychosis within two weeks of a patient's referral. The Trust had also established the Improving Access to Psychological Therapies service which provided talking therapies for conditions such as anxiety and depression for patients who did not require secondary care.

The work to eliminate ligature risks had prioritised the higher risk, acute mental health wards. Whilst this risk could never be removed entirely, the Trust did aim to nurse patients in more ligature-free areas.

NELFT had community provision for eating disorders although it did not offer in-patient beds for this condition. Work would be undertaken with commissioners if an in-patient bed was required although this was unusual for patients with eating disorders.

The CQC report had made a total of 137 recommendations covering NELFT as a whole and 106 of these had now been completed. A quality improvement programme had been introduced to encourage clinicians to make small changes in order to improve services.

Reports on safer staffing levels were compiled by the Trust on a monthly basis and all staffing trends were closely monitored. The Trust had now reduced its previous reliance on agency staff.

It was noted that the NELFT Quality Account had not been received by the boroughs.

The Joint Committee noted the position.

## 7 HEALTHWATCH HAVERING REPORTS

A. In-patient meals at Queen's Hospital

The Chair of Healthwatch Havering explained that the organisation had received a number of complaints about meals at Queen's Hospital including lack of variety, portion size and lack of assistance offered to patients who had difficulty eating. This had led to enter and view visits being undertaken to three wards in October 2016.

The overall standard of food on Bluebell A and B wards had been found to be good but the standard had been much lower on Sunrise B ward which catered for patients suffering from dementia. There was only limited food on offer and a lack of staff available to assist patients at mealtimes (it was accepted by Healthwatch Havering that staff on the ward were under significant pressure).

Improvements since the visit had included relaunching of the hospital's Feeding Buddy scheme, referral to dieticians if necessary and adjustments to the food ordering system. At least two staff were now available on each ward to assist at mealtimes.

In response, the BHRUT Chief Nurse welcome the Healthwatch report and emphasised that work had taken place to improve the position on Sunrise ward. More mealtime assistants had been recruited and meals were now ordered by patients on the day. Findings of the enter and view visits had been responded to quickly and Healthwatch were welcome to return and reinspect.

Hospital volunteers were able to be trained as mealtime assistants and there was a formal induction programme for all volunteers. The overall number of volunteers had increased by 100 compared to last year. Volunteers supported ward staff by e.g. befriending patients and also worked on the hospital reception. Barking College students also assisted as volunteers and the Pets as Therapy scheme was also available to support patients.

The hospital was required to ensure wards were safely staffed each day and this was reported on a monthly basis. Staff now took their meal breaks at a different time to patients and relatives were also welcome to

assist at mealtimes where possible. Protected patient mealtimes had also been introduced which allowed more nurses to assist with meals. There were few staff vacancies in older people's services with the most recruitment difficulties occurring on surgical wards.

The Chief Nurse confirmed that she visited wards at different times and would use action plans, retraining etc to deal with problems but it could take time to effect improvements. The Chief Nurse also confirmed she had been aware of problems on Sunrise B ward prior to the Healthwatch visit.

B. NELFT Street Triage Service

Healthwatch was supportive of this service which it considered to be very innovative. The service was operated by NELFT, the Metropolitan Police and the British Transport Police with the aim of being able to intervene with people having a mental health crisis in a public area without their being criminalised.

Mental health staff were able to respond to requests from police and hence avoid people exhibiting mental health issues being taken to a police station or to A & E.

Recommendations made by Healthwatch Havering to NELFT included the extending of the service to a 24 hour operation, giving all police officers training in dealing with mental health crises and using London Ambulance Service vehicles to get NELFT staff to incidents more quickly. London Ambulance Service had been recommended to provide a dedicated vehicle and to attend street triage meetings. Healthwatch had also recommended that police officers should receive mental health training.

Commissioners (led by Waltham Forest CCG for this service) had been recommended to support the scheme, provide funding for police training and support the 24 hour expansion of the service and the provision of a London Ambulance Service vehicle.

In response, NELFT had welcomed the support given to the scheme by Healthwatch Havering. The local CCGs had confirmed the scheme was a priority area in the East London Health and Care Partnership and that options to invest in the service were being looked at.

It was noted that no response to the report had been received from the Metropolitan Police and that Havering's Crime & Disorder Overview and Scrutiny Committee would be seeking to obtain a police response. No response had been received from Waltham Forest CCG to the report.

Calls to the team came from shop staff, neighbours etc. NELFT staff tried not to use section 136 of the Mental Health Act where people could be moved to a place of safety but more information could be provided on this power. It was noted that each Healthwatch organisation worked in a different way but it was felt that each Healthwatch would be likely to support the scheme.

NELFT staff would work with police to provide a mental health assessment and it was hoped the scheme would lead to better joint working between mental health professionals and the police. It was felt that a similar scheme could be introduced to support Council staff who may also find themselves dealing with members of the public exhibiting mental health issues.

The Committee noted the reports presented by Healthwatch Havering.

## 8 COMMITTEE'S WORK PLAN

It was agreed that a standing item should be put on the agenda for future meetings for an update on developments with the East London Health & Care Partnership.

In addition to the proposed workplan submitted,, it was agreed that the following issues should be scrutinised, if possible, by the Joint Committee during the municipal year:

- Problems with supply of oxygen to patients
- Local delivery of chemotherapy treatments
- A Healthwatch Redbridge report on the discharge pathway
- An update on maternity services to cover responses to recent CQC reports and progress since the closure of the maternity unit at King George Hospital
- Clarification over which boroughs (if any) had formally signed a memorandum of understanding re the East London Health and Care Partnership.
- Procurement issues across the local NHS.
- An update on performance of the Health 1000 project.

It was also agreed that a visit to Whipps Cross Hospital should be arranged. This would cover, if possible, maternity, A & E, changes to the hospital environment, a briefing on the planned rebuilding programme and scrutiny of the Trust’s work to prevent future cyberattacks.

9 **NEXT MEETING**

The next meeting would be held on Tuesday 10 October at 4 pm at Redbridge Town Hall.

10 **URGENT BUSINESS**

There was no urgent business raised.

**Chairman**

Havering
LONDON BOROUGH

# OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 10 OCTOBER 2017

| | |
|---|---|
| **Subject Heading:** | Whipps Cross Care for Patients with Dementia |
| **Report Author and contact details:** | **Anthony Clements,<br>Principal Democratic Services Officer,<br>London Borough of Havering** |
| **Policy context:** | **The attached presentation gives details of the policies at Whipps Cross Hospital for caring for patients with dementia.** |
| **Financial summary:** | **No impact of presenting of information itself.** |

## SUMMARY

Officers from Barts Health NHS Trust will detail, as shown in the attached presentation, the policies and procedures for caring for patients admitted to Whipps Cross Hospital suffering from dementia.

## RECOMMENDATIONS

1. That the Joint Committee considers the information presented on how people with dementia are cared for at Whipps Cross Hospital and takes any action it considers appropriate.

## REPORT DETAIL

Following the original raising of the mater by a member of the public, Barts Health NHS Trust officers have been asked to attend the meeting of the Joint Committee and explain the procedures and policies at Whipps Cross Hospital for caring for admitted patients who suffer from dementia. The Joint Committee is

recommended, having listened to the evidence submitted, to take any further action 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.


NHS
Barts Health
NHS Trust



# Caring for patients living with dementia

## Whipps Cross University Hospital

Tristan Kerr, Associate Director of Nursing

# What is dementia and delirium?

## Dementia

The Alzheimer's Society explains that dementia describes a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language. These changes are often small to start with, but for someone with dementia they have become severe enough to affect daily life. A person with dementia may also experience changes in their mood or behaviour.



## Delirium

The Alzheimer's Society explains that delirium causes a person to become easily distracted and more confused than normal. Delirium is different from dementia. For someone with delirium, symptoms come on over a matter of hours or a few days. The symptoms of dementia come on slowly, over a period of months or even years.

# Our commitment to caring for patients living with dementia

- Barts Health NHS Trust is committed to becoming dementia friendly
- We have a dementia and delirium strategy to ensure that our patients receive the care and support that they need
- Our strategy incorporates the seven key principles identified by the NHS London Acute Hospital Network for Dementia and encompasses the Dementia Action Alliance Dementia-Friendly hospital charter
- All our hospitals have their own implementation plans of our strategy. Progress is reviewed monthly and linked into the Trust-wide Older Peoples Network



NHS
Barts Health
NHS Trust

# Our dementia and delirium strategy 2013 - 2018

## Key principles



- Strong ownership and leadership for dementia throughout the Trust
- Care is person centred and individual
- Environments that are dementia friendly
- Assessment and early identification of dementia
- Supporting people with dementia to be discharged back home
- Staff are skilled and have the time to care
- Strong partnership working with people with dementia, their carers and other agencies

# Strong ownership and leadership for dementia

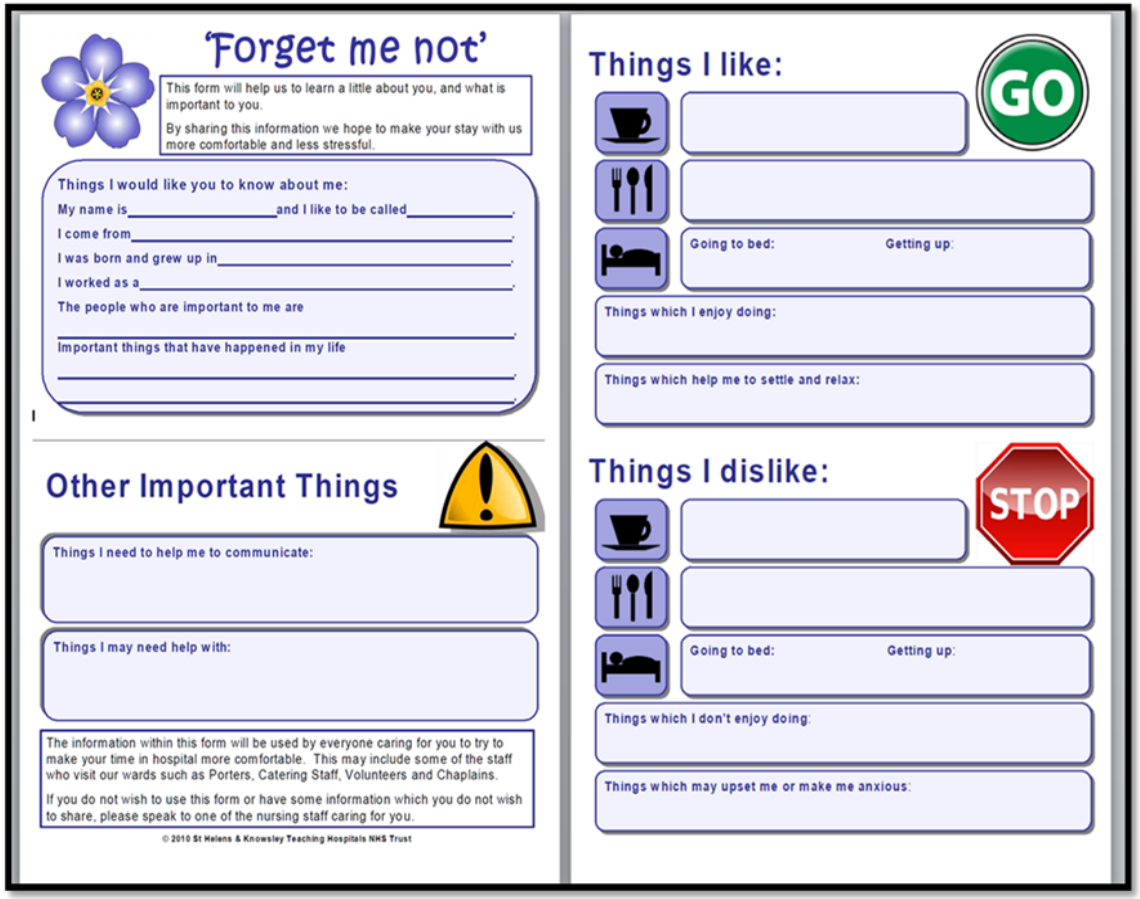
- There is visible leadership in dementia across the Trust
- Site-based dementia and delirium teams have been operational for 18 months and are fully staffed
- A multi-disciplinary dementia strategy steering group meets monthly on each site to develop and adopt best practice
- Dementia champions have been identified in all clinical and non-clinical departments
- The Trust Board regularly reviews serious incidents, falls, delayed discharges, complaints and patient experience metrics associated with patients with a diagnosis of dementia



Barts Health NHS Trust

# Care is person centred and individual

## ‘Forget me not’



‘Forget me not’

This form will help us to learn a little about you, and what is important to you.

By sharing this information we hope to make your stay with us more comfortable and less stressful.

Things I would like you to know about me:

My name is _____ and I like to be called _____.

I come from _____.

I was born and grew up in _____.

I worked as a _____.

The people who are important to me are _____.

Important things that have happened in my life _____.

Other Important Things

Things I need to help me to communicate:

Things I may need help with:

The information within this form will be used by everyone caring for you to try to make your time in hospital more comfortable. This may include some of the staff who visit our wards such as Porters, Catering Staff, Volunteers and Chaplains.

If you do not wish to use this form or have some information which you do not wish to share, please speak to one of the nursing staff caring for you.

© 2010 St Helens & Knowsley Teaching Hospitals NHS Trust

Things I like:

GO

Going to bed: Getting up:

Things which I enjoy doing:

Things which help me to settle and relax:

Things I dislike:

STOP

Going to bed: Getting up:

Things which I don't enjoy doing:

Things which may upset me or make me anxious:

# Care is person centred and individual

- We are embedding the **‘Forget me Not’** tool - a trust wide recognition scheme to aid the identification of people with dementia by staff in all departments
- Patients living with dementia having a personalised care plan to support their individual needs
- Specialist teams support patients with complex needs, including holistic therapy assessments and advice for people with swallowing or eating and drinking problems
- Our safeguarding team ensure staff who care for people with dementia are appropriately supported
- We actively seek feedback from individuals with dementia and their carers to improve our services



# Environments that are dementia friendly

- We are improving the experience and outcome of care for people living with dementia by developing dementia friendly environments
- With funding from Barts Charity, five wards have been overhauled with new flooring, new day rooms for patients and an improved layout to allow staff to be closer to patients
- Signage on wards is now specifically aimed at people with dementia, and new artwork is helping to make the spaces friendly and welcoming
- Each ward, as well as the wider hospital, is also benefiting from artwork showing familiar local landmarks
- Improvement work has been led by our dementia specialists who spoke to patients and their families to make sure the changes reflected their wishes

# Assessment and early identification of dementia

- We use the F.A.I.R dementia screening within our routine practice:
  - Finding,
  - Assessing
  - Investigating and
  - Referral
- All patients admitted over the age 75 years in an emergency have their cognition assessed
- There is support for patients and carers to access community services through signposting and onward referrals for further assessment and treatment as needed



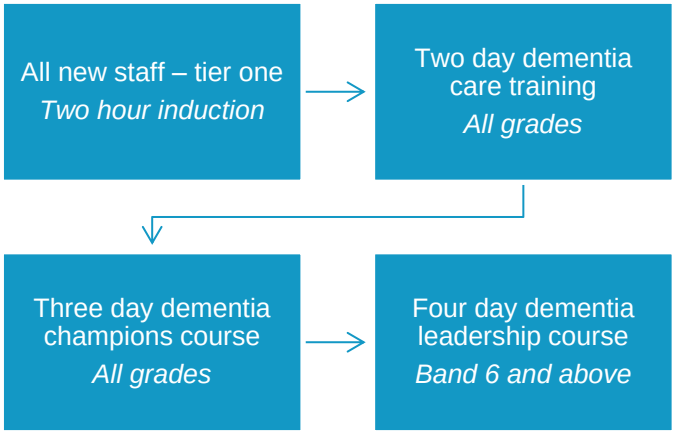
# Supporting people with dementia to be discharged back home

- We have key partnerships with services that support and facilitate discharge
- The dementia and delirium team assist with complex discharges to ensure that the person living with dementia and their carers needs are met
- Information resources available for individuals with dementia and their carers that identifies local support services



# Staff are skilled and have the time to care

- Every ward has a dementia champion and a dementia resource folder
- We have developed dementia buddies – volunteers who are trained in engaging with people living with dementia to work on our older peoples wards. We have recruited **8 dementia buddies** at Whipps Cross to date
- All new staff are provided one hour dementia awareness training on induction
- We have a dedicated dementia training plan which is accessible to staff of all levels and disciplines:



# Strong partnership working

- Barts Health is signed up to the John's campaign – which has one principle: *We should not enforce disconnection between carers and those who need care. When someone with dementia is hospitalized, the medical staff should do all within their power to make access easy for family carers and utilise their expert knowledge and their love*
- As a result, we have introduced carers badges, flexible visiting hours and information leaflets for carers to ensure that carers needs are met
- The dementia and delirium team have strong links with community organisations and resources
- We work in partnership with our local Alzheimer's societies, and various statutory and non-statutory organisations to provide support to our patients and their families



Havering
LONDON BOROUGH

# OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 10 OCTOBER 2017

| | |
|---|---|
| **Subject Heading:** | Spending NHS Money Wisely |
| **Report Author and contact details:** | **Anthony Clements,<br>Principal Democratic Services Officer,<br>London Borough of Havering** |
| **Policy context:** | **The attached report details the Spending NHS Money Wisely 2 consultation being undertaken by Barking and Dagenham, Havering and Redbridge (BHR) CCGs.** |
| **Financial summary:** | **No impact of presenting of information itself.** |

## SUMMARY

The attached presentation on the Spending NHS Money Wisely consultations is presented to the Joint Committee by BHR CCGs. The Joint Committee is asked to consider the report and respond to the consultation as it considers appropriate.

## RECOMMENDATIONS

1. That the Joint Committee considers the attached BHR CCGs report on the Spending NHS Money Wisely 2 consultation and the attached consultation document and takes any action it considers appropriate.

## REPORT DETAIL

Officers will present derails of the Spending NHS Money Wisely consultations.

## 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.

# Spending NHS money wisely 2

**Proposals for:**

- Some ‘over the counter’ medicines
- Ear wax removal
- Some injections for back pain
- Osteopathy
- Cataract surgery
- Podiatry.



**Outer North East London Joint Health Overview and Scrutiny Committee**
**10 October 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."

# Our financial challenge

- Growing and ageing population, with more people living with multiple long-term conditions
- Demand for services increases every year
- Worked closely with Barking, Havering and Redbridge University Hospitals Trust (BHRUT) to address referral to treatment time (RTT) issues
- We are in financial deficit and are legally required to balance our budget.

# What we have to do

- Make savings of **£55 million** in 2017/18 financial year (represents just over 5% of our total annual joint budget of just over £1 billion)
- Faced with some difficult choices
- Required by NHS England to find savings – have to act now.

# What else are we 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 clinicians adhere to policy on procedures of limited clinical effectiveness (POLCE) so only patients who meet strict eligibility criteria receive treatment.

# Spending NHS Money Wisely 1 (SMW1)

- Eight week consultation on no longer funding or restricting some medications and procedures
- Received 660+ responses
- After careful consideration by clinical directors, CCG governing bodies agreed two thirds of the proposals:
    - no longer funding gluten-free foods or painkillers on prescription
    - Stopping breast enlargements, face lifts and varicose vein surgery
    - Funding one IVF embryo transfer rather than three
- Changes took effect from 10 July 2017 and should amount to **£3 million of savings**.

# Spending NHS money wisely 2 (SMW2)

Looking at:

- Other ‘over the counter’ medicines
- Ear wax removal
- Some injections for back pain
- Osteopathy
- Cataract surgery
- Podiatry

**If all the proposals were implemented could save local NHS around £4 millon a year**.

# NHS prescribing

**Proposing GPs no longer prescribe the following medicines, most of which can be cheaply and easily bought over the counter:**

- Anti-malarial medicine
- Threadworm medicine
- Sleeping tablets (over the counter, for short-term use)
- Hay fever medicine
- Travel sickness medicine
- Vitamin D and probiotic supplements
- Skin rash creams, bath oils, shower gels and shampoo
- Sunscreens.

**These proposals (if implemented) could save the local NHS £575,280 a year**.

# NHS nationally: consulting on not prescribing 'low value' meds

- NHS England is consulting nationally until 21 October to no longer fund some medicines, including gluten-free products, painkillers, 'complementary' medicines and some travel vaccines

- Their proposals include some of the medicines we already agreed to stop prescribing in SMW1 – we couldn't wait

- We have promoted the consultation locally in the SMW2 consultation document and tweets, and will be formally responding

- Once results of national consultation known, we will assess new guidance and how might affect local prescribing.

# SMW2 proposals: procedures

We are proposing to no longer fund certain procedures:

- Ear wax removal
- Some injections for back pain
- Osteopathy

We are proposing to change the eligibility criteria for:

- Cataract surgery
- Podiatry

# Ear wax removal

**Propose no longer paying for people to have ear wax removed via aural microsuction.**

- Removal of excess wax from ear canal using microscope and suction device
- Should be last resort once other usually effective treatments tried (olive oil, eardrops and ear irrigation)
- If change goes ahead certain at-risk people will still receive aural microsuction (e.g. if had ear surgery or perforated ear drum).

**This proposal (if implemented) could save local NHS £403,259 a year**.

# Back pain injections

**Propose no longer funding some injections (disc, facet joint and epidural injections) for back pain.**



- Intended to temporarily relieve pain, tingling and numbness in back
- Pain management experts at BHRUT advise is limited evidence to show these injections relieve pain
- If change goes ahead, GPs will still be able to refer patients to musculoskeletal physiotherapists and pain management clinics.

**This proposal (if implemented) could save local NHS around £1.28m a year**.

# Osteopathy

## Propose no longer funding osteopathy

- Way of detecting, treating and managing health problems by moving, stretching and massaging muscles and joints
- Not widely available on NHS and we understand Redbridge is only CCG in London to offer it
- Considered an ‘alternative’ medicine or treatment, and its use is not always based on scientific evidence.

**This proposal (if implemented) could save local NHS £444,000 a year**.

# Cataract surgery

## Propose tightening the eligibility criteria for cataract surgery from 6/9 visual acuity to 6/12.



- Surgery should only be offered if cataracts are affecting ability to carry out daily activities such as driving or reading (would only apply to adults)
- To legally drive a car, must have visual acuity of 6/12 or less
- We've tested this proposal with the Local Optical Committee and revised the criteria based on their advice.

**This proposal (if implemented) could save local NHS £661,858 a year**.

# Podiatry

## Propose restricting who can have NHS-funded routine podiatry.

- Corn and callus care and toenail cutting to be available only to those with underlying medical condition e.g. diabetes or rheumatoid arthritis
- Acute podiatry care would still be available e.g. surgery for in-growing toenails and diabetic foot services
- Need to ensure people who most need podiatry get it – plan to look at how treatment offered and provided across BHR.

**This proposal (if implemented) could save local NHS £653,498 a year**.

| Proposal | Potential savings |
|---|---|
| Back pain injections | £1.2m |
| Cataract surgery | £661,858 |
| Podiatry | £653,498 |
| NHS prescribing | £575,280 |
| Osteopathy | £444,000 |
| Ear wax removal | £403,259 |
| **Total** | **£4m** |

# SMW2

- **No decisions have been made**
- E-copies of document and questionnaire sent to GP practices, trusts, councils, MPs, community and voluntary groups
- Working closely with Healthwatch and community and voluntary groups
- Drop-in sessions in each borough
- What else should we do?
- Please complete the questionnaire at:

  www.redbridgeccg.nhs.uk/spending-wisely

  www.haveringccg.nhs.uk/spending-wisely

  www.barkingdagenhamccg.nhs.uk/spending-wisely
- Engagement period ends **5pm, 15 November 2017**.

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Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

# Spending NHS money wisely 2

## *What do you think about our proposals for:*

- *Cataract surgery*
- *Podiatry*
- *Ear wax removal*
- *Some injections for back pain*
- *Osteopathy*
- *Some medications*

**Please tell us by 5pm**
**Wednesday 15 November 2017**

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

# Contents

# Introduction from clinical leads

Earlier this year, we launched an eight week public consultation on our first set of 'Spending NHS money wisely' proposals, aimed at protecting funding of local services. We want to make sure we get the best value we possibly can for every penny of taxpayer's money that goes into our local NHS.

We were heartened that when we went out to speak to the public and our patients about the challenges we faced, and the difficult decisions we had to make, that you overwhelmingly agreed with us. There were some exceptions, of course, and taking into account that feedback and our own experience as local GPs working every day in surgeries across Barking and Dagenham, Havering and Redbridge we rejected 11 of our original proposals.

You can see how your feedback was acted upon in our 'You said, We did' section on pages 8-9 so please be assured that we are listening.

That first set of changes – to NHS prescribing, gluten-free products, cosmetic procedures and IVF, should amount to around £3 million of savings this year, but we always knew we'd have the even more difficult job of looking for further savings and asking for your views again later this year. This document explains what we are proposing in the next stage of 'Spending NHS money wisely' and why we are asking for your help once again.

We are also looking at where we can make even bigger savings – in the way we work with hospital and community providers, by working more closely together wherever possible, making sure we get the most from our suppliers, our buildings – nothing is off limits.

The fact is, we still face further difficult choices if we are to continue to tackle health inequalities and improve the health of local people while keeping to our budget, which we must do. We are determined to do all we can to protect funding for our most essential health services – things like cancer care, emergency care, life threatening conditions and mental health services – for you and your families.

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

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

| | | |
|---|---|---|
| **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 |

# Introduction

This document sets out how we're looking at changing some of the things that we spend NHS money on locally.

Barking and Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Groups (CCG) are the NHS organisations that plan, design and buy (commission) local health services.

We are required to make £55 million of savings this year, having reached a point where we are in deficit and do not have enough money to continue buying all the services in the way we do now.

We want to make sure that services for local people offer the best care possible, in the most appropriate place, at the right time. It is our responsibility to prioritise services for those most in need and make sure that we make the best use of every public penny we spend, so we are considering:

No longer funding:

- Ear wax removal
- Some injections for lower back pain - disc, facet joint and epidural
- Osteopathy

Restricting who is eligible for:

- Cataract surgery
- Podiatry

We are also considering no longer prescribing a range of medications that can be bought cheaply and easily 'over the counter' without a prescription. If all implemented, these proposals could save up to **£4 million** a year.

We believe that this approach will mean we can protect the most important services for when people need them, whilst at the same time continuing to live within our financial means. We've also consulted on a range of proposals earlier this year and now we're looking at what else we could do.

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. Your opinion really counts and we need your feedback on our ideas. 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.

The consultation runs for eight weeks from 20 September 2017. **All responses must be received by 5pm on Wednesday 15 November 2017.**

For more information visit our websites:

www.barkingdagenhamccg.nhs.uk/spending-wisely

www.haveringccg.nhs.uk/spending-wisely

www.redbridgeccg.nhs.uk/spending-wisely

# Our financial situation - why we must make changes

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.

Each CCG is allocated an amount of money 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, our area is under-funded.

Demand for healthcare in Barking and Dagenham, Havering and Redbridge is increasing every year. 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.

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 to choose how to use our funds carefully to ensure that local people can access the healthcare that is most needed and that people with equal need have equal opportunity to access treatments.

We have reached a point where we are in deficit and do not have enough money to continue buying all the services in the way we do now.

We are legally required to balance our budget. To achieve financial balance, we 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 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 are responsible for ensuring that the treatments provided for the local population represent the best use of the NHS budget allocated to us for our population's health services. 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 which services and treatments we can fund and in some cases, no longer fund.

This inevitably means that difficult decisions need to be made. Unfortunately, some treatments that patients might wish to receive, and that healthcare professionals might wish to offer, cannot be funded or are only offered under certain circumstances. We've already decided to no longer fund or to restrict a range of procedures and treatments, following a consultation earlier this year, but we need to do more.

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.

To make savings we need to reduce our spending in some areas and this document sets out how we think we can do this.

**The proposals in this document are just that and nothing has been decided. We want to know what you think we should do.**

# What we've done to save money so far

We've been working hard to look at what we spend money on and where savings can be made. This has involved:

### Finding efficiencies

- working with hospital and community care providers to make the patient pathway (who a patient sees and where they go - from their first contact with an NHS member of staff, through referral, to the end of their treatment) more efficient, for example by introducing a musculoskeletal referral triage service.
- looking at contracts with our providers to make sure they are cost effective and to identify where savings could be made, for example ending contracts that cannot show measurable improvements in people's wellbeing.
- making better use of technology, for example by introducing a virtual triage for gastroenterology patients.
- making sure we are using buildings efficiently and not paying for space we don't need. For example, we're looking at reorganising our head office, fitting more people on one floor so we can give up the lease on another.

### 'Spending NHS money wisely'

From March to May this year we ran an eight-week consultation called 'Spending NHS money wisely' which set out proposals for making £5.2m of savings through no longer funding or restricting a number of medications and procedures.

We received over 660 responses, and after careful consideration agreed to stop prescribing over the counter painkillers, muscle rubs, vitamin supplements, gluten-free foods and funding of certain surgical procedures such as face lifts, varicose vein surgery and brow lift surgery. We also agreed to fund one in-vitro fertilisation (IVF) embryo transfer, instead of three.

But our governing bodies rejected proposals to stop funding sterilisation and procedures such as breast reductions and removing moles and cysts from people's faces after listening to people's concerns about the impact some of the proposals would have.

The restrictions agreed should result in around **£3 million** of savings a year.

**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.

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.

We believe 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. The public overwhelmingly agreed with us when we consulted earlier on a range of proposed changes earlier this year.

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.

GPs have told us that there are a number of procedures that they feel could benefit from clearly defined criteria so that doctors have better guidance on treatment options for some procedures and can agree in advance the best route for patients to get the treatment they need as appropriate – things like which tests to carry out or which treatments or medicines to use first.

To achieve this, we plan to bring together GPs and hospital clinicians to do a separate piece of work this year, looking at procedures including carpal tunnel surgery and some gynaecological and diagnostic procedures. On top of the benefits to patients and doctors, we expect this will also help deliver some savings to the local NHS by stopping a relatively small number of unnecessary procedures.

# Suggestions about how we could save money

We have been asking local people for suggestions about how we can save money, here are their suggestions and our responses.

| You said | We did |
|---|---|
| **Stop prescribing medicines that can be bought over the counter** | GPs have now stopped prescribing a number of medicines that can easily be bought over the counter and have limited clinical benefit to patients. We are now looking for ways to make further savings in this area – see pages 11-19. |
| **Cut down on medicines wastage** | Unused medicines cannot be re-issued to other patients because once medicines have left the pharmacy their storage conditions cannot be guaranteed and they may become less effective. We're looking at how we can reduce medicines wastage, working with GPs, pharmacists and the public. See page 10. |
| **Reuse or recycle occupational therapy and other medical equipment** | We do recycle and reuse some medical aids such as beds, mattresses, cushions and commodes and we are looking to increase the reuse of items. In Redbridge we loan rather than give these items to patients (saving around £350,000 a year) and we want to do this in Barking and Dagenham and Havering as well.<br><br>However, it is not possible to reuse every item, as some aren't suitable for reuse, such as specially made beds which are made to fit certain weight requirements. All items need to be given to the patient 'as new', so some cannot be reused because they are either damaged, dirty, too old or broken beyond repair. In some cases patients don't return equipment, or don't allow it to be collected. In other cases, the costs of collection and recycling are more than the cost of purchasing a new item. |
| **Make non-UK patients pay for treatment or ensure they have medical insurance** | All hospitals are required to check whether patients are eligible for free NHS treatment and charge people who are not eligible for any non-urgent, planned care.<br><br>We are working with our local hospitals to make sure people who are supposed to pay for their NHS care do so. Under a pilot scheme backed by the Department of Health looking at how best to establish whether or not people are eligible for free NHS care, pregnant women attending Queen's Hospital will be asked to provide a photo ID and proof of address at their first appointment. |

| | |
|---|---|
| **Patients could pay a small charge towards the cost of IVF** | That the NHS is free at the point of delivery is one of the core principles of the NHS, so we cannot charge patients for IVF. However, we have restricted who can have NHS-funded IVF treatment and the number of NHS-funded embryo transfers they can have. |
| **Review gluten-free food on prescription or offer vouchers against the cost for low-income families.** | GPs will no longer prescribe gluten-free food. People can find reasonably priced gluten-free foods in a wide range of places, including supermarkets, convenience stores, local pharmacies and online and there are plenty of foodstuffs that don't have gluten in them, such as rice and potatoes. |
| **Review what cosmetic surgery is available on the NHS.** | Following consultation, we have decided to no longer fund a number of cosmetic procedures.<br><br>Patients who need this surgery as a result of suffering from major trauma, cancer or severe burns will continue to have these procedures paid for. |
| **Reduce administration costs, the number of managers and use of agency staff** | We are three organisations that have pooled our resources to operate more efficiently, but we have reduced our limited interim staffing and general operating costs and are operating as leanly as possible. As a small organisation with a single shared management team there are limits to what further administrative savings we can make. |
| **The NHS should not treat heavy smokers, alcoholics, obese people or those abusing drugs, or should charge these people** | While we encourage people to lead healthy lifestyles and discourage them from taking illegal drugs, smoking or drinking too much, we recognise addictions such as alcoholism or drug dependency as diseases and treat them as such.<br><br>During our first 'Spending NHS money wisely' consultation earlier this year, some of you told us we should be stricter about not funding costly procedures for people who are heavy smokers, who are very overweight, or who have drug and/or alcohol issues. Our GPs regularly see patients who are heavy smokers, are very overweight or who have drug and/or alcohol issues. At the moment they routinely refer these patients to smoking cessation and other healthy lifestyle services. We have heard what some people think about us funding such treatments but we are not considering stopping them at this time. |

# What we think we should do

We have identified some further areas of NHS spending where we think making changes could save up to £4 million each year. The following pages set out our proposals.

# NHS prescribing

Every year GPs issue a large number of prescriptions for medicines, some of which can be bought more easily and cheaply without the need for a prescription (i.e. over the counter in supermarkets or pharmacies). Prescribing these medicines is often quite expensive for the NHS, especially when taking into account the cost of GP appointment times and pharmacist dispensing fees. For some of these medicines there is little evidence to show they improve people's health.

**What we have done so far**

Following a consultation earlier this year, our GPs no longer issue prescriptions for the following medicines:

- Gluten-free products
- Medicines for dental conditions
- Head lice and scabies medicines
- Rubefacient creams and gels, such as 'Deep Heat' and 'Tiger Balm'
- Omega-3 and other fish oil supplements
- Multivitamin supplements
- Eye vitamin supplements
- Colic remedies for babies
- Cough and cold remedies
- Dental prescribing
- Painkillers, such as paracetamol and ibuprofen
- Soya-based formula milk
- Some travel vaccinations:
    - Hepatitis A and B combined
    - Hepatitis B
    - Meningococcal meningitis
    - Japanese encephalitis
    - Rabies
    - Tick-borne encephalitis
    - Tuberculosis
    - Yellow fever

This is estimated to save us £1 million a year.

**Medicines wastage**

The Department of Health estimates that in England £300 million of medicines prescribed by the NHS are wasted each year. The cost of wasted medicines across Greater London is thought to be £50 million a year.

Of the £300 million of medicines wasted each year, it is thought that:

- £90 million of medicines are left in peoples' homes
- £110 million of medicines are returned to pharmacies.

**We all have a responsibility to do our bit to minimise medicines wastage**

**Only order the medicines you need**

- Check what medicines you have at home before ordering more
- Your medicines will stay on your repeat prescription, so you can always order them in future if needed

**Check your repeat prescription order is up-to-date**

- If you have stopped taking a medicine, please tell your GP and pharmacist so they can update your repeat prescription

**Don't build up stocks of medicines at home because:**

- Medicines go out of date
- Your treatment or condition may change
- The more medicines you have, the more likely it is you'll get confused about what you are taking
- It's not safe. Medicines can be dangerous if taken accidentally by someone else, especially children.

**Use GP online services**

If you have signed up for GP online services, you can cancel repeat prescriptions you no longer need online, at any time. Your GP practice can tell you if they provide GP online services and can help you to sign up. Find out more: www.nhs.uk/GPonlineservices

# Our proposals for prescribing

**We are proposing that GPs no longer issue prescriptions for some medications.**

We have now looked at other medicines GPs issue prescriptions for, most of which can be cheaply and easily bought over the counter. We have listed the medicines we don't think GPs should issue NHS prescriptions for in the table on the following pages. They are:

- Antimalarial medicine
- Threadworm medicine
- Sleeping tablets (over the counter, for short-term use)
- Hay fever medicine
- Travel sickness medicine
- Vitamin D supplements (for maintenance only)
- Probiotic supplements
- Bath oils, shower gels and shampoo (creams for skin conditions would still be prescribed)
- Skin rash creams
- Sunscreens

## Over the counter prescribing

| Type of medicine | Why we want to stop funding this | Example cost of product | Number of prescriptions issued in a year | How much these prescriptions cost the local NHS a year |
|---|---|---|---|---|
| **Anti-malarial medicine** | Antimalarial medicine is used to help prevent malaria infection (a serious tropical disease spread by mosquitoes) when people are travelling in countries where the disease is present (e.g. Central and South America, Africa and Asia).<br><br>We think travellers should include the cost of anti-malarials in their holiday budgeting, just like they have to include the cost of flights, accommodation and insurance.<br><br>Medicines can be privately prescribed by a GP or travel clinic, who can advise how to use them. | For a 2-week trip:<br><br>Proguanil and Chloroquine, £19.39 (Boots)<br><br>Doxycycline, £28.60 (Boots) | 189 | £5,041 |

| Type of medicine | Why we want to stop funding this | Example cost of product | Number of prescriptions issued in a year | How much these prescriptions cost the local NHS a year |
|---|---|---|---|---|
| **Threadworm medicine** | Threadworms are tiny worms that infect the intestines of humans and are a common type of worm infection, particularly in young children.<br><br>The infection is passed from person to person by swallowing the threadworms' eggs. The best way to prevent infection is to wash your hands after going to the toilet.<br><br>Treatments for threadworm can be bought from a pharmacy, who can advise how to use them. | Boots Pharmaceuticals Threadworm Tablets, 4 tablets to treat 4 people, £7.50 (Boots)<br><br>Lloyds Pharmacy Ovex Family Pack, 4 tablets to treat 4 people, £7.95 (Lloyds Pharmacy)<br><br>Lloyds Pharmacy Ovex Suspension Banana Flavoured Family Pack, 30ml, £9.79, (Lloyds Pharmacy) | 2.125 | £3,022 |

| Type of medicine | Why we want to stop funding this | Example cost of product | Number of prescriptions issued in a year | How much these prescriptions cost the local NHS a year |
|---|---|---|---|---|
| **Sleeping tablets** | Treatments for mild/short-term sleeping problems can be bought over the counter at low cost from supermarkets, pharmacies and other retailers.<br><br>Sleeping tablets are not guaranteed to work as they do not treat the underlying cause(s) of sleeping problems.<br><br>By making changes to bedtime habits you can often improve sleeping problems without needing to take medicine.<br><br>We intend to continue to prescribe sleeping tablets for severe sleeping problems. | Tesco Herbal Sleep Aid, 30 tablets, £2.50, (Tesco)<br><br>Boots Pharmaceuticals Sleepeaze Herbal Tablets, 30 tablets, £3.29 (Boots online)<br><br>Nytol Herbal Tablets Night Time Sleep Aid, 30 tablets, £3.69 (Boots) | 11782 | £31,622 |
| **Hayfever medicine** | These tablets, eye drops and nasal sprays are used to treat the symptoms of hay fever (an allergic reaction to pollen), including sneezing, a runny nose and itchy eyes.<br><br>Hayfever treatments are widely available at low cost from supermarkets, pharmacies and other retailers. | Tesco One a Day Hay fever & Allergy 10mg tablets, 14 tablets, £1.80 (Tesco)<br><br>Optrex Itchy Eye Drops, 10ml, £3.99 (Boots)<br><br>Boots Hay fever Relief For Adults Nasal Spray, 100 sprays £4.59 (Boots) | 148,228 | £227,518 |

| Type of medicine | Why we want to stop funding this | Example cost of product | Number of prescriptions issued in a year | How much these prescriptions cost the local NHS a year |
|---|---|---|---|---|
| **Travel sickness medicine** | This is used to treat the symptoms of travel sickness (e.g. dizziness, feeling sick and vomiting) that can occur when you are travelling (e.g. in a car, plane or boat).<br><br>Mild travel sickness can usually be improved using self-care techniques, e.g.<br>• fixing your eyes on the horizon<br>• keeping your head as still as possible<br>• distracting yourself by listening to music<br>• getting some fresh air.<br><br>More severe travel sickness can be treated with medicine, which can be bought from a pharmacy, who can advise how to use it. | Kwells Kids tablets, 12 tablets, £2.68, (Boots)<br><br>Boots Pharmaceuticals Travel Calm Tablets, 12 tablets, £2.79, (Boots)<br><br>Lloyds Pharmacy Travel Sickness Tablets, 10 tablets, £1.72 (Lloyds Pharmacy) | 12,426 | £45,650 |

| Type of medicine | Why we want to stop funding this | Example cost of product | Number of prescriptions issued in a year | How much these prescriptions cost the local NHS a year |
|---|---|---|---|---|
| **Vitamin D supplements (for maintenance only)** | Vitamin D is essential for strong bones and should be obtained from sunlight and through food rather than pills.<br><br>Note: If someone is diagnosed with too little vitamin D (deficiency) their GP will prescribe them a course of supplement tablets. Once they've completed the course of supplements and is found to have enough vitamin D, they can choose if they want to continue taking supplements (i.e. for maintenance). We intend to continue to prescribe vitamin D for deficiency.<br><br>If people want to take supplements for maintenance, they are widely available at low cost from supermarkets, pharmacies and other retailers. | ASDA Bone Health High Strength Vitamin D, 60 tablets, £2.00 (ASDA)<br><br>Boots Vitamin D, 90 tablets, £2.29 (Boots)<br><br>Tesco Vitamin D 90 tablets, £3.00 (Tesco) | 49,338 | £299,875 |

| Type of medicine | Why we want to stop funding this | Example cost of product | Number of prescriptions issued in a year | How much these prescriptions cost the local NHS a year |
|---|---|---|---|---|
| **Probiotic supplements** | There is no evidence to support claims of the health benefits of probiotics (products containing live bacteria and yeasts), such as restoring the natural balance of bacteria in the gut.<br><br>These are widely available at low cost from supermarkets, pharmacies and other retailers. | ASDA Vitamin Boosting Strawberry Yogurts Drink, 8x100g, £1.50 (ASDA)<br><br>Actimel Vanilla Yoghurt Drink, 8x100g, £2.90 (Tesco)<br><br>ActiMint Probiotic Supplement, 60 tablets, £6.25, (Lloyds Pharmacy) | 449 | £19,798 |
| **Bath oils, shower gels and shampoo** | These are used to help manage dry or scaly skin and scalp conditions.<br><br>They are widely available at low cost from supermarkets, pharmacies and other retailers.<br><br>For people with dry or scaly skin and scalp conditions we intend to continue to prescribe creams to treat these. | Oilatum Junior Bath Additive, 150ml, £3.50 (Tesco)<br><br>E45 Wash Cream for Dry and Itchy Skin, 250ml, £5.39 (Boots)<br><br>E45 Dry Scalp Shampoo, 200ml, £6.30 (Boots) | 61,783 | £365,658 |

| Type of medicine | Why we want to stop funding this | Example cost of product | Number of prescriptions issued in a year | How much these prescriptions cost the local NHS a year |
|---|---|---|---|---|
| **Skin rash creams** | These are used to treat the symptoms (e.g. irritated, scaly, bumpy or itchy skin and/or scalp) of mild skin rashes (e.g. nappy rash, heat rash and chickenpox rash).<br>Treatments are widely available at low cost from supermarkets, pharmacies and other retailers.<br>**Note:** If your rash lasts more than a few days you should visit a pharmacist or GP for advice. | Boots Pharmaceuticals Calamine & Glycerin Cream, 35g, £1.60 (Boots) | 10,661 | £36,661 |
| **Sunscreens** | Sunscreens are lotions and creams containing a sun protection factor (SPF) that help to protect your skin from burning in the sun.<br>These are widely available at low cost from supermarkets, pharmacies and other retailers.<br>**Note:** Sunscreens would continue to be prescribed for people undergoing treatment for cancer and/or specialist skin conditions. | Boots Essentials Sun Protection Lotion SPF15, 400ml, £2.49 (Boots online)<br>Tesco Soleil Sun Protect Lotion SPF15, 200ml, £3.50 (Tesco online)<br>Nivea Sun Moisturising Sun Lotion SPF30, 200ml, £6.00 (Boots online) | 1,252 | £15,016 |

***We estimate that in a year around 267,342 prescriptions are issued for the products listed above, costing the local NHS £1.05 million a year. By restricting prescribing of these we estimate we could save £575,280 a year.***

## What the NHS is doing nationally: consultation on not prescribing 'low value' medications

NHS England, the organisation that leads the NHS, has launched a public consultation on proposals to no longer routinely prescribe some medicines that are available by a prescription only or over the counter, including:

- 'Complementary' or 'alternative' medicines and treatments
- Gluten-free products
- Some travel vaccines
- Painkillers, such as paracetamol
- Erectile dysfunction, such as Tadalafil (similar cheaper products will still be available)
- Antidepressants, such as Dosulepin (more effective and cheaper products will still be available)
- Blood pressure medicines, such as Doxazosin (similar cheaper products will still be available)

The medicines have been included in the proposals if:

- they have limited effectiveness
- there are cheaper alternative medicines available that are as effective
- they are not felt to be a priority for funding.

If the proposals are implemented, national guidance would be developed to help CCGs when they decide which of these medicines to fund locally, and ultimately which medicines GPs would no longer prescribe.

**The NHSE consultation runs until 21 October 2017. You can find more information and tell NHS England your views at:**
**www.engage.england.nhs.uk/consultation/items-routinely-prescribed**

**Note:** Locally we have already consulted on stopping the prescribing of some of these medicines and have decided to not fund them (e.g. some painkillers, travel vaccines and gluten-free products). Once the results of this national consultation are known, we will assess the new guidance and how it might affect our local prescribing.

# Stopping funding certain procedures

We are proposing that the local NHS no longer funds the following procedures, because they are not essential, do not always have a demonstrable health benefit and cost the NHS a lot.

These are:

- Earwax removal
- Some injections for lower back pain (disc, facet joint and epidural injections)
- Osteopathy

## Ear wax removal

**We are considering if the local NHS should continue to pay for people to have earwax removed (known as aural microsuction).**

This is the removal of excess wax from the ear canal using a microscope and medical suction device.

Wax is produced inside your ears to keep them clean and free of germs. It usually passes out of the ears harmlessly, but sometimes too much can build up and block the ears, causing hearing difficulties.

Aural microsuction should only be used as a last resort to remove earwax once the following, usually effective, treatments have been tried:

- Olive oil
- Eardrops
- Ear irrigation with water, sometimes called “ear syringing”.

**Note:** If this proposal were to go ahead we think the following people should still receive NHS-funded ear wax removal:

- people who have had ear surgery
- people who have had a perforated ear drum
- people with severe inflammation of the ear canal
- people with a repaired or existing cleft palate (gap or split in the roof of the mouth).

***We estimate that there are 2,746 ear wax removal procedures are paid for by the local NHS costing £403,259 a year.***

## Injections for back pain

**We are considering if the local NHS should continue to fund some injections (disc, facet joint and epidural injections) for back pain.**

These injections are intended to temporarily relieve pain, tingling and numbness resulting from irritation in the lower back.

As recommended by pain management experts at our local hospital trust, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), we propose no longer funding some injections for back pain. This is because there is limited evidence to show that these injections work.

The injections we propose no longer funding are:

- Spinal disc injections (circular pads of connective tissue between the vertebrae)
- Facet joint injections (small joints located between and behind the vertebrae)
- Epidural injections for spinal claudication (walking difficulties or pain, discomfort, numbness, or tiredness in the legs that occurs during walking and/or standing).

> *"Pain can take many forms – from the short term to chronic, long-term pain. As a doctor, it's important to me that we give patients the tools to help people manage their pain and improve their quality of life. But it's also important that injections are offered that are consistent with current evidence such as the new NICE back pain guidelines, which is why I support these proposals."*
>
> **Dr Ben Huntley, Consultant in Pain Medicine and Anaesthesia, BHRUT**

If this change were to go ahead, GPs would still be able to refer patients to musculoskeletal physiotherapist for treatment and if needed, to the specialist pain management clinics at local hospitals.

***We estimate that in a year around 1,734 injections for lower back pain are paid for by the local NHS at a cost of £1.28 million a year.***

**Note:** We intend to continue to fund the following injections for back pain, which clinical evidence shows is effective:

- Medial branch blocks (diagnostic injections to the nerve that supplies the facet joint to see if the patient is likely to benefit from radiofrequency lesioning)
- Medial branch radiofrequency lesioning (using needle-electrode to cook the nerve supply to the facet joint)
- Transforaminal epidural steroid injection/dorsal root ganglion pulsed radiofrequency – when a needle electrode is used to accurately place the transforaminal epidural steroid injection and the nerve root is stunned with electricity at the same time.

## Osteopathy

**We are considering if the local NHS should continue to fund osteopathy.**

Osteopathy is a way of detecting, treating and preventing health problems (such as joint pain, sports injuries and arthritis) by moving, stretching and massaging a person's muscles and joints. It does not use medicines or surgery.

Osteopathy is considered to be a ‘complementary’ or ‘alternative’ medicine (like acupuncture, homeopathy and hypnotherapy) and although osteopaths may use some conventional medical techniques, its use is not always based on scientific evidence.

If this change were to go ahead GPs would still be able to refer patients for specialist treatment, for example to see a physiotherapist or attend a pain management clinic.

**Note:** Osteopathy is not widely available as an NHS funded treatment and we understand that Redbridge is the only CCG in London which currently funds osteopathy.

***We estimate that in a year there are 13,000 episodes of NHS-funded osteopathic treatment in Redbridge alone, costing the local NHS £444,000 a year.***

# Changing the eligibility criteria for some procedures

We are proposing to change the eligibility criteria for the following procedures:

- Cataract surgery
- Podiatry

This could mean that some people would not be able to get these procedures paid for by the NHS unless their doctor was able to prove they met the eligibility criteria.

## Cataract surgery

**We are proposing tightening the eligibility criteria for cataract surgery**

A cataract is cloudiness of the lens, the normally clear structure in your eye which focuses the light. They can develop in one or both eyes. The cloudiness can become worse over time, causing vision to become increasingly blurry, hazy or cloudy. Minor cloudiness of the lens is a normal part of ageing.

Significant cloudiness, or cataracts, generally get slowly worse over time and surgery to remove them is the only way to make it easier to see. However, you don't need to have surgery if your vision is not significantly affected and you don't have any difficulties carrying out everyday tasks such as reading or driving.

New glasses, brighter lighting, anti-glare sunglasses and magnifying lenses help reduce the impact of cataracts. Medications, eye drops, or dietary supplements do not improve cataracts or stop them getting worse.

Surgery should only be offered if you have cataracts that are affecting your ability to carry out daily activities.

**Note:** Although cataracts are often associated with age, in rare cases babies are born with cataracts or young children can develop them. **What we are proposing would only apply to adults with cataracts.**

**How well can you see?**

Visual acuity describes how well you see detail. This is usually measured using a chart with rows of letters that start with one big one at the top and get smaller row by row. During a routine eye test, you sit 6 metres from the chart. If glasses or contact lenses are worn, these should be used for the test.

Each eye is tested while the other one is covered. The rows of letters correspond to the minimum size of letter that could be seen by someone with normal vision from 6m up to 60m. The first number is the distance the chart is viewed from.

If you can only read the big letter on the top line, that's recorded as 6/60 - you can see at 6m what can usually be seen from 60m with normal vision. This would mean you would be considered severely sight impaired, or legally blind. 6/6 is normal vision (what used to be known as 20/20 vision, when distance was measured in feet not metres).

**In order to legally drive a car, you must have a visual acuity of 6/12 or less.**

**We are proposing to change the criteria for eligibility for cataract surgery.**

This would mean that if you have one cataract, surgery would only be funded if:

Your visual acuity is 6/12 or worse in the affected eye.

**and:**

1. Your visual problems mean reduced mobility, experiencing difficulties in driving, for example, due to glare, or experiencing difficulty with steps or uneven ground.

**or**

2. Your ability to work, give care or live independently is affected.

**or**

3. If you have diabetes, or a retinal condition, which requires clear views of your retina to monitor the disease or treatment

**or**

4. If you have had glaucoma which requires cataract surgery to control the eye's fluid pressure (intra ocular)

**or**

5. If you have a certain type of cataract (posterior subcapsular or cortical) and experience problems with glare and a reduction in acuity in bright conditions

**or**

6. If your vision makes it borderline whether you should drive, and surgery would be expected to significantly improve your vision

If you have two cataracts (cataracts in both eyes), cataract surgery in the second eye would only be funded if:

- The first cataract surgery does not achieve a visual acuity of 6/9 or better, with refractive correction, and the procedure is clinically indicated for the patient's individual circumstances.

**or**

- The patient has diabetes, or retinal condition, which requires clear views of their retina to monitor their disease

**or**

- The patient is left with anisometropia or any condition meaning that binocular vision is not comfortable

We have tested these criteria with our Local Optical Committee which represents local optometrists and opticians and revised the draft criteria based on their advice.

***We estimate around 4,653 cataract surgeries take place each year. Changing the eligibility criteria means that 763 fewer people will have cataract operations each year, saving the local NHS £661,858.***

**Note:** Cataract surgery is not always successful and doesn't always mean that your vision improves. A study in the British Journal of Ophthalmology found that after cataract surgery, 25% of people said their vision had either deteriorated or remained unchanged.

Black, N., Browne, J., and van der Meulen, J. Is there overutilisation of cataract surgery in England? *British Journal of Ophthalmology* 2009; **93**:13-17

## Podiatry

**We're proposing restricting who can have NHS-funded routine podiatry such as corn and callus care and toenail cutting, so that it would only be available to people who have an underlying medical condition such as diabetes or rheumatoid arthritis.**

Podiatry involves preventing, diagnosing, treating and rehabilitating abnormal conditions of the feet and lower limbs. Currently our podiatry service is provided by NELFT NHS Foundation Trust.

We spend around **£3.26 million** a year on podiatry services, but some of our GPs tell us that they find it hard to find podiatric care for people who need it. It's hard to tell how many people use podiatry services (as some people use the services regularly) but we estimate there were around **44,625** episodes of podiatric care last year. This high number suggests that while we're spending a lot on podiatry, the people who need it aren't being prioritised for care.

We need to look at how podiatry is offered and provided across Barking and Dagenham, Havering and Redbridge more widely, so we can make sure the people who most need it get it.

As part of this, we want to restrict NHS funded routine podiatric care so only people who are at risk because of their medical conditions (such as diabetes or rheumatoid arthritis) would be eligible for NHS-funded routine podiatric care such as corn and callus care and toenail cutting. If you didn't have an underlying medical condition, you would need to pay for routine podiatric care.

***If implemented we think this could save the local NHS £653,498 a year.***

**Note:** Restricting access to podiatry would still mean the following care would be available to all when needed:

- Looking at how you walk and stand (biomechanical and gait reviews) for painful foot conditions
- nail surgery for painful / in-growing toenails (under local anaesthetic)
- a comprehensive diabetic foot service, including the management of acute foot problems

# Potential savings

**If all implemented these changes could save the local NHS approximately £4 million a year.**

| Area | Potential savings identified |
|---|---|
| NHS prescribing | **£575,280** |
| Stopping the funding of:<br>• Ear wax removal<br>• Some injections for lower back pain - disc, facet joint and epidural<br>• Osteopathy | <br>**£403,259**<br>**£1,281,358**<br>**£444,000** |
| Restricting access to:<br>• Cataract surgery<br>• Podiatry | <br>**£661,858**<br>**£653,498** |

# We want to know what you think

**No decisions have been made.** We want to hear from as many people as possible about what they think about our proposals. Over the next eight weeks (until 15 November 2017) we are engaging with local people in order to explain the reasons for these proposals, outline how people might be affected and encourage them to respond.

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 email haveyoursay.bhr@nhs.net or call 020 3688 1615.

All responses will help 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.

# 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 this on our websites. We will take into account people's responses to our proposals and this will inform a more detailed EIA, which will go to our governing bodies to consider before any decisions are reached.

# Glossary

| Term | Meaning |
|---|---|
| **Acute** | Severe or intense |
| **Anisometropia** | A condition in which the two eyes have unequal refractive power. |
| **Aural microsuction** | Procedure to remove excess wax from the ear |
| **BHRUT** | Barking, Havering and Redbridge University Hospitals NHS Trust |
| **Cataract** | Cloudiness of the lens (the normally clear structure in your eye which focuses the light) |
| **CCG** | Clinical commissioning group |
| **Commission** | Buying of health services |
| **'Complementary' or 'alternative' medicines** | Medicines that fall outside of mainstream healthcare and are not always based on scientific evidence |
| **Cortical cataract** | Type of cataract that occurs in the eye |
| **Corticosteroid** | A type of steroid that can help reduce inflammation |
| **Department of Health** | Department responsible for government policy on health and adult social care |
| **Diabetes** | A long-term condition that causes a person's blood sugar level to become too high |
| **Disc** | Circular pads of connective tissue between the vertebrae of the spine |
| **Eligible** | Whether someone qualifies. In this case, the minimum criteria to access a procedure |
| **Epidural** | An injection into the back |
| **Equality impact assessment (EIA)** | A process to make sure that a policy, project or proposal does not discriminate or disadvantage against people with certain characteristics |
| **Facet joint** | Small joints located between and behind the vertebrae of the spine |

| | |
|---|---|
| **Glaucoma** | Eye condition where the optic nerve, which connects the eye to the brain, becomes damaged |
| **GP** | General practitioner |
| **Insomnia** | Sleeping problems |
| **Intra ocular pressure** | The eye's fluid pressure |
| **Malaria** | A serious tropical disease spread by mosquitoes |
| **Musculoskeletal** | The nerves, tendons, muscles and supporting structures, such as the discs in your back |
| **NELFT** | NELFT NHS Foundation Trust |
| **NHS England** | National organisation that leads the NHS in England |
| **Optometrist** | Specialist eye doctor |
| **Osteopathy** | A way of detecting, treating and preventing health problems by moving, stretching and massaging a person's muscles and joints |
| **Pharmacist dispensing fee** | Pharmacists receive a professional fee for every item dispensed. This fee is currently 90p per item |
| **Podiatry** | A branch of medicine devoted to the treatment of feet, ankles and lower legs |
| **POLCE** | Procedures of Limited Clinical Effectiveness |
| **Pollen** | A fine powder produced by flowers |
| **Posterior subcapsular cataract** | Type of cataract that occurs in the eye |
| **Probiotics** | Products containing live bacteria and yeasts |
| **Recurrent** | Occurring often or repeatedly |
| **Refractive correction** | Surgery to correct your eyesight |

| | |
|---|---|
| **Retina** | Thin lining at the back of the eye |
| **Rheumatoid arthritis** | A long-term condition that causes pain, swelling and stiffness in the joints |
| **Spinal claudication** | Walking difficulties or pain, discomfort, numbness, or tiredness in the legs that occurs during walking and/or standing |
| **Sunscreens** | Lotions and creams that protect you from the sun |
| **Threadworms** | Tiny worms that infect the intestines of humans |
| **Visual acuity** | How clearly you see |
| **Vitamin D** | A vitamin that is essential for strong bones |

# 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 it reaches us by 5pm on 15 November 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 – a physical/ mobility issue
- ☐ Yes – learning disability/mental health issue
- ☐ Yes – a visual impairment
- ☐ Yes – a hearing problems
- ☐ Yes - another issue
- ☐ 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 an employee of the NHS?**

- ☐ Yes
- ☐ No

**7. Are you responding as...?**

- ☐ An individual
- ☐ A representative of an organisation or group (please tell us which)

## What do you think about our proposals?

We want to understand your views about what we're proposing.

**You don't have to answer the whole questionnaire if you don't want to – only answer the sections you're interested in.**

## NHS prescribing

### There are a number of medications 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.

1. 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 |
|---|---|---|---|---|---|
| Antimalarial medicine (the medication that prevents malaria) | | | | | |
| Threadworm medicine (threadworms infect the intestines) | | | | | |
| Sleeping tablets (for mild sleep problems only) | | | | | |
| Hayfever medicine | | | | | |
| Travel sickness medicine | | | | | |
| Vitamin D supplements (for maintenance only) | | | | | |
| Probiotic supplements | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Bath oils, shower gels and shampoo (creams for skin conditions would still be prescribed) | | | | | |
| Skin rash creams (medication for skin conditions such as eczema would still be prescribed) | | | | | |
| Sunscreens | | | | | |

2. Is there anything else you want to tell us, or think we should consider, before making decisions about no longer prescribing these types of medication?

| |
|---|
| |

## Ear wax removal

**We are considering if the local NHS should continue to pay for people to have earwax removed.**

3. 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 paying for ear wax removal | | | | | |

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

| |
|---|
| |

## Injections for back pain

**We are considering if the local NHS should continue to fund some injections for back pain.** As recommended by pain management experts at our local hospital trust, BHRUT, we propose no longer funding:

- Spinal disc injections (circular pads of connective tissue between the vertebrae)
- Facet joint injections (small joints located between and behind the vertebrae)
- Epidural injections for spinal claudication (walking difficulties or pain, discomfort, numbness, or tiredness in the legs that occurs during walking and/or standing).

This is because there is limited evidence to support the effectiveness of these injections.

5. Please tell us what you think of this 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 stop paying for spinal disc injections | | | | | |
| The local NHS should stop paying for facet joint injections | | | | | |
| The local NHS should stop paying for | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| epidural injections | | | | | |

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

| |
|---|
| |

## Osteopathy

**We are considering if the local NHS should continue to fund osteopathy.**

Osteopathy is considered to be a 'complementary' or 'alternative' medicine (like acupuncture, homeopathy and hypnotherapy) and although osteopaths may use some conventional medical techniques, its use is not always based on scientific evidence.

7. 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 paying for osteopathy | | | | | |

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

## Changing the eligibility criteria for some procedures

### Cataract surgery

**We are proposing tightening the eligibility criteria for cataract surgery**

9. 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 tighten the eligibility criteria for cataract surgery | | | | | |

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

## Podiatry services

**We're proposing restricting who can have NHS-funded routine podiatry, so only people who have an underlying medical condition such as diabetes or rheumatoid arthritis can receive routine podiatry (such as corn and callus removal and toe nail cutting) paid for by the NHS.**

11. 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 tighten the eligibility criteria for podiatry | | | | | |
| Routine podiatric care should only be funded for people with an underlying medical condition. | | | | | |

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

| |
|---|
| |

## General comments

13. Within the last two years have you or a member of your immediate family:

| | Yes | No |
|---|---|---|
| Had ear wax removal paid for the NHS? | | |
| Had injections for back pain paid for by the NHS? | | |
| Had treatment from an osteopath paid for by the NHS? | | |
| Had routine podiatry (corn, callus and toe nail cutting) paid for by the NHS? | | |
| Had cataract surgery paid for by the NHS? | | |

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

| |
|---|
| |

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

| |
|---|
| |

16. 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 15 November 2017**

# We want to hear from everyone

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 রডেব্রজি কছিু স্বাস্থ্য পরষিবোয় আমরা যে পরবির্তনগুলো 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 পতে 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۔

Havering
LONDON BOROUGH

# OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 10 OCTOBER 2017

| | |
|---|---|
| **Subject Heading:** | BHRUT Improvement Update |
| **Report Author and contact details:** | **Anthony Clements,<br>Principal Democratic Services Officer,<br>London Borough of Havering** |
| **Policy context:** | **The attached presentation gives details of improvement work being undertaken at Barking, Havering and Redbridge University Hospitals' NHS Trust (BHRUT)** |
| **Financial summary:** | **No impact of presenting of information itself.** |

## SUMMARY

Officers from BHRUT will detail, as shown in the attached presentation, improvement work currently in progress at the Trust.

## RECOMMENDATIONS

1. That the Joint Committee considers the information presented on improvement work at BHRUT and takes any action it considers appropriate.

## REPORT DETAIL

Following detailed scrutiny, at both ONEL and borough level, of the delays at BHRUT encountered by patients awaiting treatment, Trust officers will present details of improvement work being undertaken at the Trust on a number of issues and areas.

## 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.

# BHRUT IMPROVEMENT UPDATE

**Jon Scott**
**Interim Chief Operating Officer**




TAKING PRIDE IN OUR CARE

Barking, Havering and Redbridge University Hospitals NHS Trust

# 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 |

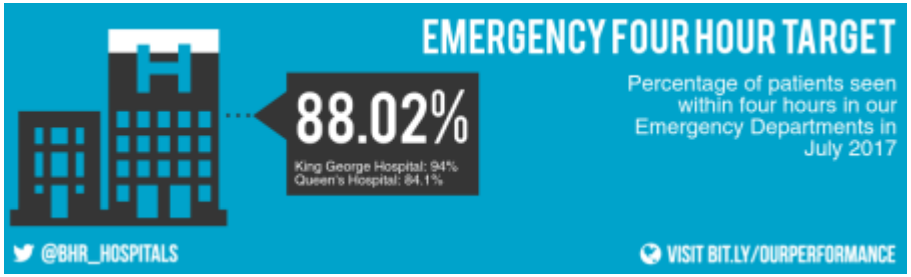
# MUST DO ACTIONS – MARCH 2017 REPORT

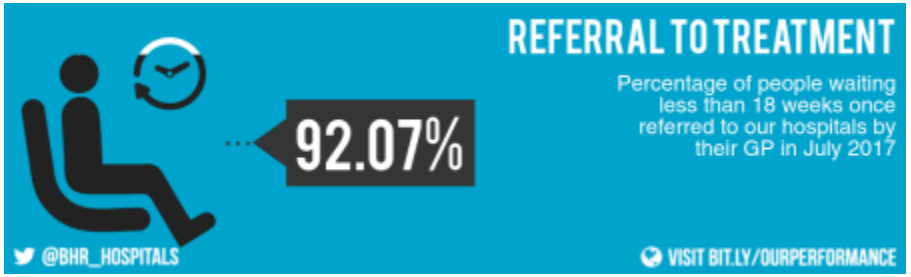
| Actions | Comments |
|---|---|
| **Must Do 1** - Ensure there is oversight of all training done by locums particular around advanced life support (ED) | Completed and process in place |
| **Must Do 2** - Take action to address the poor levels of hand hygiene compliance | Completed with a improvement of compliance that meets Trust target. A further detailed plan is in place to continue to improve |
| **Must Do 3** - Ensure fire safety is maintained by ensuring fire doors are not forced to remain open (PAEDS) | Completed |
| **Must Do 4** - Ensure staff have a full understanding of local fire safety procedures, including the use of fire doors and location of emergency services (PAEDS) | Completed – monitoring compliance with improvement walks |
| **Must Do 5** - Ensure hazardous waste including sharps bins is stored according to related guidance and EU directives. This includes the consistent use of locked storage facilities. (PAEDS) | Completed |
| **Must Do 6** - Take action to improve the response to patients with suspected sepsis | Completed – Metrics have shown improvement and national CQUINs met to date |
| **Must Do 7** - Take action to improve the levels of resuscitation training | Completed |
| **Must Do 8** - Ensure all patients attending the ED are seen by a clinician in a timely manner | Continued work in ED that includes this 'Must Do' and preparation for winter pressures |

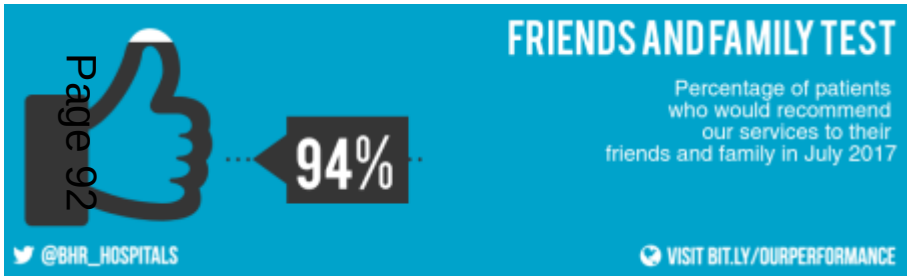
# EXECUTIVE TEAM UPDATE

- Matthew Hopkins (CEO) back after successful kidney transplant
- Nadeem Moghal (Medical Director) back after cancer recovery
- Deborah Tarrant (People & Organisational Devt Director) back after illness
- Sarah Tedford (Chief Operating Officer) has moved on – process of permanent recruitment under way – Jon Scott, interim COO
- New Director of Communications appointed – to be announced

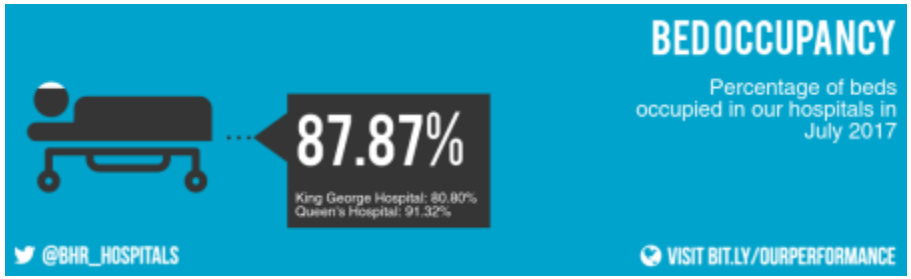
# PERFORMANCE HEADLINE SUMMARY







# REFERRAL TO TREATMENT

- 92% national Referral To Treatment standard hit for first time in 3 years – three months ahead of trajectory
- Massive effort from staff and primary care colleagues
- Just 8% of patients waiting longer than 18 weeks for June and July
- At beginning of 2014, waiting list included over 1,000 people waiting longer than 52 weeks – now down to around single figures
- Huge joint recovery plan (delivered in partnership with local commissioners) has seen thousands of patients treated
- Thousands of extra clinics and nearly 100,000 appointments delivered

# RECRUITMENT AND WORKFORCE

- Continued focus on recruiting and retaining staff (especially nurses)
- Specialist Recruitment Nurse now in post and working on strategy
- Student Open Evening tonight (September 27)
- Very successful recruitment event at Queen's, with another one in the pipeline
- Excellent engagement and support from local media partners

# STROKE SERVICES

- Demand on our stroke services continues to increase
- Need to provide strategic focus and leadership
- New Director of Stroke Services:
  Dr Sree Andole – very experienced expert lead

# THE PRIDE WAY – RAPID PROCESS IMPROVEMENTS

- **Electronic Discharge System** (July) – focus on reducing the lead time in getting the EDS from ward to pharmacy, so discharge can occur more quickly and smoothly
- **Serious Incidents** (August) – identifying how we can take more immediate actions after the report of a Serious Incident, so changes can be implemented more quickly
- Building on work already undertaken focusing on the **First 24 Hours** for frail and elderly patients
- Pride Way Leaders the next step – to make sure our leaders are the very best they can be

# SERVICE RELOCATIONS – BEDDING IN WELL

- Antenatal, Pre-Assessment, and Phlebotomy relocating main operations to King George.
- The space, facilities and services are better, providing patients with a safer, improved experience.
- More room, more natural light, better cubicle space, and new waiting areas.
- Space for future expansion, bigger scanning rooms, and a children's play area.

# IMPROVING TECHNOLOGY

- Bluespier theatre management
- VitalPac software system to record patient data at bedside

# UPCOMING PRIORITIES

- Substantial investment and capital redevelopment over Winter
- Emergency Department/Urgent Care Centre improvements at both Queen's and King George Hospitals
- Surgical Assessment Unit opening
- Major new scanning equipment in radiology – Halcyon and True Beam
- Pathology equipment upgrade to improve our assessment of samples
- NICU/Children's short stay assessment unit


# ANY QUESTIONS?

Havering
LONDON BOROUGH

# OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 10 OCTOBER 2017

| | |
|---|---|
| **Subject Heading:** | **Update on East London Health & Care Partnership and NEL Sustainability and Transformation Plan** |
| **Report Author and contact details:** | **Ian Tompkins**<br>**Director of Communications & Engagement**<br>**East London Health & Care Partnership** |
| **Policy context:** | **The attached report gives an update on the work of the Partnership to protect and improve local health and care services.** |
| **Financial summary:** | **No impact of presenting of information itself.** |

## SUMMARY

This report provides an update to the Joint Committee on the development of the East London Health & Care Partnership, including its purpose and priorities and engagement with stakeholders.

The report also covers the development of the North East London Sustainability and Transformation Plan (NEL STP).

The Partnership submitted a draft NEL STP to NHS England on 21 October 2016. It outlined the challenges for health and care services in east London and included a series of delivery plans to address our local priorities.

Further work is continuing to develop the plan in more detail and updates can be presented to the Joint Committee as they become available

For more information on the Partnership and NEL STP please go to http://www.eastlondonhcp.nhs.uk or email: enquiries@eastlondonhcp.nhs.uk

## RECOMMENDATIONS

1. That the Joint Committee considers the attached report and takes any action it considers appropriate.

## REPORT DETAIL

### 1. Background

1.1 In December 2015 NHS England planning guidance required health and care systems across the country to work together to develop sustainability and transformation plans (STPs). The STP for East London is being developed by the East London Health & Care Partnership. The plan is known as the NEL STP because the NHS has divided London into five areas: north east; north central; north west; south west; and south east.

### 2. The purpose and priorities of the East London Health & Care Partnership and the development of the NEL STP

2.1 See Appendix 1

### 3. Engagement

3.1 We recognise the involvement of local people is crucial to the development of the NEL STP. In developing the plan we engaged with stakeholders, including Healthwatch, local councils, the voluntary, community and social enterprise sector, and patient representatives. Their initial feedback was incorporated into the draft NEL STP submitted to NHS England on 21 October 2016.

3.2 Work to obtain further feedback is ongoing. A series of public engagement events and activity is planned for 2018. Local Healthwatch organisations and others are also helping us gather and understand the views of patients and communities. They will focus on gauging public views on a) promoting prevention and self-care b) improving primary care and c) reforming hospital services.

### 4. Financial considerations

4.1 The NEL STP will include activities to address current financial challenges across the health and social care economy. The ambition is to ensure that all NHS organisations are able to achieve financial balance by the end of the five year period of the plan.

## 5. Legal considerations

5.1 The East London Health & Care Partnership Board is developing a plan as stipulated by the NHS England guidance.

## 6. Equalities considerations

6.1 An equality screening has been completed to consider the potential equality impact of the proposals set out in the NEL STP. This can be viewed at http://www.eastlondonhcp.nhs.uk and includes:

- An overview of all the initiatives included in the NEL STP narrative to determine at which level equality analyses should be undertaken i.e. NEL STP level, Local Area Level, CCG/borough level or London-wide level.

- An initial assessment of the East London STP overarching 'Framework for better care and wellbeing'.

- Actions to be undertaken during further detailed equality analyses.

The screening recognises that the initiatives included in the STP will be implemented at different times, hence further equality analyses will need to be undertaken over the life of the STP programme.

**Appendices**

Appendix 1: General update on the East London Health & Care Partnership October 2017

Appendix 2: East London Health & Care Partnership transformation priorities

Appendix 3: What East London Health & Care Partnership is doing and what it means for local people

Appendix 4: East London Health & Care Partnership governance structure

**IMPLICATIONS AND RISKS**

None of this update report.

## BACKGROUND PAPERS

None.

## Appendix 1: General update October 2017

# Index

## 1. Background and context (our public narrative)

As more and more people choose to live and work in east London, and more of us are living longer, the demand on health and social care services is at an all-time high.

Our doctors, nurses, paramedics and other health and care professionals are looking after record numbers of people every day as our population grows faster than in any other part of the country.

Despite immense pressures, local hospitals are continuing to treat A&E patients as fast and effectively as any major western country.

Our GP, mental health and community services are among the very best in the country, and local councils are providing vital care to the most vulnerable.

It's thanks to the dedication and hard work of the professionals involved, and the support of many thousands of voluntary carers, community and charity organisations across the area that we are getting the care we need.

But change must be allowed to happen, and things improved, if we are to protect the health and care services we value so much, not just for now but for future generations.

The NHS has constantly adapted and must continue to do so as our community and our health needs also change.

It is now able to treat people with new drugs and clinical care that weren't available in the past. With this comes an increase in life expectancy, but also a rise in the ailments of old age. More people now have conditions including heart disease, arthritis and Type 2 diabetes.

There are big opportunities to improve care by making common-sense changes to how the NHS has historically worked and bring it closer to the social care services run by local councils.

This a chance to deliver improvements that matter:

- to make it easier to see a GP;
- to speed up cancer diagnosis;
- to offer better support in the community for people with mental health conditions;
- to provide care for people closer to their home.

If we do nothing and carry on providing and using services in the way we do now, without any changes, we will not only miss out on these improvements, we will fail to keep up with the growing demand and simply won't have enough money to keep services going as now.

In the east London area alone, there will be a £580m shortfall in funding within four years, by 2021. Services and facilities may have to close and standards of care will suffer if not addressed urgently.

Change is required, and fast, to help keep us healthy and well in the future and to receive care when we need it.

We all have a part to play in this – all of those providing the services, and all of us using them. We can all do our bit.

It's why neighbouring NHS hospitals, community and mental health trusts, family doctors, pharmacies, local councils and others have come together to plan for the future and redesign local health and care services to benefit us all – now and in the years ahead.

Working as the East London Health & Care Partnership, and backed by the leaders of all the organisations involved, they are combining their expertise and resources to develop ways of giving our nurses, doctors and care staff the best chance of success to look after us when we need them to.

The organisations behind the Partnership are:

**NHS**

Clinical Commissioning Groups

Barking & Dagenham; City & Hackney; Havering; Newham; Redbridge; Tower Hamlets; Waltham Forest

'Provider' Trusts

Barking, Havering and Redbridge University Hospitals Trust; Barts Health

NHS Trust; The Homerton University Hospital NHS Foundation Trust; East London NHS; Foundation Trust; North East London NHS Foundation Trust

**Councils**

Barking & Dagenham; City of London Corporation; Hackney; Havering; Newham; Redbridge; Tower Hamlets; Waltham Forest

With a shared goal to help people live healthy and independent lives, the Partnership's mission is to protect vital services and provide better treatment and care built around the needs of local people, safely and conveniently, closer to home.

A top priority is to reduce the pressures on our hospitals and accident and emergency departments. A&E is all too often used as the only door into health and care services, when ideally people should be supported by NHS 111 staff, GPs, community staff and resources in their own homes.

The Partnership also wants better outcomes for cancer patients, people with diagnosed with diabetes and improvements to mental health services, and to help people become independent with access to care at home.

Reshaping services to provide them in the right place, where people need them most, supported by the right team of staff from across health and social care, with the right resources, is a key and urgent requirement.

The response to the demand on services needs to offer better alternatives that help prevent people's health deteriorating. This isn't just to make the most efficient use of the resources and money available, but to provide a better quality of care and services in the community, where local people have told us they want them.

Attempting to improve the hundreds of health and care services for the two million people of east London – a population expected to grow by around 30,000 more people in 2017 alone – is a daunting and complex task, but many of the most beneficial changes can be made quite simply.

Significant improvements are already being made by joining services up and people are starting to feel the benefit. The area now has some of the best care provision and facilities in the country, but there's still much to do.

Although they operate safely, some our hospitals aren't fully equipped to meet the needs of modern healthcare. Waiting times for appointments and treatments must be reduced. And more has to be done to safeguard our most vulnerable people, such as the elderly, disabled and those with mental health difficulties.

**'Barrier busters'**

The East London Health & Care Partnership isn't afraid to tackle these challenges. It will build on the successes achieved so far and bring health and social care providers even closer together, breaking down any barriers between them as necessary.

The good work already being done to meet more localised needs will continue. The Partnership is not there to undo what works, slash budgets or act secretly behind closed doors. Instead, it will drive forward wider benefits that can only be achieved by everyone working together, coming up with new ideas and better ways of working that can put a stop to duplication and unnecessary expense.

The Partnership's main priorities are:

- To help local people live healthy and independent lives
- To improve local health and care services and outcomes
- To have the right staff in the right place with the right resources to meet the community's needs
- To be a well-run, efficient and open Partnership

It's North East London Sustainability and Transformation Plan (NEL STP) sets out how these priorities, and those of the wider health and care sector, will be turned into reality.

The plan describes how the Partnership will meet the health and wellbeing needs of east London by improving and maintaining the consistency and quality of care, and plugging the shortfall in funding of services.

It proposes improvements that can benefit the whole area. This includes the availability and quality of specialist clinical treatments, a better use of buildings and facilities and the introduction of digital technology to improve services for local people.

The NEL STP is not the only thing the Partnership is doing to help local people live healthy and independent lives.

The involvement of councils is enabling the provision of health and care services to be aligned with the development of housing, employment and education, all of which can have a big influence.

But the biggest single factor in the long term is to prevent ill health and in particular deaths caused by the effects of lifestyle choices such as diet, lack of exercise and smoking.

This is something we can all play a part in – everyone living and working in east London. It's not just down to the authorities. It's up to all of us to do those little things each day that help us stay healthy and fit.

And it's not just about watching what we eat and drink, or being more active. It's about using services in the right way.

Rather than immediately going to the doctor or calling for an ambulance when we don't need to, we can go to the pharmacist and get advice from telephone and online services first.

We can all do our bit. If we do this, and get behind the work of the East London Health & Care Partnership, the prize is being able to lead healthy and independent lives, and get the care we can trust and rely on when we need it.

## 2. The NEL STP in detail

The *North East London Sustainability and Transformation Plan (NEL STP)* sets out how local health and care services will transform and become sustainable over the next five years, building and strengthening local relationships and ultimately delivering the vision of the NHS Five Year Forward View.

Forty four such plans have been developed throughout England. They are geographically set around 'footprints' that have been locally defined, based on natural communities, existing working relationships, patient flows and taking into account the scale needed to deliver the services, transformation and public health programmes required.

The NEL STP has been defined as one for north east London by NHS England, because it has divided the capital into five 'footprints': north east; north west; south east; south west; and north central.

Originally drawn up in June 2016, and then redrafted following engagement with key stakeholders, the NEL STP was submitted to NHS England and NHS Improvement on 21 October 2016.

The plan is currently only a 'draft'. It will continue to evolve as the organisations concerned develop it further, agree shared solutions, and as we receive feedback from stakeholders.

The NEL STP describes how the organisations involved in the partnership will:

- Meet the health and wellbeing needs of its population
- Improve and maintain the consistency and quality of care for our population
- Close the financial gap.

All of the organisations involved in the NEL STP face common challenges, including a growing population, a rapid increase in demand for services and scarce resources. By working together they will be best placed to drive change and make sure health and care services in north east London are sustainable by 2021.

The NEL STP builds on existing local transformation programmes and supports their implementation including:

- Barking and Dagenham, Havering & Redbridge (BHR)
- City and Hackney
- Newham, Tower Hamlets and Waltham Forest: Transforming Services Together programme
- The improvement programmes of our local hospitals, which include supporting Barts Health NHS Trust out of special measures.
- Vanguard projects eg Tower Hamlets Together

The organisations behind the NEL STP are actively seeking to collaborate where it makes sense to do so, sharing learning from the devolution pilots and transformation programmes.

## 2.1 NEL STP vision and priorities

The vision of the NEL STP is to:

- Measurably improve health and wellbeing outcomes for the people of east London and ensure sustainable health and social care services, built around the needs of local people.
- Develop new models of care to achieve better outcomes for all, focused on prevention and out-of-hospital care.
- Work in partnership to commission, contract and deliver services efficiently and safely.

To achieve this vision, we have identified a number of key transformation priorities:

- The right services in the right place: Matching demand with appropriate capacity in east London
- Encourage self-care, offer care close to home and make sure secondary care is high quality
- Secure the future of our health and social care providers. Many face challenging financial circumstances
- Improve specialised care by working together
- Create a system-wide decision making model that enables place-based care and clearly involves key partner agencies
- Using our infrastructure better

These priorities have now been categorised under four headings:

- Healthy and independent local people
- Improving services
- Right staff, right place, right tools
- A well-run partnership

More information on this is given in Appendix 2

To deliver the NEL STP we are building on existing local programmes and setting up eight work streams to deliver the priorities.

The work streams are cross-cutting east London-wide programmes, where there are benefits and economies of scale in consolidating a number of system level changes into a single programme.

The work streams are:

- Promote prevention and personal and psychological wellbeing in all we do
- Promote independence and enable access to care close to home
- Ensure accessible quality acute services
- Productivity
- Infrastructure
- Specialised commissioning
- Workforce
- Digital enablement

Each delivery plan sets out the milestones and timeframes for implementation.

The full NEL STP, and eight delivery plans, can be found on our website www.eastlondonhcp.nhs.uk

The delivery plans are currently being refreshed. Updated versions are due to published in the autumn.

A summary of what the Partnership is planning to do across services, such as urgent and emergency care, primary care and mental health, and what it means for local people, is given in Appendix 3.

## 2.2 Partnership governance

The launch of the NEL STP process signalled the move towards working in larger geographical areas and the need to develop governance arrangements to support strategy development and change at a system level. To achieve this, 20 organisations in East London have been working together to develop the East London Health and Care Partnership (ELHCP).

The Partnership governance structure is attached as Appendix 4.

Progress has been made in bringing the governance groups together.

- ELHCP Community Group – A group of local people, voluntary sector, and other key stakeholders to promote system wide engagement and assurance.

  A wide range of organisations and people (around 300 in total) from across east London have been invited to co-create the group.

An initial meeting was held on 4 July and attended by nearly 100 people and work to develop the group is ongoing. More information is given in section 4 on page 10 below.

- ELHCP Mayors and Leaders Advisory Group - To provide a forum for political engagement and advice to the ELHCP NEL STP

  Cabinet members (health) from the eight east London councils have held three meetings to date to discuss how this Group could develop. See section 3 on page 9 below.

- ELHCP Social Care & Public Health Group – Directors of Children's and Adult Services and Directors of Public Health

  The directors of adult services are setting up a working group to look at the current and future challenges relating to the social care workforce across east London, including recruitment and key worker accommodation

- ELHCP Assurance Group – An independent group of audit chairs and local authority scrutiny members to provide assurance and scrutiny

  This Group is due to hold its first meeting soon. Borough scrutiny committees are being invited to nominate members to join the Group.

- ELHCP Finance Strategy Group -To provide oversight and assurance of the consolidated east London financial strategy and plans to ensure financial sustainability of the system.

  This group is now meeting regularly. It includes council and NHS chief finance officers among its members.

The arrangements are underpinned by a Partnership Agreement (see Appendix 4) which, while not legally binding, intends to ensure a common understanding and commitment between the partner organisations of:

- The scope and objectives of the ELHCP NEL STP governance arrangements
- The principles and processes that would underpin the ELHCP NEL STP governance arrangements
- The governance framework / structure that would support the development and implementation of the ELHCP NEL STP

The Partnership Agreement has now been circulated to the member organisations of the ELHCP for signature.

## 3. Engagement with Local Authorities

The ELHCP is engaging widely with stakeholders to shape its governance arrangements. Engagement with local authorities has been paramount and is being achieved through various forums.

There are now three local authority representatives on the Partnership board:

- Tim Shields, LB Hackney (for City and Hackney)
- Kim Bromley-Derry, LB Newham (for Newham, Tower Hamlets and Waltham Forest)
- Andrew Blake-Herbert, LB Havering (for Barking & Dagenham, Havering and Redbridge)

Cabinet members (health) from the eight east London councils have held three meetings to date to discuss how the Mayors and Leaders Advisory Group could develop.

At the most recent meeting, on 23 June, the cabinet members expressed a strong desire to be more involved in the work of the Partnership, and the shaping of ideas, especially in the development of proposals around accountable care systems and a single accountable officer role. A similar request for more involvement has come from the various Health & Wellbeing boards and some scrutiny committees.

The Partnership chair, Rob Whiteman, and exec lead, Jane Milligan, are now exploring ways of doing this. This includes having political representation on the Partnership board and in the development of transformation programmes.

The cabinet members have also been asked to nominate fellow members to join the Community Group (referred to in 2.2 on page 7 above).

Scrutiny members are being asked to join the Assurance Group. The INEL and ONEL JHOSCs have been invited to nominate members from each to join this Group, but this may end up happening on an individual borough basis.

The Partnership is also actively encouraging local authority officers to be involved in the transformation work streams listed on page 7 above.

## 4. Involving local people and communications/engagement generally

STPs have been widely criticised for being put together too hastily with little consultation.

The timescale set by NHS England to produce the initial plans was tight. As a consequence, there was only a limited time for engagement. Some key stakeholders felt disengaged from the process, as did patient representatives. Also, much of the detail behind the plans was initially kept under wraps giving rise to accusations of secrecy and the STPs being seen as no more than 'hit lists' and cuts to services.

NHS England acknowledges this criticism, but it caused significant reputational damage to what is a genuine and necessary attempt to deal with very real challenges.

The immediate priority of our communications and engagement strategy has therefore been to repair that damage.

Most, if not all, of our key stakeholders recognise and understand the challenge. We want to rebuild their trust and confidence and engage with them in a more positive way so they are involved in developing shared solutions.

A starting point has been to talk about a partnership rather than a plan. It is why we changed our name to the East London Health & Care Partnership.

The NEL STP itself is still being referred to as such, but it is just one of many things the organisations involved can do together to protect and improve health and care services for the people of east London. Our plans to explore the link between health and housing, starting with a conference on 18 October, is one example

It was also felt east London was a more appropriate and familiar way of describing the area as a whole rather than north east London – the name used by the health service to denote the area.

Next is to communicate in an open and honest way; unravel the jargon, speak in plain and simple language and be accessible and transparent. Most importantly, we must listen to what people have to say.

Relevance is also important. Our communications will reflect a knowledge and understanding of the many different audiences we want to reach and be targeted to suit each group. What does it all mean for them? How are their interests being taken into account? What part can they play?

Local relevance and insight is particularly important. We will work closely with our communications and engagement colleagues in the partner organisations at borough level to make full use of their knowledge and networks.

An online Briefing Room has been set up as a central source of information and materials for members of the Partnership to adapt and use in local communications and engagement activities. This includes narratives around the NEL STP (what it is and what it isn't); the various transformation plans and programmes (as they emerge); facts and figures; presentations (tailored for specific audience); information videos; and case studies.

At the heart of our stakeholder engagement will be the Community Group – a subgroup of the East London Health and Care Partnership.

Part of the Partnership's governance structure, the Community Group's principal purpose is to act as a reference group to support the development of the Partnership's strategies, plans and activities and recommend the most effective ways for it to communicate and engage with its many different audiences.

Nearly 100 representatives from the voluntary, business, education, health and care sectors attended an event on 4 July for stakeholders and partners that could form our Community Group.

It is in effect a 'group of groups', made up of a range of people from professional organisations, the education and business sector to voluntary organisations, local councillors, Healthwatch and other patient and public groups.

How such a wide and diverse group comes together and gets involved, and how the Community Group develops, is still 'work-in-progress'. A working group of some of those that attended the event on 4 July is helping plan the next steps.

In the meantime, some of the organisations and public and patient representatives are being invited to take part in the Partnership's activities, such as improvements to the signposting of services.

A determined effort is also being made to involve young people in the Community Group. This is currently being progressed through local councils, NHS organisations, colleges and universities.

Another key audience is, of course, frontline staff – not just those in the NHS, but in councils too. Their buy-in is key and we have started engaging with them to create understanding about what the Partnership, and the NEL STP, means to them.

We very much want staff to be involved in shaping services and our internal communications will reflect this. They will recognise the contribution everyone has to make, encouraging and valuing people's achievements, opinions and ideas.

If we are to give staff the effective help and support they need it's vital we listen to what they have to say, and demonstrate what we do as a result.

While staff and the other key stakeholders in the Community Group are taking precedence in the immediate future, we eventually want to reach out and engage with as many people as possible, including the wider public.

The Partnership's website has been rebuilt, with an improved design. (www.eastlondonhcp@nhs.uk)

An easy guide to what the Partnership plans to do and what it means for local people is to be published on the website in September. Printed copies will be made available for people that don't have access to the internet, with extracts placed in local publications.

Social media and YouTube are also being used to raise awareness of the challenges to health and care in east London, promote service improvements and run prevention campaigns.

The Partnership is also planning to hold a series of public engagement events across east London during 2018.

Designed in collaboration with local councils and NHS organisations, with at least one major event in each borough, the events will be used to create awareness and understanding of what the Partnership is doing and what it means for local people. The larger events will feature a 'Question Time' session, and current and planned improvements to services will be showcased in a mini expo.

The Partnership communications and engagement team are working closely with their 300 plus colleagues in the member organisations to create shared opportunities to increase audience reach and give consistent messaging. They are also forging links with wider comms networks across London, including those in other boroughs, the Met Police, London Fire Brigade, TfL, professional organisations, eg Royal College of Nursing, and national charities. The Partnership's comms and engagement is seen as leading in the STP field.

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Appendix Two

East London Health & Care Partnership

# Transformation Priorities

# Four big issues and four Priorities

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Poor health, growing population & more demand | Variable access and quality of services | Lack of workforce, poor technology and buildings | Unaffordable health & social care system |
| **Healthy & independent local people** | **Improving services** | **Right team, right place, right resources** | **Well run partnership** |
| •Preventing ill health and lose of independence<br>•Tackling inequalities<br>•Good mental well-being | • More services out of hospital and integrated in primary, mental, social & community care<br>• Improved priority services: maternity, mental health, cancer, urgent & emergency care<br>• Strong hospital & specialist services | •Healthy work places<br>•Skills & career development, recruitment & retention<br>•Housing for key workers<br>•Digital & online services<br>•Better buildings | • Partnerships<br>• Productivity – value for money<br>• Better organised - new organisations bringing together providers & commissioners<br>• Living within our means |

# Our story

The transformation agenda for health and social care across East London is significant and exciting. We are challenging ourselves to be clear that more of the same isn't enough, or will provide fit for purpose health and care going forward. These are the four big challenges the ELHCP want to tackle:

## 1. Healthy and independent local people

- We have one of the largest and fastest **population** growth rates in the country - 18% over the next five to ten years
- This is both growth of a younger population and also the older population
- East London also has a transient population and areas of intense **health inequalities** and deprivation
- People want their **whole health and social care needs** considered as one and we too often treat and manage people in parts, in particular not making sure that people's mental as well as physical health are treated equally. We have also traditionally focused more on resourcing physical health needs than mental and well-being needs.

## 2. Improving services

- **Resources** (capacity) are not necessarily in the right part of the system, often still tied up in acute hospitals rather than in the **community,** where people tell us they want them.
- Access is too often through A&E, at a point of crisis. The front door to the system should be people's own front doors with care provided by multi-disciplinary teams across health and social care, supported by the voluntary sector and our strong local communities.
- The problem with accessing care in a crisis through A&E means our solutions tend to be too much about providing care around a few hundred hospital beds, rather than care around the one and half million beds in people's own homes.
- This support should be centred in the home, and using digital technology and more self-care support to prevent crisis and maintain independence.
- It's not only about demand and capacity not lining up, the **quality** of some of our services and the outcomes people get are variable –and we want the best standard for everyone across East London
- Access to primary care is **variable** and the Care Quality Commission has highlighted services, **quality** and **outcomes** across our providers that need to improve
- Some services are not as **resilient** as they could be, for example primary care and urgent and emergency care services
- We have a long history of innovation through working with patients and clinicians to co-design individual components of care, but this hasn't been easy to spread more widely.

# Our story

## 3. Right team, right place, right resources

- We have the opportunity to innovate training, roles and ways of working.  It's about the right care, at the right time, in the right place and most importantly – the right team.
- Community–based working often gives more autonomy to staff and releases them to innovate and provide whole person care- and this is important, as not only is capacity not always in the right part of the system, but we need new types of roles, development opportunities and ways of working as finding and keeping the **workforce** these days is challenging, especially with the cost of living and housing in London.
- We also have serious challenges our estates and technology.  We have some of the best buildings, but also others that are not fit for purpose, such as Whipps Cross Hospital.  We also have estate with old hospital buildings that could be re-purposed used for new integrated health and social care facilities, creating health campuses
- People live their lives on their smart phones now and there is an urgent need for health and social care services to become more **digital friendly**

## 4. Well run partnership

- Ultimately all our challenges above mean that the **financial** as well as service and quality sustainability of our health and care system is impacted.  There is scope to be more productive and if we do not seize the opportunity our financial challenges and sustainability will continue and service stability will be affected.
- In recent years the system has become **fragmented**: causing duplication, not always working to the best advantage for the patient or local people and putting artificial  barriers between professionals and organisations across health and local government services. We need to make sure we are organised well and working in partnership.
- Individual institutions will not address the financial or quality goals we have, and in order to get the best of our collective resources we need to transform how we work together using a  **partnership** approach, rather than working with an individual organisation focus.

East London Health & Care Partnership

# BETTER CARE AND WELLBEING IN EAST LONDON

East London Health & Care Partnership

## We are:

### NHS

NHS Barking and Dagenham Clinical Commissioning Group

NHS Redbridge Clinical Commissioning Group

NHS City and Hackney Clinical Commissioning Group

NHS Tower Hamlets Clinical Commissioning Group

NHS Havering Clinical Commissioning Group

NHS Waltham Forest Clinical Commissioning Group

NHS Newham Clinical Commissioning Group

East London NHS Foundation Trust

Homerton University Hospital NHS Foundation Trust

North East London NHS Foundation Trust

Barking, Havering and Redbridge University Hospitals NHS Trust

Barts Health NHS Trust

### Councils

London Borough of Barking & Dagenham

City of London

Hackney

Havering London Borough

Newham London

London Borough of Redbridge

Tower Hamlets

Waltham Forest



# BETTER CARE AND WELLBEING IN EAST LONDON

## We can all do our bit

With an ever growing population, and more of us living longer, the challenge to keep us healthy and well has never been bigger.

As more and more people choose to live and work in east London, the demand on health and social care services is at an all-time high. Our doctors, nurses, paramedics and other health and care professionals are looking after record numbers of people every day as our population grows faster than in any other part of the country.

Despite immense pressures, local hospitals are continuing to treat A&E patients as fast and effectively as any major western country. Our GP, mental health and community services are among the very best in the country, and local councils are providing vital care to the most vulnerable.

It's thanks to the dedication and hard work of the professionals involved, and the support of many thousands of voluntary carers, community and charity organisations across the area that we are getting the care we need.

But change must be allowed to happen, and things improved, if we are to protect the health and care services we value so much, not just for now but for future generations.

The NHS has constantly adapted and must continue to do so as our community and our health needs also change.

It is now able to treat people with new drugs and clinical care that weren't available in the past. With this comes an increase in life expectancy, but also a rise in the ailments of old age. More people now have conditions including heart disease, arthritis and Type 2 diabetes.

There are big opportunities to improve care by making common-sense changes to how the NHS has historically worked and bring it closer to the social care services run by local councils.

This a chance to deliver improvements that matter:

- to make it easier to see a GP;
- to speed up cancer diagnosis;
- to offer better support in the community for people with mental health conditions;
- to provide care for people closer to their home.

If we do nothing and carry on providing and using services in the way we do now, without any changes, we will not only miss out on these improvements, we will fail to keep up with the growing demand and simply won't have enough money to keep services going.

In the east London area alone, there will be a £580m shortfall in funding within four years, by 2021. Services and facilities may have to close and standards of care will suffer if not addressed urgently.

Change is required, and fast, to help keep us healthy and well in the future and to receive care when we need it.

We all have a part to play in this – all of those providing the services, and all of us using them. We can all do our bit.

It's why neighbouring NHS hospitals, community and mental health trusts, family doctors, pharmacies, local councils and others have come together to plan for the future and redesign local health and care services to benefit us all – now and in the years ahead.

Working as the East London Health & Care Partnership, and backed by the leaders of all the organisations involved, they are combining their expertise and resources to develop ways of giving our nurses, doctors and care staff the best chance of success to look after us when we need them to.

# BETTER CARE AND WELLBEING IN EAST LONDON

With a shared goal to help people live healthy and independent lives, the Partnership's mission is to protect vital services and provide better treatment and care built around the needs of local people, safely and conveniently, closer to home.

A top priority is to reduce the pressures on our hospitals and accident and emergency departments. A&E is all too often used as the only door into health and care services, when ideally people should be supported by NHS 111 staff, GPs, community staff and resources in their own homes.

The Partnership also wants better outcomes for cancer patients, people with diagnosed with diabetes and improvements to mental health services, and to help people become independent with access to care at home.

Reshaping services to provide them in the right place, where people need them most and supported by the right team of staff from across health and social care, is a key and urgent requirement.

The response to the demand on services needs to offer better alternatives that help prevent people's health deteriorating. This isn't just to make the most efficient use of the resources and money available, but to provide a better quality of care and services in the community, where local people have told us they want them.

Attempting to improve the hundreds of health and care services for the two million people of east London – a population expected to grow by around 30,000 more people in 2017 alone – is a daunting and complex task, but many of the most beneficial changes can be made quite simply.

Significant improvements are already being made by joining services up and people are starting to feel the benefit. The area now has some of the best care provision and facilities in the country, but there's still much to do.

Although they operate safely, some our hospitals aren't fully equipped to meet the needs of modern healthcare. Waiting times for appointments and treatments must be reduced. And more has to be done to safeguard our most vulnerable people, such as the elderly, disabled and those with mental health difficulties.

## 'Barrier busters'

The East London Health & Care Partnership isn't afraid to tackle these challenges. It will build on the successes achieved so far and bring health and social care providers even closer together, breaking down any barriers between them as necessary.

The good work already being done to meet more localised needs will continue. The Partnership is not there to undo what works, slash budgets or act secretly behind closed doors. Instead, it will drive forward wider benefits that can only be achieved by everyone working together, coming up with new ideas and better ways of working that can put a stop to duplication and unnecessary expense.

The Partnership's main priorities are:

- To help local people live healthy and independent lives
- To improve local health and care services and outcomes
- To have the right staff in the right place with the right resources to meet the community's needs
- To be a well-run, efficient and open Partnership

The Partnership's *Sustainability and Transformation Plan (STP)* sets out how these priorities, and those of the wider health and care sector, will be turned into reality.

It describes how the Partnership will meet the health and wellbeing needs of east London by improving and maintaining the consistency and quality of care, and plugging the shortfall in funding of services.

The plan proposes improvements across the whole of east London, such as the availability and quality of specialist clinical treatments, how buildings and facilities could best used, particularly those in need of renewal, and the introduction of digital technology to enhance services for local people.

The involvement of councils enables the vision for better health and care provision to be aligned with the development of housing, employment and education, all of which can have a big influence on people's health and well being.

The Partnership is committed to being transparent and engaging fully with key stakeholders and the wider public in the development of its plans.

But the biggest single factor in the long term is to prevent ill health and the time pressure and financial pressure preventable conditions put on the NHS. This is something we can all play a part in – everyone living and working in east London. It's not just down to the authorities.

Public health information and advice will be strengthened. Information and support to help us live healthier lives will be made more widely available, online and through social media. It's up to us to enjoy life to the full by doing those little things each day that help us stay healthy and fit. We can watch what ourselves and our families eat and drink and all get more active.

Rather than immediately going to the doctor or calling for an ambulance when we don't need to, we can go to the pharmacist and get advice from telephone and online services first.

We can all do our bit and if we do this, and get behind the work of the East London Health & Care Partnership, the prize is being able to lead healthy and independent lives, and get the care we can trust and rely on when we need it.

# PREVENTION

## Our aims

- **Better support to stop smoking**
- **Better screening, treatment and support for diabetes**
- **Help you look after your own general health and wellbeing**

More and more people are choosing to live, work and stay in east London.

Major regeneration of the area is creating growth and opportunity, bringing new jobs and housing, better transport, shopping and leisure facilities, making it an attractive place to call home.

But while this is improving east London as a place, and making it generally more prosperous, are we actually investing in ourselves and taking care of our personal future health and wellbeing?

Some 40 per cent of all deaths in England are preventable and are caused by the effects of lifestyle choices including diet, lack of exercise, smoking, alcohol and drugs.

Treating preventable diseases, such as heart disease and smoking-related lung cancer, costs the NHS in England £11 billion each year.

About 1.2m people in London still smoke. Of these, 280,000 live in east London and the local NHS spends £56m a year treating people for illnesses caused by it.

Type 2 diabetes is also preventable.

One in six patients in hospital in England has diabetes, 90 per cent of whom have Type 2 and it costs the NHS £1million an hour to care for them – 10 per cent of the total NHS spend.

More than half of all adults in east London are overweight or clinically obese. This is less than the national average of 63 per cent, but London has the highest rate of childhood obesity of any city of its size in the world.

If we fail to tackle preventable illnesses, not only will this situation continue, and likely get worse, the sustainability of our health and care services will be put at risk.

The East London Health & Care Partnership has three priorities to help tackle these issues:

- To help people stop smoking. We will especially target children and young people, so they fully understand how harmful and expensive smoking is – both to the individual and, in terms of treatment, to the NHS
- To reduce diabetes. We want to improve early diagnosis and provide ongoing support for those identified 'at risk'. This includes offering places on the National Diabetes Prevention Programme, where people are given a personal health and wellbeing coach to help with their diet and exercise. We also want to improve outcomes for those living with Type 1 and Type 2 diabetes, ensuring they receive regular follow ups and have access to specialist advice when needed.
- To improve workplace health. Around 24 million working days are lost in London each year because of sickness absence or injury. We will help business and public sector organisations across east London, including our own, give better health and wellbeing support to staff. We will promote healthy eating and physical activity and create support services for dealing with stress and other health issues, including those who want to stop smoking or reduce the amount of alcohol they drink.

But it's not just down to the authorities; we all have a stake in our own health. There are many things we can do in our daily lives to take better care of ourselves – such as eating more healthily, reducing alcohol intake and getting plenty of exercise.

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.





## What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Providing better support in our hospitals, mental and community health and primary care services to help people stop smoking
- Improving screening processes to better identify those at risk of contracting Type 2 diabetes, and offering courses to help those people change their lifestyles
- Making the care that people with Type 1 and Type 2 diabetes receive in GP surgeries and hospitals the same across east London
- Empowering people, through flexible self-care courses, to better look after their diabetes and avoid unnecessary trips to hospital
- Working with local schools, colleges and universities, employers, libraries and voluntary services to provide better support for young people with diabetes
- Improving workplace health across east London, starting with the NHS. Happier, healthier NHS staff means better healthcare for patients.

## What does it mean for local people?

- Better support to stop smoking, with help and advice available at many health and care centres, workplaces and online
- Better screening, diagnosis, treatment and support for people with diabetes
- New services to help young people, and pregnant women, manage diabetes better
- Better opportunities and more support to stay healthy at work
- Greater consistency of healthcare opportunities and support across east London
- Help to help you take better care of yourself

## What can you do?

- If you smoke, try to stop and seek help to do so
- Cut down on sugary food and drinks
- Eat smaller portions and enjoy a balanced diet, including vegetables
- Keep hydrated – plenty of water!
- If you drink alcohol, do so sensibly and watch how much you drink
- Try to do some physical exercise every day. Just taking the stairs instead of the lift once a day, or going for a quick stroll, can make a difference

**And if you do these things yourself, support a family member or friend that wants to do the same!**

## Take an NHS Health Check

**The NHS Health Check is a health check-up for adults in England aged 40-74. It's designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. As we get older, we have a higher risk of developing one of these conditions. An NHS Health Check helps find ways to lower this risk.**

**If you are in this age group without a pre-existing condition, you can expect to receive a letter from your GP or local authority inviting you for a free NHS Health Check every five years.**

**In the meantime, there are other ways of getting your health checked. Visit www.nhs.uk for more information on this and many other topics.**

# URGENT & EMERGENCY CARE

## Our aims

- **Make it easier to understand the range of services available and how to access them quickly**
- **Provide more services in local communities, so they are accessible and convenient. This will also reduce the pressure on hospitals**
- **Make it easier to see a GP and bring services together**

Our hospital Accident & Emergency (A&E) Departments face some of the most intense pressures in our local health and care services, with growing numbers of people attending them each year.

Around 100 people are currently visiting the A&Es across east London every hour. But many of them do not need to be there, as they have relatively minor problems that can be treated elsewhere.

With people unsure of where to go for treatment, there is a huge demand on busy A&E services.

Some 68 per cent of patients have told us they do not know the difference between facilities such as 'Urgent Treatment Centres' and 'Minor Injury Units'. We want to change this.

An immediate priority for the East London Health & Care Partnership is to give better information on how and where we can all get the right care and treatment, including advice on ways we can look after ourselves.

There are three ways in which you can access health services and help to reduce pressure on our hospitals:

- **'Click'** - online information and support and to book urgent or routine appointments when needed.
- **'Call'** – for people who don't have access to the internet and those who need more advice or reassurance from a healthcare professional.
- **'Come in'** – where patients really need to see a healthcare professional.

...and we are improving all three.

**'Click' and 'Call' – information and support online and by telephone through NHS 111**

### Click

Online support and information 24/7 through the NHS 111 website at **www.nhs.uk**. Here you get information on a range of health issues, and in a variety of languages, to help you decide what action to take, including what to do if you need to speak to a clinician.

### Call

If you do not have access to the internet, or need further health advice after going online, you should firstly try calling your GP. If your GP is unavailable, you can call NHS 111 by simply dialing 111.

The NHS 111 telephone service is being improved from next year, enabling you to speak to a wider range of qualified healthcare professionals, including nurses, GPs and pharmacists.

Calls to NHS 111 about the very young and older people (babies under one and people over 75) will always be directed immediately to a qualified healthcare professional.

Speaking to NHS 111 will ensure you are getting the right level of advice and support. If you need to be seen by someone, you will be booked an appointment at the most appropriate place, such as with your own GP or at an Urgent Treatment Centre close to where you live.

Staff from care homes and community health staff are also now using NHS 111 for clinical advice. It is helping many people avoid the need to go to hospital and be treated and cared for at home instead.

### Come in

Where patients really need to see a healthcare professional because it is an emergency.

### GP Practices

We don't just want to make it easier to book an appointment with a GP. We also want to offer them at a more convenient time.

It's now possible to book appointments online at many surgeries. An increasing number are extending their opening hours to cover evenings and weekends.

In some instances you may not need to visit a surgery at all. You could have the appointment with a doctor, or nurse, by a video link from your smartphone instead.

We are also looking to free GPs, and other healthcare professionals in local surgeries, from paperwork so they can spend more time with their patients, especially those with complex conditions.

Improvements to information systems, and the links between surgeries, hospitals and specialist services, will give doctors and other clinical specialists quicker access to records and test results, enabling them to plan and give better care to patients.

### Community

A priority is to provide care closer to, or in, people's homes. It's why we are bringing all the relevant services together in local neighbourhoods.

GPs, community nurses and other NHS specialists will be based alongside council care teams in centres across east London, within easy reach of the main residential areas, to provide comprehensive treatment and support – not just in the centres themselves, but also in the surrounding homes.

Bringing expertise together in this way will do more than just streamline services. With more staff than traditional GP practices, and equipped with the latest facilities and technology, the centres will be able to stay open longer and offer a greater range of services – from 8am to 8pm, seven days a week.

### Urgent Treatment Centres

If your need cannot be treated by a GP, you may be directed or booked for an appointment at your nearest Urgent Treatment Centre.

Located across east London, Urgent Treatment Centres give treatment for minor injuries including: sprains, strains and broken bones; injuries to the back shoulders and chest; minor head and eye injuries; minor burns and scalds; insect and animal bites; and wound infections.

Before heading off to one of these centres, we recommend people contact NHS 111 first so they can be directed to the right place. If you do go to an Urgent Treatment Centre and your need can be better met elsewhere you will be redirected. It's therefore best to give a 'click' or 'call' to NHS 111 first to ensure you get it right and don't waste time.

### Accident & Emergency Departments

If you need to attend an Accident & Emergency Department (A&E) we want to ensure you are treated as soon as possible.

For some emergency conditions, we are setting up special areas in A&Es where people can be quickly assessed and treated so they can, when possible, go straight home without being admitted to hospital.

An example would be for a clot in the lung (pulmonary emboli) or leg (deep vein thrombosis). You will be treated by a team of specialists in a separate part of the A&E and may be able to leave the same day, with medication and a schedule of follow up treatment if needed.

## What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Providing better information to the public on where to get the most appropriate healthcare.
- Launching a new, improved NHS 111 online and telephone service, with better links to other health services such as GPs, pharmacists, Urgent Treatment Centres, mental health specialists and community health professionals.
- Improving access to weekend and evening GP appointments.
- Saving some visits to the surgery by enabling patients to speak to a doctor or nurse online or via a video link from a smartphone.
- Improving information systems for GPs to free them up from paperwork, see more patients and plan and give better care.
- Bringing community nurses, GPs, other NHS specialists and social care staff under one roof in local communities.
- Creating consistency in the services available at Urgent Treatment Centres, so people understand what treatment can be given to them.
- Creating special areas in the hospital for specific emergency conditions to avoid people being admitted to hospital when there is no medical need for this.



## What does it mean for local people?

- It will be easier to understand what healthcare services are available, and where.
- By calling or visiting NHS 111 online you will be able to get all the advice you need on how and where you can get the best care.
- It will be easier to book an appointment with a GP. Appointment times will be more convenient, including evenings and the weekends. In some instances you may not need to go to the surgery at all. Instead, you could speak to the doctor or nurse over the phone, online or via a video link from a smartphone.
- You will be able to see a range of health and social care professionals, quickly and conveniently in one place, close to your home.
- Wherever you live in east London, you will have access to an Urgent Treatment Centre for the treatment of minor injuries, including broken bones and minor burns.
- We will strive to give every patient the best possible care and treatment. If you need to be admitted to hospital, we want to reduce the time you have to spend there and get you safely home as soon as possible.

# PRIMARY CARE SERVICES

## Our aims

- **Make it easy to see your local GP or healthcare professional**
- **Improve the quality of services provided, so it is consistently good**
- **Bring services together to make them more accessible and convenient**

Primary Care services are usually the first point of contact the public has with the NHS. They include GP surgeries or practices, pharmacies and dentists.

Across east London there are examples of excellent primary care services. Many are among the best in the country, but there are also some that need improving.

We want all of our health and care services in east London to be the very best and are working with clinicians and staff in primary care to ensure they are consistently good across the area, both now and in the future.

Information on the many improvements we are making is also given elsewhere in this guide, especially in the section on Urgent and Emergency Care. This includes information about the NHS 111 service, which you can contact online or by telephone for advice and help, day and night, when you don't feel well and are unsure about what to do and where to go.

We want to make it easier to book an appointment with a GP. We also want to offer them at a more convenient time.

It's now possible to book appointments at many surgeries online. An increasing number are extending their opening hours to cover evenings and weekends.

In some instances you may not need to visit a surgery at all. You could have the appointment with a doctor, or nurse, by a video link from your smartphone instead.

We are also looking to free GPs, and other healthcare professionals in local surgeries, from paperwork so they can spend more time with their patients, especially those with complex conditions.

Improvements to information systems, and the links between surgeries, hospitals and specialist services, will give doctors and other clinical specialists quicker access to records and test results, enabling them to plan and give better care to patients.

For minor ailments it's often quicker in the first instance to visit your local pharmacy rather than GP surgery.

Pharmacists are skilled, qualified healthcare practitioners who will be able to see you immediately and offer advice and medication for a range of complaints such as hay fever, conjunctivitis and flu. They offer many other services as well, including flu vaccinations and help with stopping smoking.

An increasing number of pharmacists in east London are able to offer urgent repeat medication. NHS 111 can also help with this.

An important priority is to provide care closer to, or in, people's homes.

It's why we are bringing all the relevant services together in local neighbourhoods, in the form of hubs.

GPs, community nurses and other NHS specialists will be based alongside council care teams in centres across east London, within easy reach of the main residential areas, to provide comprehensive treatment and support – not just in the centres themselves, but also in the surrounding homes.

Bringing expertise together in this way will do more than just streamline services. With more staff than traditional GP surgeries, and equipped with the latest facilities and technology, the hubs will be able to stay open longer and offer a greater range of services – from 8am to 8pm, seven days a week.

As well as making primary care more accessible and convenient, we want to improve the quality of services so people experience the best possible treatment and care – whoever they are and wherever they live.





## What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Providing better information to the public on where to get the most appropriate healthcare.
- Launching a new, improved NHS 111 online and telephone service, with better links to other health services such as GPs, pharmacists, Urgent Treatment Centres, mental health specialists and community health professionals.
- Improving access to weekend and evening GP appointments
- Saving some visits to the surgery by enabling patients to speak to a doctor or nurse online or via a video link from a smartphone.
- Improving information systems for GPs to free them up from paperwork, see more patients and plan and give better care.
- Bringing community nurses, GPs, other NHS specialists and social care staff under one roof in local communities.
- Helping GP practices improve the experience of their patients, including better staff training and development
- Helping GP practices improve services for people with long term conditions, such as diabetes
- Projecting the mix and number of GPs and other Primary Care staff that will be needed to meet the needs of the public in the future, and working hard to recruit them
- Working together to retain current staff for longer, making east London an attractive place to work for both existing and new recruits

## What does it mean for local people?

- It will be easier to understand what healthcare services are available, and where.
- By calling or contacting NHS 111 online you will be able to get all the advice you need on show and where you can get the best care.
- It will be easier to book an appointment with a GP. Appointment times will be more convenient, including evenings and the weekends. In some instances you may not need to go to the surgery at all. Instead, you could speak to the doctor or nurse over the phone, online or via a video link from a smartphone.
- You will be able to see a preferred clinician if you wish and are prepared to wait longer for an appointment.
- You will be able to see a range of health and social care professionals, quickly and conveniently in one place, close to your home.
- Your overall experience of Primary Care will be better and consistent. You will feel you are treated as a person, not a number

# MENTAL HEALTH

## Our aims

- **Improve access to services and cut waiting times for treatment**
- **Treat mental and physical health needs as one**
- **Address the wider determinants on mental health, e.g. housing and employment**

Mental health services in east London are among the best in England, but they face tough challenges ahead.

The area's growing population is placing unprecedented demands on services, with higher numbers of people needing mental health support.

One in four of us will have problems with our mental health at some time in our lives. Whether it is a concern about a job, financial problems, a relationship, bereavement or the pace and pressures of modern life, it can happen to any of us.

- People with a serious mental health illness die on average 15 years younger than the rest of the population.
- Physical and mental health issues are intrinsically linked – 30 per cent of people with a long-term condition have a mental health problem and 46 per cent of people with a mental health problem have a long-term condition.
- Mental health service users in east London are two to three times more likely to die of cancer, circulatory or respiratory disease than the rest of the population.
- 50 per cent of lifetime mental health conditions are first experienced by the age of 14, 75 per cent by the age of 24.
- 60 per cent of people in contact with secondary care mental health services are not in employment.
- 47 per cent of people with serious mental illness smoke compared to 20 per cent of the wider population.
- 30 per cent of people with serious mental illness are obese compared to 10 per cent of the general population.

Many people with mental health problems have to rely on emergency departments (A&E) for help.

- People with mental health problems in east London attend A&E nearly three times as often as others. They are also three times more likely to be admitted to hospital in emergencies than others.
- More than 20 per cent of all emergency admissions in east London can be attributed to mental health service users, who only make up seven per cent of the overall population.

No one should experience mental illness without the right support. But with more and more people needing it, and only so many resources available, we will have to change the way our mental health services are delivered.

We are making the provision of sustainable mental health services across east London one of our top priorities, but believe we can go further.

Working in partnership, bringing the NHS and councils together, our ambition is to:

- Develop new models of care that address mental and physical health and social care needs as one.
- Provide good service user education to reduce stigma and promote resilience.
- Help people with more serious mental health problems to find and remain in employment – a key factor in their recovery.

We also want to find the right place for people to live, with the right support close by – essential in helping them get well.

Creating opportunities and providing good quality care in the community, including specialist services, is an underlying aim of the East London Health & Care Partnership. It is part and parcel of helping people live happy and independent lives, and nowhere is this more important than in mental health.





## What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Working with partners to address the wider determinants of mental health e.g. access to accommodation, education and employment.
- Supporting the roll out of digital self-management tools such as the London Digital Mental Wellbeing Service (www.digitalwellbeing.london).
- Developing an east London-wide suicide prevention strategy.
- Supporting employers to improve staff mental health and emotional wellbeing via programmes such as Mental Health First Aid.
- Developing our talking therapies services so there are more appointments with reduced waiting times.
- Integrating mental health services into GP surgeries, A&E and general hospitals.
- Developing perinatal mental health services for expectant mums and mums of new babies.
- Improving services for people experiencing a crisis by ensuring everyone in crisis can access mental health crisis support 24/7.
- Delivering mental health treatment at home.
- Delivering specialist mental health services for children and young people closer to home.
- Developing a new Child and Adolescent Mental Health Unit Psychiatric Intensive Care Unit here in east London.

## What does it mean for local people?

- Improved access to, and shorter waiting times for, psychological therapies.
- A wider range of mental health services to be accessible via your GP.
- Your mental and physical health and social care needs treated as one, wherever and whenever necessary.
- Enhanced support to access the right education, employment and accommodation opportunities for people with mental health issues.
- People in east London will have access to the same range of mental health services wherever they live.

# CANCER

## Our aims

- **Cut waiting times for appointments**
- **Diagnose and treat any cancer quickly, with better education and information for the public**
- **Improve care and outcomes for people**

Parts of east London compare poorly with the rest of England in helping to prevent, and treat cancer.

Local people aren't living as healthy a lifestyle as others elsewhere. The area has higher-than-average rates of smoking and obesity and fewer take part in any form of physical activity.

People are also not going for check-ups as often as they should, greatly reducing the chances of survival because a cancer hasn't been detected and treated early enough.

The facts are simple:

- More than 40 per cent of cancers diagnosed in the UK last year could have been prevented by people adopting healthier lifestyles.
- Up to 10,000 deaths in England could be avoided each year if cancer is diagnosed earlier and treatment started sooner.

But we can all do something about it.

The East London Health & Care Partnership is making the prevention of cancer, and improving outcomes for people that have it, a top priority.

We are going to improve information on screening for breast, cervical and bowel cancer and other forms of the disease. This includes better signposting on when and where you can be screened, and what you can do yourself to check for symptoms.

We especially want to reach out to those that don't have regular health checks, or who don't like seeking help.

We want to cut waiting times for appointments and ensure patients from all backgrounds have access to timely, high quality modern treatments. Working with some of the best expertise there is, we want people to live well after treatment and increase their chance of survival.





## What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Ensuring all patients who are referred for an urgent appointment with a specialist are seen within two weeks.
- Making sure patients are receiving their tests and diagnostics on time to enhance early diagnosis and treatment and improve cancer survival.
- Enabling better communication between GPs, hospital consultants and other specialists to allow faster and more effective treatment and care.
- Encouraging patients in east London to take up their screening.
- Improving information technology and administrative processes to make sure the cancer referral pathway is effective and patient care is joined up.
- Listening to patients and carers to ensure we meet their needs and keep improving their care.
- Working with public health services to improve prevention and lifestyle choices.

## What does it mean for local people?

- If you are referred urgently by your GP or another health care professional you will be seen within two weeks.
- If you have a cancer diagnosis, you will receive treatment quickly in order to improve your chances of survival.
- A number of health and social care professionals will be involved in your care to ensure your care is joined up.
- Your experience of care will be positive because we are listening to you and making improvements.
- If you take up screening when you get an appointment, you are likely to receive early detection and treatment.

## What can you do?

We will do our bit to turn things round, and make sure east London does everything it can to beat cancer. But you can play your part too and take good care of yourself. It is by far and away the best thing you can do to avoid this disease.

Do yourself, your family and friends a favour and:

- stop smoking
- avoid too much alcohol
- eat well
- keep active
- check yourself over regularly
- register with a GP
- attend regular screening appointments

**If your GP refers you to the hospital for a test, or to be seen, please make sure you attend the appointment.**

# MATERNITY

## Our aims

- **Improve information and advice about pregnancy to help prevent any problems**
- **Give women greater control and more choice about how and where they give birth**
- **Make them feel safe and secure, cared for and supported**

East London has the fastest growing population in the UK and the highest birth rate.

Our health and care services must cope with this growth and continue to ensure all goes well for the mums and babies. But it's not the only challenge.

More women of child bearing age are living with a long-term health condition, such as diabetes or heart disease. This can lead to a complex birth, requiring extra care and attention. We need to help women prevent and better manage these conditions.

Our vision for maternity services in east London is for them to be safe, caring and kind. We want it to be easier for women to find out about the services, and for care to be focussed around the needs of the woman and her family.

We want all women to feel safe and secure during their pregnancy. We want them to have a choice about how and where they give birth and to feel supported throughout.

For our staff, our culture is to promote innovation and continuous learning. We want to create a working environment where they feel valued – one that will help us attract and retain the best people.

We are one of seven areas across the country taking part in the Better Births Initiative to make care safer and give women greater control and more choices during their pregnancy. It aims to reduce the number of different midwives and doctors seen during pregnancy, so a proper relationship can be built.

We will strive for continual improvement in all that we do to ensure the best, and happiest, outcome for every mum and baby.





## What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Listening to, and working with, women in east London to understand their needs and design care around them.
- Giving women greater choice about how and where they give birth.
- Making it easier for people to get help and information and book appointments.
- Ensuring safe and high quality care for all mums and babies.
- Ensuring there are enough midwives to cope with the increasing number of births. There is currently a shortage of midwives in east London, many are retiring or moving away from the area. We need to recruit more and keep them here.
- Working together to ensure every woman gets continuity of care throughout her pregnancy and birth. We want to reduce the number of different midwives and doctors she sees, so a proper relationship can be built.

## What does it mean for local people?

- You will have a greater choice about where and how you give birth.
- You will have easier and better access to help and information, including advice on how to keep well before, during and after pregnancy. You will also be able to book appointments online.
- You will likely see the same midwife throughout your pregnancy to ensure continuity of care.
- The plan for care during your pregnancy will be developed and agreed between you and your midwife or obstetrician.
- If you have a long-term condition, such as diabetes, or you are having twins or other multiples, you will be seen by your midwife and obstetrician regularly and may be referred to a specialist.
- Your overall experience of care during and after your pregnancy will be positive and of high quality. We want you to feel safe and secure, cared for and supported.

# MEDICATION

## Our aims

- **Ensure the right medicines are used, at the right time, for the right patients**
- **Reduce medicine waste**
- **Make it easier to get prescribed medicine when it is needed**

To be truly effective, medicines must be used properly and responsibly – from those that help get us better when we're ill, to those that keep people with long-term conditions alive.

The East London Health & Care Partnership's aim is to ensure the right people, get the right medicine at the right time. We don't want people taking medicines they don't need.

New medicines are being introduced all the time. This includes those available over the counter from pharmacists and supermarkets, as well as those only available on prescription.

GPs, pharmacists and other healthcare professionals must have a good understanding of what medicines their patients are taking and what they can and cannot do. They also need to know the side effects of the medicines and how and when they should be taken.

Evidence from the Royal Pharmaceutical Society shows there is an urgent need to get the fundamentals of medicine use right.

For example:

- Only 16 per cent of patients who are prescribed a new medicine take it as prescribed.
- At least six per cent of emergency re-admissions are caused by avoidable adverse reactions to medicines.
- It's estimated at least £300m is wasted on medicines each year across England.

The overuse of anti-biotics is also something we need to get right. It is weakening their effectiveness and making them counter-productive. The World Health Organisation says resistance to antibiotics is one of the biggest threats to global health.

We will be improving education and information about medicines and encouraging people to become less dependent on them, including antibiotics.

There are alternative and often more effective ways to treat and prevent common ailments.

Taking regular Vitamin C and Zinc supplements, for instance, can prevent colds developing. If you do have a cold, steaming your nose and mouth for up to 15 minutes, four times a day, and drinking plenty of fluids, can alleviate the symptoms.

For people with long-term conditions, alternatives to medication can include following a particular healthy eating regime and an exercise programme.

An example is for those with high cholesterol. A diet rich in plant sterols and stanols, that block the body's absorption of cholesterol, can avoid some people having to take drugs called statins. They are substances that are naturally found in small amounts in plants – in fruit, vegetables, pulses and grains. You can also buy spreads, cereals and yoghurt-style drinks which have been fortified with them. Regular exercise also helps and sometimes reduces the need for blood pressure medication.

Physical activity can also help with mental health conditions, such as depression, as can getting sufficient sleep and being more involved in communities to combat loneliness.

We also need to reduce the prescribing of medicines that are proven to have limited clinical value.

Around £3.8m is currently being spent on them every year in east London. It doesn't just represent poor value for money – which could be better spent on other health and care services – the use of such medicines is not in the best interest of patients.





It is not always necessary to go to a GP for treatment for minor ailments, or for medication that can be bought over the counter in a pharmacy or shop without a prescription. A pharmacist can give advice for problems such as coughs, colds, fevers, hay fever and eye infections.

For those taking medication for a long-term condition, your GP will regularly review what you are taking and adjust it as and when needed. If your surgery has a practice pharmacist you can ask them to check the medication too.

## What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Following national recommendations from NHS England, we are reviewing the prescribing of certain medicines. They are those for which there is limited evidence about their effectiveness.
- Buying some medicines from alternative better value suppliers. These are the unbranded items that do exactly the same thing, but for a lot less money. It will enable any savings to be better spent on other health and care services.
- Helping people take charge of their overall health and achieve better outcomes without a dependency on medication. Holding regular reviews with patients to identify medicines they no longer need.
- Reducing medicines waste
- Reducing resistance to antibiotics by moderating the amount and type prescribed. Educating patients and prescribers on the importance of completing courses of antibiotics when necessary.
- Ensuring we have sufficient pharmacists where they are needed. This includes clinical pharmacists within GP practices and/ or clinics in order to help ensure the right medicines are used, at the right time for the right patients.

## What does it mean for local people?

- You will be able to get professional medical advice for all minor ailments in pharmacies, including out of hours pharmacies.
- Pharmacists will give you advice on the nature of medicines available to buy over the counter and what you will need a prescription for.
- You will not be prescribed medicines for which there is limited evidence about their effectiveness or where there are safer alternatives.
- You will not be prescribed antibiotics unless they are essential.
- You will be less likely to be kept in hospital waiting for medicines to be prescribed.
- The cost of prescribing medicines to you as a tax-payer will be less, meaning money can be better spent on other health and care services.

# THE RIGHT STAFF IN THE RIGHT PLACE WITH THE RIGHT RESOURCES

## Our aims

- **Ensure we have the we have right number of good quality staff to look after people, now and in the future**
- **Make services and care accessible and convenient, consistent and personal**
- **Give the best possible treatment and care by ensuring our staff have access to all information and resources they need**

# THE RIGHT STAFF

There is a considerable shortage of staff to fill key roles in health and care services. It's one of the biggest challenges the sector is facing in meeting the demands of a growing and ageing population.

Not as many people want to become doctors or nurses or care workers as used to.

Doctors, nurses and care workers cannot afford to live in London because of high property prices and a chronic shortage of suitable accommodation.

People also want more flexible jobs and careers so they can manage their other responsibilities like childcare or looking after an older relative.

Many GPs are due to retire soon, and a quarter of nurses leave their profession after just five years.

Nearly 20 per cent of jobs in registered social care lie vacant.

We are having to rely heavily on temporary staff, who come at higher rates than permanent staff and are not always available.

While we are still managing to provide services safely, action is needed to tackle the shortages, both now and in the future.

## Attracting staff

The regeneration of many parts of east London is making it an increasingly attractive place to live and work. We need to promote this more strongly and sell its strengths.

In future when we advertise for staff, we will not just give details about the job and organisation. We will tell people about the wider benefits of the area – its transport, shopping and restaurants; the nurseries, schools and colleges; the many leisure attractions. Most importantly, we will help find them a home and offer affordable key worker accommodation. This is the single most important factor in recruiting staff to work in London and is something we are currently working on with housing providers and developers.

But we don't just want to attract staff from outside the area. Far from it. We want to recruit 'home-grown' talent too and are working with local schools, colleges and universities to do more of this. Creating job and career opportunities in our public services for the people that already live here will always be a priority for the partnership.

When we have recruited good quality people to come and work with us, we want to keep them.

To do this we need to offer more training, research and career development opportunities, with the ability to work across different organisations.

For example, midwives in east London are now getting the chance to work in all different areas of the profession not just one – home births; deliveries in birthing centres; hospital labour wards; experience of complicated births. It's this sort of variety, and the opportunity to progress a career without having to keep moving home, that's a big factor in retaining people.

As well as offering careers, we will also be putting more emphasis on looking after the health and wellbeing of our staff, including how to manage stress. Difficulty with this is a major reason why many doctors, nurses and carers leave the profession. We want to ensure the right support is in place to help them.

## What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Collaborating with councils and housing associations to ensure there is affordable accommodation for key workers.
- Expanding roles in GP surgeries (including physician associates, clinical pharmacists, practice healthcare assistants and care navigators) and developing an endoscopy and community nurse workforce.
- Promoting east London as a place, with all its attractions and benefits, to encourage more staff to live, work and stay here.
- Working with education and training providers to develop job and career opportunities in health and care for local residents.
- Offering more training, research and career development opportunities.
- Looking after staff so they can better look after the people of east London.

## What does it mean for local people?

- More healthcare professionals likely to be taken on and retained to look after you and your family's health and care needs – now and in the future.
- A continuity of care wherever you are treated – in hospital, in the community and at home.
- More job and career opportunities in local health and care services

# THE RIGHT STAFF IN THE RIGHT PLACE WITH THE RIGHT RESOURCES

## THE RIGHT PLACE

Having staff in the right place might be a hospital, a GP surgery or even a patient's home.

Whether staff work in a hospital trauma centre or in the community, we are enabling and encouraging them to work together across the range of health and care services. We want to stop working in silos. The focus will be on following patients, not patients following us.

Where we can we are looking to put local health and care, and other public services, in the same building. This isn't just to save money, but to encourage closer working between them – and to stop the public having to go to lots of different places.

When a building is no longer required, the money recouped from the sale or rent will be reinvested locally to help improve or rebuild those we do need.

Although we have many modern facilities in the area, we also have buildings that are more than 100 years old and no longer fit for purpose. Whipps Cross Hospital in Waltham Forest definitely needs rebuilding, and we are working on this right now. We want all of our facilities to be up to date and functional, ready for future advances.

A greater use of digital technology will also help ensure services are provided in the right place. We want staff to have greater flexibility over how and where they work so they can spend more time in local communities. It also saves money on costly building space, which can be better spent on patient care.

Technology brings other benefits too.

Using a digital device to constantly monitor someone's heart, or provide a video link to a doctor or nurse, for instance, can enable a patient needing that type of care to stay in the comfort of their own home, yet remain in constant touch with expert help and support should it be needed.

It will not only make care accessible and convenient, but more consistent and personal. It's very likely you will see the same staff throughout your care rather than lots of different people.

If you are unfortunate enough to have an accident requiring major surgery, for instance, once you have been discharged from hospital the same team of physiotherapists will visit you at home to help you fully recover. As well as saving numerous trips back and forth to the hospital, it will avoid you constantly having to repeat your medical history, or details of any medication, to a number of different people.





### What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Ensuring staff can offer a continuity of care to all patients.
- Enabling staff to work in the community – making services more accessible and convenient and saving on costly building space.
- Looking to share the buildings we do need with other public services, not just to save cost but to make things more convenient for people.
- Improving buildings and facilities in need of repair or modernising.
- Tapping into the opportunities digital technology offers to give patients better and more convenient access to services. This includes appointments via a video link and apps to monitor their own health and progress.

### What does it mean for local people?

- Care will be accessible and convenient, more consistent and personal
- More care will be given to you in your home or close by, helped by digital technology
- You will more likely see the same staff throughout your care, establishing a relationship with them that generates assurance and trust
- No need to keep repeating your medical history and medicines to different health and care professionals.

# THE RIGHT STAFF IN THE RIGHT PLACE WITH THE RIGHT RESOURCES

## THE RIGHT RESOURCES

It's vital our staff have all the resources they need to do their job effectively.

As we have already said, digital technology will enable staff to spend more time in local communities. We will continue to invest in it to ensure they have easy and reliable access to all the information and data while out and about.

The right resources also means creating better links between the many different information and IT systems across health and care services.

Many of them have been developed independently of one another and, as a result, they can't 'talk' to each other. It's slowing down information exchanges between organisations and delaying the results of clinical tests. We are joining systems up to overcome these problems.

And it's not just about information technology.

To give effective treatment and care, staff need access to an array of equipment and resources, from hi-tech medical scanning systems to basic office supplies. We are working together to make sure they have it, investing in new kit and facilities where needed and joining up our buying teams to secure the best possible deals.





### What are we doing?

Some of the things we want to do will take longer than others, but we are doing all we can to make them happen as quickly as possible.

- Continuing to invest in digital technology to ensure staff can work anywhere in the community with the information and data they need.
- Joining up IT systems to speed up information exchanges and the sharing of records so staff can plan, and give better treatment and care.
- Working together to ensure staff have all the modern facilities and equipment they need to do their jobs effectively

### What does it mean for local people?

- More care can be given in or closer to your home as a result of staff being better equipped to work flexibly
- Your treatment and care will be planned and managed more effectively thanks to improved IT systems and the sharing of records
- Modern equipment and facilities will enable you to get the best possible treatment and care

East London Health & Care Partnership

First Floor, Vicarage Lane Health Centre,
10 Vicarage Lane, Stratford E15 4ES

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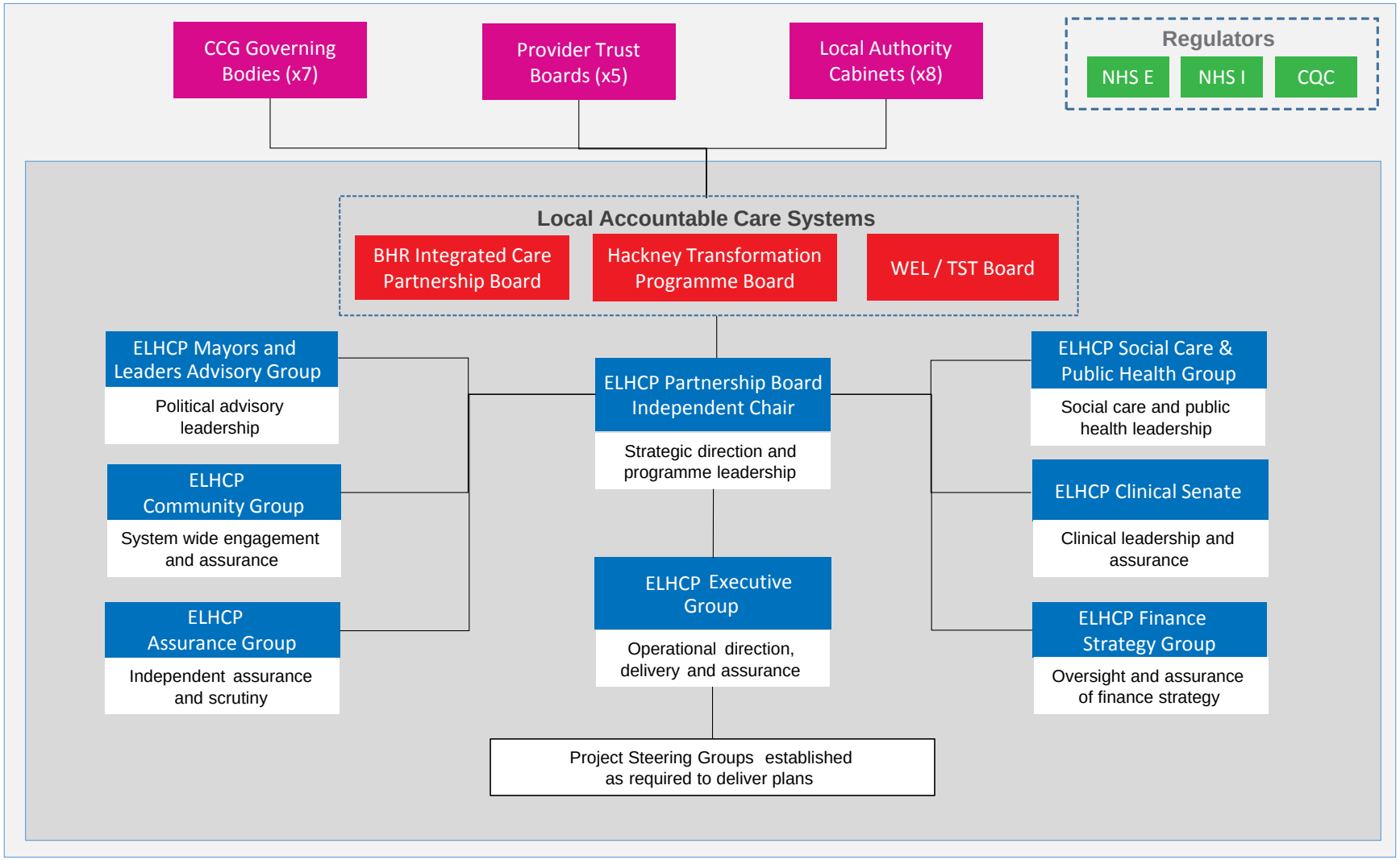
East London Health & Care Partnership

# Governance structure



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Havering
LONDON BOROUGH

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

| | |
|---|---|
| **Subject Heading:** | Reports from Healthwatch Redbridge |
| **Report Author and contact details:** | **Anthony Clements,<br>Principal Democratic Services Officer,<br>London Borough of Havering** |
| **Policy context:** | **The attached reports detail a project currently being undertaken into patient discharge from hospital by Healthwatch Redbridge.** |
| **Financial summary:** | **No impact of presenting of information itself.** |

## SUMMARY

The attached Enter and View report has been written in response to concerns raised in regards to the patient discharge pathway in Redbridge. Healthwatch Redbridge (HWR) had heard from patients and relatives who were concerned that they were experiencing difficulties accessing services once they were discharged from hospital.

Healthwatch Redbridgevisited all discharge lounges within the three main hospitals providing inpatient treatment (Whipps Cross, King George's and Queens). The initial report for BHRUT services is attached and the organisation is currently working on the report for Whipps Cross Hospital discharge lounge.

Further concerns were raised when Halthwatch undertook to follow a patient on their journey from leaving hospital to returning home. The report; "From Hospital to Home: A Patient Discharge Journey" highlights the failure of hospital and home treatment services to offer the appropriate support to a particular patient.

A number of issues have been highlighted with the service providers and commissioners including:

- The discharge pathway from Whipps Cross Hospital was not clear.
- Poor patient communication which was often confusing and erratic.
- Poor service provider communication which led to a breakdown of services until HWR intervened.

Healthwatch Redbridge would like to thank the patients, visitors and staff at the hospitals for their assistance and contributions to this report. Healthwatch Redbridge would also like to thank Mrs H, the patient we followed for their report for her support in allowing her story to be told.

The Joint Committee is asked to consider the reports and take any action it considers appropriate.

## RECOMMENDATIONS

1. That the Joint Committee considers the attached Healthwatch Redbridge reports and takes any action it considers appropriate.

## REPORT DETAIL

Officers will present and summarise the main features of the attached Healthwatch Redbridge reports following patient discharge from Whipps Cross Hospital and their recent Enter & View activity to the discharge lounges for King George's and Queen's Hospitals.

## 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:** Healthwatch Redbridge is concerned that patients in the West Redbridge area may be receiving a poorer service provision than those in other areas of the borough.

## BACKGROUND PAPERS

None.

healthwatch Redbridge


# From Hospital to Home:

## A Patient Discharge Journey……..

This report is available to download from our website, in plain text version, **Large Print**, and can be made available in Braille or audio versions if requested.

Please contact us for more details.

**020 8553 1236**

www.healthwatchredbridge.co.uk

## Introduction

Healthwatch Redbridge (HWR) have been conducting a number of projects to assess the quality and safety of Hospital discharge procedures and rehabilitation services throughout the borough following a number of issues and concerns raised by patients and carers.

**It should be noted that some of the support provided by Healthwatch Redbridge was technically outside of our remit insofar as we should have supported the patient (Mrs H) to engage with an independent advocacy service. However, we took the decision to follow the patient journey and to intercede on her behalf in order to review the complete discharge pathway.**

## Background

On 20 October 2016, we were contacted by Mrs H, a 78 year old lady who lives in the West of Redbridge. She contacted us as she was facing problem regarding her discharge from Whipps Cross Hospital.

The first time HWR visited Mrs H she was extremely distressed and said,

***'I feel like throwing myself under a bus, I can't go on like this'***

***(Mrs H)***

She felt that she had lost her independence. She told us that since being in hospital she is having to wear incontinence pads, and can't do anything unaided. Prior to fracturing her ankles she told us that she was able to live independently, walk with support of a tri-wheeler frame and to go out on her own. She told us she feels that her mobility has been taken away from her. At this visit HWR obtained written consent from the patient allowing them to contact service providers on her behalf.

In December, HWR contacted Redbridge Clinical Commissioning Group (RCCG) to ascertain the discharge pathway for Redbridge Patients admitted to at Whipps Cross Hospital. Written information was provided in March 2017 from Redbridge CCG which stated the a teleconference takes place between the hospital, Redbridge Social services, North East London Foundation Trust (NELFT) and the continuing Health Care Team in the CCG for any Redbridge patients that are ready to be discharged. A plan is agreed, taking into account the health & social care responsibilities linked to the patient.

Mrs H spent 6 months in a nursing home before being discharged to her own home with a package of care.

## The journey after discharge from Hospital

Mrs H was admitted to Whipps Cross hospital due to fracturing both her ankles. After staying in hospital for a few days (Bracken Ward), the ward doctor told her she was ready for discharge. However, she was non-weight bearing and needed a nursing home placement for 6-8 weeks until she was able to weight bear.

She was anxious and concerned that she did not know what would happen. She also felt it was clear from the conversation she had with the doctor that he was unsure of the discharge pathway for Redbridge residents as he told her '*The pathway for Redbridge Patients attending Whipps Cross Hospital was not clear*'.

This statement was later confirmed by a friend of Mrs H who was present when the Dr spoke to her.

On 25 October, Mrs H was discharged to a local nursing home. She said that neither the discharge arrangements nor care plan were discussed with her prior to discharge.

Mrs H faced a number of additional problem with the services at Whipps Cross Hospital in regards to appointments, communication between departments and a lack of information at each stage of her journey, for example:

- When she attended the fracture clinic in November she was not given details of follow up appointments. She was provided with Air boots to wear until she saw the consultant and told that she would need rehabilitation but not told how it would happen.

- Mrs H had to continuously telephone the departments at the hospital to obtain information regarding follow up appointments.

- Mrs H also contacted Patient Advice & Liaison Services (PALS) on numerous occasions regarding the problem she was facing and as a result of this the doctor that had discharged her from Bracken ward called her at the nursing home. He tried to sort out a follow up appointment although there was confusion in regards to when the appointment was to be made (3 months written in the notes but Mrs H was told to return in 3 weeks). He was able to arrange an appointment for the following week for her to see the orthopaedic consultant.

- The doctor from Bracken ward also told HWR once the patient is discharged it is the responsibility of the orthopaedic team and IRS to arrange the next stage between them. The doctor told HWR that prior to discharge the Intensive Rehabilitation Service (IRS) had been sent a

telephone referral which they did not accept as weight baring status was not known and neither was discharge destination.

- The doctor also said that once the plaster casts were removed the Community Therapy service had become involved and visited Mrs H at the nursing home but was not able to provide any therapy. The doctor also contacted the IRS team who had said they would contact the Community Therapy team.

- HWR spoke to the consultant's secretary and a follow up appointment was made with an orthopaedic consultant.

- When Mrs H attended the orthopaedic appointment she was given a letter for physiotherapy. When contacted the IRS team and they said that they would need a letter from the hospital to say Mrs H is now weight bearing before they could start any physiotherapy.

- Once it was confirmed that she was 'weight bearing', she was told she would need additional support, however she was not told who to contact regarding physiotherapy.

- There was a lack of communication between the hospital and the Intensive Rehabilitation Services (IRS), prior to and after discharge. HWR contacted the IRS team and were told that:

> *'The patient referral was not completed by Whipps Cross Hospital staff to IRS, thus IRS didn't have notification of discharge and did not pick up as unaware of the patient.'*
>
> *'The patient had a pre-existing referral with Redbridge health and social care physiotherapist.'*
>
> *'On assessment by the team (Community Physiotherapist) no weight bearing status for the patient had been recorded and they have been chasing the hospital for this information.'*
>
> *Lead Physiotherapist, NELFT*

- A letter was obtained by HWR from the secretary of the orthopaedic consultant so that the IRS team could start physiotherapy.

- Between December 2016 and January 2017, the team attended the Nursing home to provide physiotherapy for about 28 days. At this stage she was able to walk with a frame, make a cup of tea and transfer from the bed, so they said she would be safe to cope at home.

- The IRS team referred Mrs H to Community Health & Social Care services and said a social worker would contact her.

HWR arranged for Mrs H to meet with the Patient Experience Lead (PEL) from Whipps Cross Hospital to discuss her concerns. HWR staff supported Mrs H to develop some questions that she could raise at the meeting. The meeting took place in April. The responses received by MRS H were copied to NELFT in order for them to comment.

Some of the responses to the questions are shown below:

1. We have been told that IRS were not informed of Mrs H discharge date and destination. Please can you clarify why this might have occurred?

   ***Barts Health response:***

   ***Whilst a referral was made to IRS the discharge destination was not known so IRS would not accept the referral. In retrospect the ward should have waited until a discharge destination was known or called IRS back. This has been taken forward as learning and we apologise for not doing this.***

   ***A physiotherapist from the Community Therapy Service saw Mrs H after she had her cast removed and she informed Mrs H there was not much she could do for her. IRS confirmed that the physiotherapist had contacted them via a phone referral but they did not have the capacity to take the patient and asked her to call back on Monday, but it appears she did not.***

   ***There was a breakdown in communication between Community Therapy and IRS, both are managed by NELFT not by Barts Health.***

   **NELFT response:**

   **T*he process regarding non-weight bearing referrals has been shared with all hospitals. A patient that is referred for a CCG funded bed should be discussed with IRS before completion of the written form. The form is then completed and submitted to the CCG. When discharge date and destination is found for the patient, a referral for IRS should be made. No referral was made for Mrs H although it was identified that she was to be referred for a non-weight bearing bed***

2. Mrs H asked why she was not given a follow up appointment by the orthopaedic team when she had the plasters removed from her ankles. She said she had difficulty contacting the doctor's secretary. HWR rang

the secretary and I think PALS intervened, as well the Dr from Bracken Ward and she was finally given a follow up appointment.

***Barts Health response: Barts Health have taken this as an action point to raise the communication and follow up processes with the Associate Director of Nursing responsible for the fracture clinic***

3. The patient said she was sent to a nursing home as she was non weight bearing but she was not aware of a care plan and she was just told she was going there. She said that no-one discussed this with her. She told us she did not know if she had a social worker

***Barts Health response:***

***Whilst it is clear from the notes and numerous Multi-Disciplinary Team (MDT) meetings it is not clear these meetings included Mrs H. There are also references in the notes that discussions took place re discharge to the nursing home and assumptions made that she would retain this information and understood the importance of it.***

***In 2016 the non-weight bearing pathway was not fully in place which had a negative impact on Mrs H discharge.***

***There is a pathway for Redbridge patients and Mrs Harbour was referred to IRS as a part of this pathway. However this did not happen we are sorry this did not happen for Mrs H.***

***NELFT response: Mrs H was not referred to IRS for therapy as part of the non-weight bearing process.***

4. The patient was told by a doctor on Bracken Ward that ' there is no clear pathway for Redbridge Patients' is this the case. If it is not then why do the clinicians not know the clear pathway?

***Barts Health response:***

***The organisation acknowledged that at the time of Mrs H discharge this did appear to be true but reassured that that progress had been made since. They apologised for the negative experiences Mrs H had faced. The medical team have now been made aware of the non-weight bearing pathway.***

5. Mrs H said that when she went to see the consultant and had the Air boots removed, she was given a form for physiotherapy but no other information. Please can you clarify this? She did not know who to contact, why did the Consultants team not contact the IRS team?

***Barts Health response: In general the more able patients are able to make their own appointments and attend their physiotherapy appointment in the department. I do not believe this was the best option for Mrs H. We are unable to comment as to why the consultant did not contact the IRS.***

***Please apologise to Mrs H on our behalf, a meeting will be held with the therapy team to highlight the importance of clear communication.***

***This case will be discussed to ensure this does not happen again.***

## Other issues faced by Mrs H.

1. Whilst at the care home the patient informed HWR of the lack of care she receives at the home. She informed us of problem regarding staff shortages and waiting too long for personal care to be dealt with. **HWR have informed the local Quality Surveillance Group regarding this and they have said they will visit the home.**

2. Mrs H informed us she was not told that she would have to pay for a carer to accompany her to hospital appointments. She only found this out when she received a bill from the home.

3. Mrs H felt IRS were an excellent team and she felt really positive about being able to do the things she could after the physiotherapy they provided.

4. Due to the pain in her knee and her other health problem she was unable to do the exercises unaided and she informed us that the carers at the home had told her they were not trained to do these exercises with her.

5. When being discharged by the IRS team they told her that she would be referred to the Continuing Health & Social Care Service (CHSCS); a social worker would contact her as she was safe to return home. The social worker conducted an assessment but Mrs H felt she was not able to cope at home and refused to return home as she felt she would benefit from some inpatient rehabilitation. She asked the Social worker to refer her to the Ainsley Ward at Whipps Cross Hospital (inpatient rehabilitation).

6. HWR spoke to the social worker who had been told by the IRS team that Mrs H would not be eligible for further inpatient rehabilitation, however he did not agree with this response.

7. The social worker felt that Mrs H would benefit from inpatient rehab as she did not have any, (or insufficient) follow up from the nurses at the nursing home with physiotherapy exercises/mobility (after IRS ended their care) which has led to her weakness and deconditioning.

8. After speaking to the social worker HWR contacted the nursing home manager to ask questions regarding the care plan, discharge summary from IRS, wheelchair access etc. HWR are awaiting a response from the nursing home.

9. Mrs H informed HWR that the social worker had told her that her funding would end in 2 weeks and she did not know what to do. HWR called her social worker who said he would try and extend it.

10. The social worker asked the CCG to extend the funding until the patient had the opportunity for further rehabilitation.

11. The local MP, John Cryer, had also become involved and contacted different organisations on Mrs H's behalf.

12. The funding was extended and the IRS came to the nursing home for about 15 days to provide further physiotherapy.

13. When the IRS team discharged Mrs H she was able to stand assisted by 2 people and mobilise using a gutter frame assisted by 2 people. They suggested that she could return to her home with a double handed care package. Furthermore, she would benefit from some further therapy once she is back in her own home.

14. On 5 May Mrs H returned to her own home with a care package. This package consisted of four calls per day with 2 carers and two domestic calls per week. She informed us her GP is also referring her to community physiotherapy.

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healthwatch Redbridge

# Enter & View Report

Queens Hospital:
Inpatient Discharge Lounge Tuesday 25 April
Outpatient Discharge Lounge Wednesday 26 April

King George Hospital
Discharge Lounge Tuesday 25 April

This report is available to download from our website and can be made available in a plain text version, **Large Print**, in Braille or audio versions if requested.

Please contact us for more details.

**020 8553 1236**

www.healthwatchredbridge.co.uk

## Visit Details

| | |
|---|---|
| **Service Provider** | **Inpatient Discharge Lounge**<br>**Queens Hospital**<br>**Barking, Havering & Redbridge**<br>**University Trust (BHRUT)**<br>**Rom Valley Way,**<br>**Romford,**<br>**Essex, RM7 0AG** |
| **Contact Details** | **Senior Sister: Christina Szentes**<br>**01708 435000** |
| **Date/time of visit** | **25 April 2017 1pm-3pm** |
| **Type of visit** | **Announced visit** |
| **Authorised representatives undertaking the visits** | **Authorised Representative Team:**<br>Lead Representative – Naina Thaker<br><br>Representatives –<br>Ogechi Ejimofor & Elaine Freedman |

| | |
|---|---|
| **Service Provider** | **Outpatient Discharge Lounge**<br>**Queens Hospital (BHRUT)**<br>**Rom Valley Way,**<br>**Romford,**<br>**Essex, RM7 0AG** |
| **Contact Details** | **Alison Franklin**<br>**01708 435000** |
| **Date/time of visit** | **26 April 2017 1pm-3pm** |
| **Type of visit** | **Announced visit** |
| **Authorised representatives undertaking the visits** | **Authorised Representative Team:**<br>Lead Representative – Sarah Oyebanjo<br><br>E&V Representatives –<br>Hyacinth Osborne & Elaine Freedman |

| | |
|---|---|
| **Service Provider** | **Discharge Lounge**<br>**King George Hospital (BHRUT)**<br>**Barley Lane,**<br>**Goodmayes,**<br>**Ilford, IG3 8YB** |
| **Contact Details** | **Comfort Ajagbe**<br>**01708 435000** |
| **Date/time of visit** | **25 April 2017 1pm-3pm** |
| **Type of visit** | **Announced visit** |
| **Authorised representatives undertaking the visits** | **Authorised Representative Team:**<br>Lead Representative - Sarah Oyebanjo<br><br>Enter & View Representative – Thomas Thorn |

| | |
|---|---|
| **Contact details** | **Healthwatch Redbridge**<br>**5th Floor, Forest House**<br>**16-20 Clements Road**<br>**Ilford, Essex IG1 1BA**<br><br>**020 8553 1236** |


## Acknowledgements

Healthwatch Redbridge (HWR) would like to thank the staff and patients at Queens Hospital Inpatient Discharge Lounge for their hospitality.


## Disclaimer

Please note that this report relates to findings observed during our visits made on **25 & 26 April 2017.**

Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time of the visits.

## What is Enter & View?

Part of the local Healthwatch programme is to carry out Enter & View visits. Enter & View visits are conducted by a small team of trained Healthwatch volunteers & staff, who are prepared as 'Authorised Representatives' to conduct visits to health and social care premises.

Enter & View is the opportunity for Healthwatch Redbridge to:

- Enter publicly funded health and social care premises to see and hear first-hand experiences about the service.
- Observe how the service is delivered, often by using a themed approach.
- Collect the views of service users (patients and residents) at the point of service delivery.
- Collect the views of carers and relatives through evidence based feedback by observing the nature and quality of services.
- Report to providers, the Care Quality Commission (CQC), Local Authorities, Commissioners, Healthwatch England and other relevant partners.

Enter & View visits are carried out as 'announced visits' where arrangements are made with the service provider, or, if certain circumstances dictate, as 'unannounced' visits.

Enter & View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation – so we can learn about and share examples of what a service does well.

## Introduction

Healthwatch Redbridge (HWR) conduct E&V visits to the discharge lounges at Queens's hospital, King George Hospital & Whipps Cross Hospital to review and understand the discharge procedures used within hospitals primarily serving the Redbridge area.

The visits were planned as part of our work programme as concerns have been raised by a number of service users regarding hospital discharge processes.

## Purpose of the visit

Healthwatch Redbridge has used the visits as part of a project responding to concerns raised by local people regarding safe hospital discharge. A number of concerns have been identified such as discharges being completed late in the evening & long waits for medications. Further concerns have been raised by a number of Care homes, who have told us that, in their opinion, some residents have been discharged too early leading to them needing to be

readmitted or they were sent home with little or no information about their diagnosis.

These visits are also in response to findings in regards to our project looking at Intermediate Care in Redbridge. Some concerns were raised that there is no clear discharge pathway for services users that live in the west of Redbridge.

The results of the visits will allow us to review, understand and report the discharge protocol within the three hospitals.

## Strategic Drivers

- BHRUT & Barts Health Discharge Protocols
- HWR Intermediate Care Review
- Part of the HWR Work Plan 2016-17
- Reporting to Redbridge Health Scrutiny Committee in regards to safe hospital discharge in the borough

## Methodology

Prior to the visits, we conducted a review of our signposting log and database systems to identify discharge issues raised by patients and relatives. A number of key concerns were raised during the last year, such as patients (or their relatives) feeling they had been discharged too early which, in some cases, had led to readmission; and long waiting times for medications to be organised.

In July 2015 Healthwatch Havering conducted an Enter & View Visit to the discharge lounge at Queens Hospital[1] and the Ambulance Waiting Area[2] (Outpatients Discharge Lounge). Our visit was also seen an opportunity to assess if any changes or improvements had been made to the service since the recommendations made by Healthwatch Havering.

Questions were written to reflect the issues identified. Additional questions were added relating to the Accessible Information Standard[3]. The standard is there to ensure people who have a disability, impairment or sensory loss, receive information in a way they can understand and any communication support they may need.

The visits were was approved by the HWR Enter & View Task Group.

[1] http://www.healthwatchhavering.co.uk/sites/default/files/full_report_final_-_discharge_1.pdf
[2] http://www.healthwatchhavering.co.uk/sites/default/files/full_report_final_-_ambulance_1.pdf
[3] www.england.nhs.uk/accessibleinfo

The visits to Queen's hospital took place on 25 & 26 April and the visit to King George hospital was conducted on 25 April. All establishments were informed by email two weeks prior to the visits taking place.

On arrival at Queen's hospital, the lead representative informed reception staff of their visit and requested to speak to the delegated staff member. As the visits were announced prior to attendance; a member of the Patient Experience team and the discharge lounge manager met representatives escorted them to the lounges.

Representatives were shown around the different areas of the discharge lounge by the ward manager. Two representatives spoke to patients and staff whilst another spoke to the ward manager.

At King George Hospital the team made their own way to the discharge lounge. On arrival at the discharge lounge, representatives introduced themselves to staff and informed them of the purpose of the visit. They then spoke to staff and patients in the lounge.

A leaflet explaining the role of Healthwatch was left with each person spoken to.

At the end of the visit the representatives thanked the staff members and told them that the draft report would be sent shortly.

The reports are sent to each provider so that they have an opportunity to request any factual inaccuracies be corrected prior to publication.

## Results of Visit

Representatives spoke with patients, relatives (where available) and staff, using a standard set of questions. Representatives took the time to explain who they were and why they were there. They confirmed with individuals that they were happy to speak with them and that their responses would be confidential and anonymised before publication.

Where appropriate, each visit has been reported separately and recommendations identified for each lounge.

A comprehensive response is shown at the

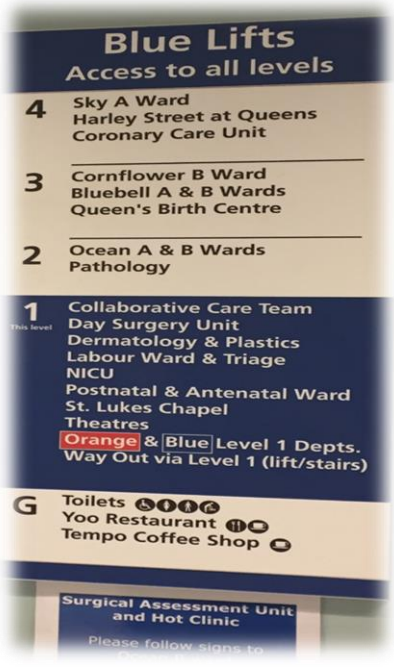
## Inpatient Discharge Lounge - Queens Hospital

The visit was conducted in two parts. The Lead Representative met with the discharge lounge manager or the person in charge at the time of our visit, to confirm the details below.

| Questions | Responses |
|---|---|
| **What are the opening times of the discharge lounge?** | **8am to 8.30pm Monday to Sunday.** |
| **How many patients can the lounge accommodate?** | **Chair area - 23 patients but if some patients remain in their wheelchairs then 2 to 3 more patients can be accommodated.**<br><br>**Bed area - 5 patients** |
| **What are the current staffing levels in the discharge lounge?** | **3 qualified nurses**<br>**3 Health Care Assistants** |
| **Which areas of the hospital do the patients in the discharge lounge come from?** | **Inpatient wards, Accident & Emergency (A&E), Medical Receiving Unit (MRU) & Elderly Receiving Unit (ERU)** |

### Observations at the premises:

*(Please see Appendix 1 for further information)*




- No clear signage to the discharge lounge seen when entering the main hospital reception.
- No clear signage by the lifts that led to the discharge lounge.
- Accessible parking is available at the hospital however the lounge is located on the first floor some way from this area. Representatives were told that patients are taken in a wheelchair by a porter or ambulance staff to the ambulance or the pick-up point.


- The first sign representatives noted was on the wall immediately outside the discharge lounge.

- On arrival, representative noted that there were 3 patients waiting in the seating area of the lounge and another patient in the bed area. When representatives were leaving they noted the chair area had filled up significantly.

## Speaking with the Manager:

*(Please see Appendix 2)*

**Discharge process**

- The manager said that the discharge lounge is used for patients who need transport or are waiting for a relative to collect them. The patients are also often waiting for their medication.
- The ward contacts the discharge lounge to make them aware they have a patient that is ready for discharge.
- At this stage the nurse will check the discharge summary has been finalised on the computer system and, once confirmed the patient is accepted by the discharge lounge and a porter will bring them down. The porter will also bring any equipment that the patients may have to take home, such as a walking frame or commode etc.
- When the patient arrives at the lounge the nurse will check their any medications they may have and secure them for safe-keeping until the patient transport is available or a relative comes to collect them.
- The health care assistant or nurse will then complete a comprehensive handover form.
- The relatives or the place to which the patient is going are also informed at this time that the patient is in the discharge lounge. If the medications are not ready and the relative is happy to come back and collect them, then they can collect the patient at any time.
- Patients going to a nursing, care or residential home are prioritised as there often is a cut off time that they will be accepted there. However, if the facility is happy to accept them without their medications then the medications will be sent on later by taxi. Patients with learning disabilities or dementia are also prioritised.

- When a patient is ready to be discharged, they are provided with a discharge summary which is also emailed to their GP at the same time. Their medications will be checked with the patient prior to leaving the discharge lounge.
- When asked which service causes the biggest delay in the discharge process, the manager said it can be a range of different things but communication between departments is often a problem. Sometimes medications can cause a delay.
- The manager told representatives that discharges have been delayed due to medication not being ready or the cut off time for a residential or care home has been reached. This has occasionally led to a patient being kept in overnight when they are medically fit to be discharged.
- When the manager was asked which day is the busiest in the discharge lounge she said it is often a Monday or Friday but this can vary.

**Take Home medication**

- When a patient requires medication to take home, the pharmacy is informed electronically that the patient is in the discharge lounge.
- Medication can be tracked by nursing staff on the discharge lounge. When it is ready it will be collected by a porter.
- If the pharmacy does not have the medication in stock the pharmacist will speak to the patient and arrangements will be made for it to be collected the next day.

**Ambulance service**

- If the patient requires hospital transport they are booked onto the system with the proviso that the patient is still awaiting medications.
- The amount of time the patient may have to wait depends on their needs. If a patient is in a wheelchair or needs to take equipment with them they will need more space in the ambulance and may wait longer. However, if the patient can sit in the ambulance chair they may not need to wait as long.

**Accessible information**

- The manager said that they are informed in the handover and when they come onto the discharge lounge if a patient has a communication impairment. There is also a section on the booking form that allows staff members to input information about an impairment.

- If they have a hearing impairment or visual impairment they are asked if a sign can be displayed near them to alert staff (see below).

- If a patient has a visual impairment then staff will speak to them. However, if the patient is deaf/blind then a relative will be contacted to discuss medication. The learning disability nurse can also be contacted to enable communication.
- The discharge lounge does not have a hearing loop.
- There is a notice on the nurse's station which provides 10 top tips for communicating with people with hearing impairments which staff should follow.

  If a patient is able to write then they will be provided with pen and paper to make the communication process easier.
- A patient with a learning disability should come to the ward with a Learning Disability passport which should have been completed on the ward. There is also a Learning Disability nurse available.
- Representatives noted there were no signs to advise patients that information can be made available in other formats such as large print.

**Complaints Procedure**

- Representatives did not see a complaints/compliments procedure on the wall/board during the visit. However, the manager said that if a patient has a complaint then staff will try to deal with it.
- If the patient is still not happy then the Patient Advice & Liaison Service (PALS) is contacted. If this happens then the sister in charge will also be contacted by the discharge lounge staff.

**Refreshments**

- Patients are regularly asked if they would like any refreshments.
- Tea/Coffee and snacks are available anytime. If a patient comes to the lounge at a meal time (1pm & 4.30pm), hot meals are also available.
- Carers or relatives are also offered refreshments.

## Speaking with staff:

*(Please see Appendix 3)*

- A representative spoke to one Health Care Assistant on the day of the visit to ask them about their role in supporting patients using the lounge.
- When asked about how they would identify a patient with an impairment they said they would do this through communication with the patient as it is often not clear from the notes.
- When asked what they felt caused the most discharge delays they said delays to medication and hospital transport.
- The staff member said the latest time a patient is discharged from the lounge is 7pm to 7.30pm. If they are still there after this time they are transferred to the observation ward.
- The staff member told representatives there were no written complaints information but if a patient had a complaint they would do their best to resolve it. If they were unable to deal with the issue they would be escalate it to senior staff.

## Speaking with patients:

*(Please see Appendix 4)*

Authorised representatives spoke to six patients during their visit.

- Four patients had been admitted and two had arrived at the hospital that day. All the patients had been admitted through the A&E department and were unplanned admissions.
- On average, the representatives noted the patients in the lounge appeared to wait about 2 hours.
- The patients' experience of the discharge process was variable.
    - One patient being discharged to a residential home stated that no discussion had occurred regarding their discharge.
    - Two patients stated that no discussion had taken place regarding their discharge, however when asked about medications and services it appeared that a discussion may have taken place.
    - One patient knew the name of the person who was responsible for their discharge.
    - A patient that is a regular user of the hospital was familiar with the process and knew their visit would be for the morning and the ambulance for the return journey home was booked prior to the appointment.
- Of those who needed medication, all were waiting for it.

- Two patients indicated that their discharge had been delayed by the wait for medication.
- One patient's delay was caused by waiting for a porter and another had to wait for a trolley.
- Three patients stated that they had not been informed of the reason for a delay.
- Three patients going to their own home said that they had been involved in deciding what care and support they needed.
- Two patients returning home who did not require any support had no discussion, neither did the patient returning to a residential home.
- Further support requirements varied; one patient was told what to do on returning home whilst another was given a selection of leaflets indicating the existence of further charitable provision. One patient was referred to the Intensive Rehabilitation Service[4].
- None of the patients spoken to required additional equipment when they returned home.
- Patients who had spent some time in the discharge lounge stated that the service and the food was good.
- Patients were asked if they had any further comments. One patient said there were not enough ambulances and another said they had to wait a long time for transport. One patient said that the medication process takes too long and it is worse on a Sunday as the pharmacy closes early.
- Of the patients we spoke to only one had a sight impairment, but he was not asked by the staff in the discharge lounge if he had a communication impairment.

[4] **Intensive Rehabilitation Service (IRS):** delivers intensive rehabilitation within a patients' home.

## Recommendations

- Signage for the discharge lounge should be clearer. Directions to the lounge should begin at the entrance to the hospital.
- All information should be made available in different formats for those with communication impairments (easy read, online, large print, BSL videos etc). Patients should be made aware that information can be provided
- BHRUT has recently been awarded the Deaf-Aware Quality Mark by the Royal Association of Deaf People (RAD[5]).
    - We were disappointed with the lack of information or support available for patients with a hearing impairment.
    - The hospital should consider installing a hearing loop in the discharge lounge.
    - The hospital might wish to consider asking its own Deaf Access Group to review the discharge lounge and make recommendations.
- The complaints/compliments procedure should be clearly visible and available for all patients. The procedure should be available in a range of accessible formats.
- The length of time patients are waiting for their medication needs to be reviewed. Better systems could reduce discharge delays.
- The staff should ensure that patients are made aware of the reason for any delay in their discharge.
- The hospital should ensure that all patients are involved in discussions regarding their discharge arrangements.

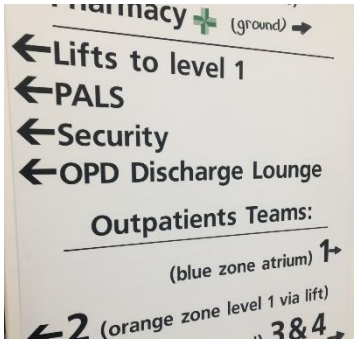
[5] https://www.bhrhospitals.nhs.uk/search/text-content/queens-becomes-the-first-hospital-in-the-country-to-receive-deafaware-quality-mark--1562

## Outpatient Discharge Lounge - Queens Hospital

| Questions | Responses |
|---|---|
| What are the opening times of the discharge lounge? | 7:30am- 6pm<br><br>Patients typically arrive at 9:30am |
| How many patients can the lounge accommodate? | Chair area - 40 patients maximum<br><br>Bed area- none |
| What are the current staffing levels in the discharge lounge? | 3 staff members: 1 staff nurse/ Healthcare assistant, 1 front of house and 1 manager |
| Which areas of the hospital do the patients in the discharge lounge come from? | Outpatients department |

## Observations at the premises:

*(Please see Appendix 1 for further information)*




Signage from the reception to the lounge says 'OPD Discharge lounge' and this might confuse patients who are unsure about what OPD means.

Outside the lounge, there is signage which says 'Outpatient Discharge Lounge' which is large and easy for patients to see.

The complaints/ compliments procedure wasn't available on the board/ wall during the visit.

On arrival to the ward, the manager and one staff member were at reception and a nurse could be seen attending to a patient. The nurse was easily identifiable by her uniform.

## Speaking with the Manager:

*(Please see Appendix 2)*

**Discharge process**

- The manager said that the outpatient discharge lounge is a waiting area for those who need ambulance transport and no other services are available. The pharmacist can talk to the patients directly if necessary.
- The booking form for transport is completed and sent to the team online. Patients are then brought down by the porter and they aim for the patients to leave within the hour.
- The manager said that they have more patients on the days that the anti-coagulation clinics are run. This is on Monday, Wednesday and Friday.
- Staff in the discharge lounge are not responsible for booking follow up appointments. The clinics book the patients in directly for their follow up appointments. In some cases, patients call in enquiring about a service and they are directed to the relevant department.
- The booking system for the ambulance service is completed online by the Trust. The bookings are signed off by the clinicians.
- On average, the patients are discharged from the lounge by 5:30pm.
- There is a priority system for those who are severely unwell.

**Accessible information**

- The manager said that majority of their patients are regular users of the service so they know their needs and how to support them.
- There is also a section on the booking form that allows staff members to input information about their disability.
- The manager said that she would support someone with a visual impairment by speaking clearly to them.
- If a patient has a hearing impairment then staff would ensure that the patient can see them so that they can lip read. Patients with learning disabilities usually have an escort with them.
- There was a hearing loop available but the manager was not sure how to use it.

Com**plaints procedure**

- If the patient has a complaint then they are directed to the manager or PALS. The manager said that most of the complaints are about patients that have not been booked in for the ambulance service and staff in the discharge lounge do not deal with these bookings.

**Refreshments**

- On arrival, the nurse makes the patient a cup of tea and also gives them biscuits. If the person is there for a while a packed lunch can be ordered for them from the kitchen.

## Speaking with Staff:

*(Please see Appendix 3)*

- The lead representative spoke to one Healthcare Assistant and one front of house staff member on the day of the visit.
- Both staff members said that their role is to support the patients whilst they are in the discharge lounge. The patient's information is sent to them then patients wait in the lounge for transport.
- When asked about how they would identify someone with an impairment, one staff member said that she would know when speaking to the person. Another staff member said that most of their patients have already been to the clinics so this would have been identified at the clinic and they would have an escort with them.
- If a patient has a visual impairment, then staff would speak to the person clearly and ensure that they are standing in front of them.
- If a person has a hearing impairment, they would use eye contact and lip reading.
- If a person has a learning disability, the staff would respond to them depend on the individual's needs and they would adapt the information that may be required. Both staff members mentioned that people with learning disabilities usually come with a carer.
- They were both aware of the hearing loop but were unsure about how it works.
- Both staff members said that they stop accepting patients at 5pm and most patients leave before 7pm. If the patient is still waiting to be discharged after this time then a staff member will wait until all the patients have left the lounge.
- There was no physical copy of a complaints procedure but staff members said that they would direct patients with complaints to the manager or PALS.

## Speaking with patients:

*(Please see Appendix 4a)*

Authorised representatives spoke to seven patients during their visit.

- The average waiting time was 30 minutes. The maximum waiting time during our visit was 1 hour.
- Of the seven patients that we spoke to, none of them had been told about the waiting time for the transport.
- Six patients that we spoke to require a follow up visit and this had been arranged for them by the clinic that they visited.
- Four of the patients that we spoke to had a communication impairment, however, none of them had been asked about this.
- Many of the patients were regular users of the service and said that they do not have an issue with the discharge lounge. However, sometimes waiting for transport can be a long process.
- An authorised representative observed an elderly woman get up from her wheelchair to go to the bathroom by herself. It would be useful for patients to have a buzzer or bell to enable them to alert staff if they require any support.
- With regards to providing refreshments, one diabetic service user said when he asked for another biscuit, staff refused as they said they only serve one courtesy biscuit.
- Overall, the patients were happy with the service because they said that staff were friendly and offered them refreshments when they entered the lounge.

## Recommendations

- The hospital should ensure that abbreviations are not used such as, 'OPD' for 'Outpatients Department' as service users may not be aware of what the acronym means.
- The complaints/ compliments procedure should be clearly visible and available for all patients. The procedure should be available in a range of accessible formats.
- The staff should be provided with training on how to communicate effectively with people with communication needs.
- BHRUT had recently been awarded the Deaf-Aware Quality Mark by the Royal Association of Deaf People (RAD)
    - We were disappointed with the lack of information or support available for patients with a hearing impairment.
    - The hospital should ensure that staff receive adequate training in using the hearing loop in the discharge lounge.
    - The hospital might wish to consider asking its own Deaf Access Group to review the discharge lounge and make recommendations.
- Patients should be informed about the waiting time for the transport and kept informed about any delays.
- Patients should be asked if they have a communication need when they arrive in the lounge as this will ensure that they are treated in a way that suits their needs.
- Support should be provided for those patients in the lounge that may require it.
- Adequate refreshments should be available for service users, especially for those patients that may require them due to their health condition.

## King George Hospital Discharge Lounge

| Questions | Responses |
|---|---|
| What are the opening times of the discharge lounge? | 8am to 8.30pm Monday to Sunday. |
| How many patients can the lounge accommodate? | Chair area - 8 patients<br><br>Bed area - 4 patients<br><br>If a woman is admitted in the bed area then they wouldn't admit any men and vice versa. |
| What are the current staffing levels in the discharge lounge? | 2 staff members: 1 staff nurse and 1 support worker |
| Which areas of the hospital do the patients in the discharge lounge come from? | Inpatients, Outpatients & Haematology department |

### Observations made at the premises:

*(Please see Appendix 1 for further information)*


The hospital has a large map near the reception of the hospital however the map does not show the discharge lounge.

The discharge lounge is close to the entrance of the hospital thus making it easy to access disabled parking.

Signage in front of the discharge lounge identifies the area as a 'departure lounge'.


The complaints/ compliments procedure wasn't available on the board/wall during the visit. Staff mentioned that they usually have leaflets informing patients of the procedure, however there were none available on the day.

On arrival at the discharge lounge, there were three people in the waiting area and a further two people arrived during our visit.

## Speaking to the Manager:
## *(Please see Appendix 2)*

**Discharge process**

- The manager explained that prior to the arrival of the patient to the lounge, staff members from the other ward will call to provide them with all the relevant information. The ward informs the patient that the discharge lounge is just a waiting area thus ensuring that everything is in place before the patient arrives.
- The discharge summary, package of care and key safe arrangements must be ready before the patient comes in to the lounge. The patient is provided with a discharge summary containing any information for medication if applicable.
- The manager said they do not have a specific day that is always busy. This can change every week.

**Take home medication**

- After the handover, the request is faxed to the pharmacist.
- Medication can be tracked by staff on the computer system. If necessary, they can call the pharmacy to ascertain the reason for the delays. The pharmacist usually delivers the medication. However, if they are busy then it will be collected by staff from the discharge lounge.
- On the previous weekend, we were told there was a three hour wait for medication from the pharmacy.

**Ambulance service**

- This service is booked online for patients. Staff call the team to find out how long the waiting time is. The maximum time is 4 hours but on the day of the visit it had been 30 minutes to an hour. The average waiting time depends on how busy they are.
- Staff said that this service is one of the reasons for the delays in discharging patients on time. During the Easter holiday, there was a situation where a patient waited for 6/7 hours for an ambulance but this is a rare incident.

**Accessible information**

- The manager said that patients would be asked prior to coming to the discharge lounge about their communication needs.
- When providing accessible information for someone with a visual impairment, staff ensure that they talk to them and explain information clearly.
- If a patient has a hearing impairment, staff write down the information or speak to them face to face.
- People with a learning disability are provided with easy to read information that has pictures. The information is provided in a way that the patient can understand so it is suited to the patient's needs.
- The manager showed the lead representative the communications book used to communicate with patients who have a learning disability.
- Staff said that they do not have a hearing loop for people who use a hearing aid.

**Latest discharge time**

- The manager said that staff normally finish at 8:30pm but it is sometimes delayed to 9pm. They inform the site manager at 8pm to ensure that whoever is waiting in the discharge lounge is prioritised. The last person to leave the discharge lounge on the day prior to our visit was at 8:10pm.
- The manager showed the representative the discharge time book and within the last month, patients have generally been discharged before 8pm.

- Priority is given to patients from care homes who have a cut off time in which they must arrive back to the home.
- The manager said that the pharmacy and ambulance service are the two reasons for the biggest delays in discharging patients.

**Refreshments**

- Patients are offered a cup of tea and a choice of biscuits and fruits when they arrive in the lounge.
- Patients are encouraged to ask for refreshments whilst they are in the lounge.

## Speaking with Staff:

*(Please see Appendix 3)*

The authorised representative spoke to one staff member.

**Discharge procedure**

- The staff member said that the patient's information is sent from the ward. This would include information about medication and the handover sheet.
- The ambulance is usually booked by the ward otherwise the discharge team will book it.
- The patient is welcomed and offered a drink and some food.
- When the patient's medication arrives in the lounge, the patient is free to go if they have their own transport. If they require ambulance transport they would have to wait till it is available.
- The discharge summary is printed and given to the patient when they leave the lounge.

**Accessible information**

- Staff said that the handover sheet will provide information about the patient's communication needs.
- Patients with visual impairment would be spoken to clearly.
- The communications book will be used for people with hearing impairments and people with learning disabilities. Furthermore, those with learning disabilities will also have their learning disability passport.
- The discharge lounge does not have a hearing loop.

**Latest discharge time**

- Staff confirmed that the latest discharge time is 9pm.
- If the patient is waiting to be discharged after this time then staff will contact the ambulance team and the site manager.
- If the person came to the lounge from A&E then they will go back to minors. If the patient is from a ward then staff will come from the ward to sit with the patient.

**Complaints procedure**

- Staff said that patients are sent to PALS or given a leaflet if they wish to make a complaint.

## Speaking with patients:

*(Please see Appendix 4)*

- On arrival at the discharge lounge, there were three patients waiting. The authorised representatives spoke to one patient as the other two were unable to complete the questionnaire for different reasons.
- During our visit, another two patients came into the discharge lounge however they were both unable to complete the questionnaire.
- The patient, who the authorised representative spoke to, had been waiting in the discharge lounge for 45 minutes. He was transferred from Queens's hospital 5 days ago. His admission in to the hospital was not planned and he was admitted through A&E.
- The patient said that he was spoken to about the arrangements for being discharged on the day that he was due to be discharged.
- He was not involved in planning his discharge from the hospital and his discharge was delayed due to waiting for medication.
- He was not aware of the name of the person responsible for his discharge but was provided with a reason for the delay.
- He was returning to his own home and all the different options were discussed with him.
- He said that he was not involved in deciding any care or support that he may need once he has been discharged from the hospital.
- Prior to coming to KGH, someone discussed the care and support available at Queens's hospital but did not follow up with this at KGH.
- He was not provided with any information about his recovery once he returns home.

- The patient was not provided with any emergency telephone numbers.
- The patient was not using hospital transport on the day of the visit.

## Recommendations

- Directions for the discharge lounge should begin at the entrance of the hospital.
- The hospital should ensure that the signage is clear and the name on all the signs is the same so as not to confuse patients.
- The complaints/compliments procedure should be clearly visible and available for all patients. The procedure should be available in a range of accessible formats.
- BHRUT has recently been awarded the Deaf-Aware Quality Mark by the Royal Association of Deaf People (RAD)
    - We were disappointed with the lack of information or support available for patients with a hearing impairment.
    - The hospital should consider installing a hearing loop in the discharge lounge.
    - The hospital might wish to consider asking its own Deaf Access Group to review the discharge lounge and make recommendations.
- The length of time patients are waiting for their medications needs to be reviewed. Better systems could reduce discharge delays.
- The hospital should ensure that all patients are involved in the discussion regarding their discharge from the hospital.

## Provider Response

Further to the recommendations made by your enter and view visit, we would like to thank Healthwatch for presenting key recommendations to be addressed. A number of the findings and recommendations relate to all of the areas visited and therefore, where relevant, this response responds to each issue across all areas.

**Directions and signage:**
It is recognised that there is not sufficient signage in either hospital for patients and visitors to locate the discharge lounges. For Queen's Hospital, a review of signage to the discharge lounges has taken place between the estates team, the patient experience team and the bed/site management team supported by our signage partner and agreement was reached regarding new signage. For KGH, there is a signage and wayfinding group meeting on 19th July 2017 and this group has been asked to undertake a similar review as a matter of urgency.

**Complaints/compliments materials:**
We have reviewed our current concerns/complaints poster and made this available in A3 size in the inpatient lounges. The complaints department are currently reordering their leaflets. In the meantime, all discharge lounges have been provided with a stock of PALS leaflets and advised how to reorder when needed. In addition, a comment card facility has been placed in both inpatient discharge lounges so that patients can feedback on their experience.
In addition, for the outpatient discharge lounge at Queen's Hospital, G4S have been asked to publicise their own complaint procedure.

**Accessible information:**
Although a significant amount of work has taken place to improve accessibility and communication for our patients, the findings of Healthwatch Redbridge during this visit are acknowledged. An audit has been undertaken at Queen's Hospital to identify all areas where a hearing loop is not in place and may be required. An immediate request has been sent to the estates team to have a hearing loop put into both discharge lounges at Queen's Hospital. At KGH, an order had already been placed for installation of hearing loops and the estates team have been asked to ensure one is put into the inpatient discharge lounge. Following installation, the estates team will undertake an audit of these areas to ensure all staff know how this works and that this is suitable signage for patients who use the hearing loop facility.

To support patients whilst in the discharge lounges, we have ensured that the "top tips for communicating with deaf people" poster is displayed in all

discharge lounges. We have also displayed the text service available for deaf people. We will create a further poster to make patients aware of their right to have their communication needs known and met.

The hospital also uses a communication book to support patients with communication needs. A reorder is being placed and all discharge lounges will be provided with a copy of this once received.
The Deaf Patient Access Group are going to be made aware of the Healthwatch Redbridge Enter and View Report at the next meeting and will be asked to support a further review/walkabout of each discharge lounge to ensure any further recommendations can be implemented.
We have ordered confidential patient information boards which are covered and not visible to the public where patient communication needs can be identified to staff by use of relevant magnets.

**Keeping patients informed:**
The Trust is aware of the challenges associated with discharging patients and there are value streams developed to investigate and implement solutions for this. However, it is essential that we keep patients up to date with what is happening and the reasons for delays. The bed and site management team have been asked to reiterate to all inpatient discharge lounge staff the need for regular and useful updates for patients. This helps to manage expectations and reduces anxiety.

**Refreshments:**
It was disappointing to read of the patient who had not been provided with an additional biscuit when they asked for it. Generally, patients refreshment needs are met on an individual basis however, G4S have been asked to reiterate to all their staff that this is an important part of the patient experience.

**Medication:**
The Trust has a value stream which is looking at the discharge process. During w/c 3rd July 2017, a Rapid Process Improvement Week (RPIW) was held with relevant staff and using The PRIDE Way methodology, a significant improvement in length of time it takes to request TTA medication from pharmacy once a decision has been taken to discharge a patient. Further RPIWs later in the year will look at the time it takes from dispensing medication to the patient receiving the medication to take home.

In the meantime, it is important that discharging nurses manage patient expectations and make them aware of the processes that need to be completed including medication before a patient can physically leave the

hospital. This will be taken to the Senior Sister/Charge Nurse meeting for cascade to ward staff.

**ACTION LOG**
**An action log has been provided to Healthwatch Redbridge detailing the issues and actions being taken over the next three months to address the recommendations made in the report.**

**CONCLUSION**
We would like to take the opportunity to thank Healthwatch Redbridge for undertaking this Enter and View visit and for the feedback provided in the report. We are addressing the issues raised and are managing these as part of the on-going aim to improve patient experience in relation to the discharge lounges.

## Distribution

- BHRUT
- Care Quality Commission
- Redbridge Health Scrutiny Committee
- Healthwatch England

## Observations for discharge lounge visit

**What are you going to be looking for?**

| **Representatives will be looking to assess whether there is:**<br>**Please tick the appropriate box & add comments underneath.** | **Yes** | **No** |
|---|---|---|
| Is there sufficient & clear signage to the premises being visited?<br>Comments- | | |
| Is the signage clear, unobstructed, and easily readable; these may be room numbers, signs on doors, signs to toilets, signs to consulting rooms.<br>Comments | | |
| Is there accessible parking close to the discharge lounge?<br>Comments- | | |
| Is there an appropriate fire alarm - with flashing red light as well as the bell?<br>Comments- | | |

1

| | **Yes** | **No** |
|---|---|---|
| Do you feel that staff were interacting with patients in a satisfactory manner; were they facing the patients whilst talking to them, using body language as well as verbal communication, was plain language being used?<br>Comments- | | |
| Do you feel that staff were treating patients as an individual, addressing their needs and were aware of what they needed to do to make communication easier and clearer for the patient<br>Comment- | | |
| Are staff easily identifiable; did they wear uniforms or names badges?<br>Comments | | |
| Is the written communication in accessible formats?<br>Comments- | | |
| Is the complaints/compliments information available in different formats?<br>Comments- | | |
| Please add any other observations you may wish to comment on. | | |

2

## Questions for Lead staff

| | |
|---|---|
| What are the opening times of the discharge lounge? | |
| How many patients can the lounge accommodate? | |
| Please can you tell us about the discharge process? | |
| Is the discharge summary provided to patients? | Yes ☐ No ☐<br><br>If YES, please provide details.<br><br>If NO, who is it given to? |
| How many staff are there in the lounge? | |
| Do you have any days that are busier than others? | Yes ☐ No ☐<br><br>If yes, please can you provide reasons for this. |
| Do patients have their take home medications with them when they arrive in the lounge? | Yes ☐ No ☐<br><br>If No, what is the procedure for this? |
| How do you know if a patient in the lounge has a communication need? (Visual impairment, hearing impairment, learning disability? | |
| If the patient has an impairment in what format would you provide information? | Visual impairment<br><br>Hearing impairment<br><br>Learning disability |
| Do you have a hearing loop? | Yes ☐ No ☐<br><br>If yes, do you know how to use it? |
| With regards the ambulance service, please could you tell us how the booking system works? | |



| | |
|---|---|
| (How long on average do patients have to wait, what problems can occur etc) | |
| With regards take home medications, how do you liaise with the pharmacy? (are the medications ordered prior to patient coming to lounge, do you have to order them etc) | |
| Which service do you feel causes the biggest delay in the discharge process? | Please provide some details. |
| What is the latest time a patient is discharged from the lounge? | |
| If a patient is still waiting to be discharged after this time what is the procedure? | |
| Are the patients in the lounge prioritised for any reason? (are patients for care homes prioritised etc) | Yes ☐ No ☐<br><br>If yes, please provide details. |
| Do you have a complaints procedure<br><br>(If the staff member says No, ask how the patient could make a complaint) | Yes ☐ No ☐<br><br>If yes, Please could you provide some details |
| What facilities are there for refreshments? (Are hot meals provided, is there a good choice, are all diets catered for etc) | |
| Is there anything else you would like to tell us? | |

Appendix 2- Questions for Lead Staff

Questions for Staff

Job Role

| | |
|---|---|
| Please can you tell us about the discharge procedure | |
| Is the discharge summary provided to patients | Yes ☐ No ☐<br><br>If Yes, please provide details.<br><br>If No, please can you tell me have the GP received it? |
| How do you know if a patient in the lounge has a communication need? (Visual impairment, hearing impairment, learning disability? | |
| If the patient has an impairment in what format would you provide information? | Visual impairment<br><br>Hearing impairment<br><br>Learning disability |
| Do you have a hearing loop? | Yes ☐ No ☐<br>If yes, do you know how to use it? |
| Which service do you feel causes the biggest delay in the discharge process? | Please provide some details. |



Hospital Discharge

| | |
|---|---|
| What is the latest time a patient is discharged from the lounge? | |
| If a patient is still waiting to be discharged after this time what is the procedure? | |
| Do you have a complaints procedure<br><br>(If the staff member says No, ask how the patient could make a complaint) | Yes ☐ No ☐<br>If yes, Please could you provide some details<br><br>If, No ask how the patient could make a complaint. |
| Is there anything else you would like to tell us? | |

Questions for Hospital Discharge - Patients

| Questions for Patient | |
|---|---|
| 1. How long have you been in hospital? | |
| 2. What time did you arrive in the discharge lounge? | |
| 3. Do you have a visual impairment, hearing impairment, or learning disability? | Yes ☐ No ☐<br>If yes, please specify<br>If No please go to question 5 |
| 4. Have the staff in the discharge lounge asked you if you have any communication needs?<br>(hearing impairment, visual impairment, learning disability | Yes ☐ No ☐<br>If Yes, please provide details of the way in which they communicate with you? (BSL interpreter, Communication Book, Large Print) |
| 5. Was your admission to hospital planned? | Yes ☐<br>No ☐ |
| 6. If NO were you admitted via: | GP ☐ A&E ☐<br>Other (Please state) |
| 7. Which ward are you being discharged from: | |
| 8. Did anyone talk to you about arrangements for being discharged? | Yes ☐ No ☐ Not sure ☐ |
| 9. If YES, when was the first time your date of discharge was mentioned to you? | At time of admission ☐<br>The day after admission ☐<br>A few days before discharge ☐<br>On the day of discharge ☐ |
| 10. Do you know the name of the person that was responsible for your discharge? | Yes ☐ No ☐ |





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|---|---|
| 11. Were you, or a family member/ carer involved in planning your discharge from hospital? | Yes ☐ No ☐<br>If yes, please provide brief details. |
| 12. Was your discharge from the ward delayed for any reason? | Yes ☐ No ☐ Not Sure ☐<br>If YES, please provide brief details. |
| 13. Have you been kept informed of the reason for the delay? | Yes ☐ No ☐<br>If yes, please provide brief details. |
| 14. Where are you being discharged to: | Your own Home ☐ Other ☐<br>Care/Nursing Home ☐<br>Intermediate Care Ward ☐<br>Community Hospital ☐ |
| 15. If you are not returning to the place from where you were admitted, were the different options discussed with you? | Yes ☐ No ☐<br>Not Sure ☐ |
| 16. Have you been involved in deciding what care and support you would need once you are discharged from hospital? | Yes ☐ No ☐<br>Yes (please provide some brief details) |
| 17. What care and support have you been offered? | Reablement (independent living skills support at home) ☐<br>Supported Hospital Discharge (Intensive Rehabilitation Service) ☐<br>Home Care ☐<br>No support was required ☐<br>I was not offered any support ☐<br>Other (please state) ☐ |

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|---|---|
| **18. Do you require any special equipment to be arranged for when you get home, for example a wheelchair, raised toilet seat, hand rail etc?** | Yes ☐ No ☐<br>**If No, go to question 20.** |
| **19. If YES, can we call you in a few days to ask if the equipment arrived on time.** | Yes ☐ No ☐<br>**Please provide contact details**<br>**Name:**<br>**Phone number:** |
| **20. Have you been provided with any information regarding your recovery once you were discharged from hospital? (E.g things you can and cannot do etc.)** | Yes ☐ No ☐<br>If Yes, please provide details.<br>(was it in written format or verbal) |
| **21. Have you been given any emergency telephone numbers, if you required them once you were discharged?** | Yes ☐ No ☐ |
| **22. Do you require a follow up appointment?** | Yes ☐ No ☐<br>If Yes, which service is it for? |
| **23. Has it been arranged for you?** | Yes ☐ No ☐ |
| **24. Have you been given any medication to take at home?** | Yes ☐ No ☐ |
| **25. Are your medications ready?** | Yes ☐ No ☐ |
| **26. If they were not ready, were you given a reason for them not being ready.** | Yes ☐ No ☐<br>Please provide some details |





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|---|---|
| **27. Do you understand the instructions/information you were given about the medication** | Yes ☐ No ☐<br>If No, how do you think this could be improved. |
| **28. Did anyone talk to you about you are getting home/care or nursing home/intermediate care ward/community hospital or other (please choose the appropriate option based on the patient's response to question 14)** | Yes ☐ No ☐<br>If yes, please provide details |
| **29. Are you using hospital transport today?** | Yes ☐ No ☐<br>If No, how are you getting to the place you are returning to ? |
| **30. If you are using hospital transport, can we contact you in a few days to ask how you how you felt about the service?** | N/A ☐ Very Good ☐ Good ☐<br>Okay ☐ Poor ☐ Very poor ☐<br>Please provide your contact details.<br>(If not already provided)<br>Name:<br>Phone Number: |
| **31. Please could you tell us about your experience in the discharge lounge today?**<br>**(treatment, food, toilets etc)** | |
| **32. Is there anything else you would like to tell Healthwatch?** | |

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