HEALTH SCRUTINY SUB-COMMITTEE

Minutes of the meeting held at 4.00 pm on 11 July 2012

Present

Councillor Judi Ellis (Chairman)

Councillors Reg Adams, Ruth Bennett, Roger Charsley, Peter Fookes, David Jefferys, Mrs Anne Manning, Catherine Rideout and Charles Rideout

Angela Clayton-Turner, Leslie Marks and Angela Harris (Chair, Bromley LINk)

Also Present

Councillor Graham Arthur, Councillor Robert Evans and Councillor Diane Smith

1 APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTE MEMBERS

Apologies were received from Councillor John Getgood and Councillor Peter Fookes attended as alternate. Apologies were also received from both Lynne Powrie representing Carers Bromley and her alternate Maureen Falloon.

2 DECLARATIONS OF INTEREST

Councillor David Jefferys declared a personal interest as Vice President of a major pharmaceutical company.

3 QUESTIONS FROM COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

There were no questions.

4 MINUTES OF THE MEETING OF HEALTH SCRUTINY SUB-COMMITTEE HELD ON 16TH FEBRUARY 2012

Members commented on the previous minutes and it was noted that apologies for absence should have been recorded for Councillor Robert Evans and that the word *"fiancés"* at paragraph 8 of minute 22 replaced with "*finances"*. It was also highlighted that the start of the fourth sentence at Minute 16 should read *"Angela Clayton-Turner"*.

Democratic Services Note: the minutes published with the agenda were an early draft not reflecting subsequent amendments. As such, arrangements will be made for the correct version of minutes to be agreed by email with the Committee and Co-opted Members. When agreed, these minutes will be published on the Council's website via the following link:

http://cds.bromley.gov.uk/ieListMeetings.aspx?CId=445&Year=2012

5 MATTERS ARISING FROM PREVIOUS MEETINGS

There were no comments on this item.

6 ORPINGTON HEALTH SERVICES PROJECT

Subject to final approval by NHS London and sign off by the PCT Chair and Clinical Commissioners Chair, formal consultation on the future of Orpington health services was scheduled to begin on 16th July 2012.

A presentation on the proposals (i.e. what people would be consulted on) was given by the Project Director, Orpington Health Services Project and a confidential draft consultation document was tabled. A copy of the PowerPoint Presentation is attached at **Appendix A**.

A Pre-Consultation Business Case, agreed by the local Clinical Commissioners on 5th July 2012, had been developed to demonstrate a robust, evidence- based, clinical case for change and to outline the future proposals.

The Project Director's report to Members set out how it was believed the four tests for reconfiguration proposals (under the revision to the NHS operating framework in England 2010/11) had been met prior to consultation.

Support from GP commissioners - engagement with GP commissioners and the broader GP community had been continuous throughout the lifetime of the Project, with GP commissioners being central to the project. The project had ensured that emerging proposals are also aligned with the emerging local CCG strategy. Engagement had taken place between August 2011 and June 2012, and would continue through consultation and implementation.

The Orpington GP cluster had also been engaged in shaping the emerging picture at each of their meetings.

Strengthened public and patient engagement - the Project had engaged and captured the views and feedback of a wide range of people e.g. Bromley and Orpington residents, patient advocacy groups, Orpington hospital staff, GPs, Clinical Commissioning leads, Bromley LINks, Bromley OSC, NHS London, Bromley MPs and Councillors. Engagement took place between September 2011 and June 2012 and would continue through consultation. Engagement

had been undertaken in an open and transparent process and was found by the Health Gateway Review team to be well managed, inclusive and effective.

Clarity on clinical evidence base - there had been strong clinical leadership throughout the Project. Various clinicians such as SLHT clinical leads, Clinical Commissioners and GPs had been involved in the project and had assisted with assessing the needs of the population currently requiring services from Orpington Hospital e.g. long-term conditions such as diabetes. The clinicians had assisted in identifying opportunities to improve the services delivered to the population e.g. co-location with specialist services, improving primary care estates, increasing independence.

The information and evidence collected showed a strong clinical case for a new model of care for services currently delivered from Orpington Hospital and opportunities to further integrate services to meet wider health and wellbeing needs of the local population.

Consistency with current and perspective patient choice - all recommended approaches for consultation would result in services currently delivered on the Orpington Hospital site being transferred to alternative locations. Accessibility and patient choice had been key considerations in developing viable options for delivering services to meet local population needs.

Information and evidence collected indicated that the proposed changes would not have a significant impact on patient choice and in many cases would result in increased choice.

The Project Director's report also advised that NHS London had invited the National Clinical Advisory Team (NCAT) to review the reconfiguration of services currently provided at Orpington hospital. The visit on 25th April 2012 included meetings with the project team, GP Commissioners, patient and public representatives, staff involved with intermediate care, and clinicians of the services to be relocated.

NCAT was asked to look at the clinical safety of the proposals and whether they met the requirements for a quality local service and also to address the Secretary of State's four criteria for service redesign.

NCAT agreed that there was a strong clinical case for change; however, they made a number of recommendations to strengthen the project.

A Health Gateway Review of the Project, carried out from 14th to 16th May 2012 assessed the Project as Amber – *"Successful delivery appears feasible but issues require management attention. The issues appear resolvable at this stage of the programme/Project if addressed promptly"*. Five key recommendations were made to increase the likelihood of the project achieving its objectives; these were in the Pre Consultation Business Case and were all being actioned.

A Health Inequalities and Equality Impact Analysis had been developed and positive impact on inequalities was expected on the well being approach being supported.

There was potential for adverse impact for some people with a disability if a hydrotherapy pool was no longer provided although the report indicated that the overall benefits for population health care justified any potential adverse impact. It was also intended to review each of the NHS patients with long-term care plans involving hydrotherapy in order to minimise any potential adverse outcomes. In addition, NHS patients would be able to access hydrotherapy via the pool at Queen Mary's Sidcup (QMS).

There would be some travel impacts in moving the service to QMS and the numbers of patients impacted (felt to be small) along with alternative choices to mitigate the impacts were being investigated as the next stage of the impact assessment.

Many benefits were also expected from a well being approach and some settings identified had been found to increase and improve access.

It was proposed to run the consultation for 14 weeks from 16th July 2012 to 29th October 2012. To ensure wide access and help people engage with the consultation, a number of channels would be made available including:

- online, via website and email address;
- telephone facilitated feedback, offering help to capture information;
- written feedback via the post;
- in person at events; and
- via an intermediary advocacy service.

A number of consultation materials would be produced, including:

- a full consultation document containing a series of questions about the proposals;
- a consultation summary document to all households in Bromley;
- a briefing outlining how different individual services would be affected by any proposals;
- poster promoting the consultation with advice on how to engage;
- freepost postcard to request a full consultation document;
- a consultation website as part of the SE London cluster site; and
- a short film outlining the key issues.

In her introductory comments, the Project Director indicated that NHS London was content that consultation requirements had been met - the Committee's consideration was the final stage in the pre-consultation process. She advised that consultation would be extended if it was necessary to make any changes resulting from the South London Health Trust (SLHT) being put into administration. The Managing Director/Director of Public Health added that GPs and the Clinical Commissioners Group (CCG) were keen for the

proposals to be taken forward as it was best for Orpington. The focus was not about the SLHT but about what was best for Orpington; it was about a commissioning g process and what would be delivered for the borough - the principle of going forward was not dependent on the SLHT.

The Director explained that the consultation document would be provided on white paper. Councillor Mrs Manning suggested that a larger font is used and she highlighted some grammatical concerns in the early part of the full document. The Project Director explained that a short summary leaflet would be provided to all households with a tear-off slip to request the full consultation document. A summary leaflet had also been produced along with a document and questionnaire in easy read format. Members were also advised of a meeting on 7th August 2012 for NHS clients with a disability who might be affected by proposals for the hydrotherapy pool.

In addition to details provided in the PowerPoint presentation at **Appendix A,** the Orpington Health Services Project Director provided other comments including those summarised below:

- a mix of care was necessary in the right places - the right set of services was necessary in the right places to meet needs;

- every area of Orpington has a high reliance on out patient services;

- it was necessary to look at alternative care pathways;

- there was an aim of re-developing an extended Health Centre (wellbeing centre) to provide a range of community outpatient Services and health promoting support – a larger Centre was preferred to a smaller one (certain needs could be met with smaller Centres with other services provided in hospitals but this approach was not preferred);

- on proposals for sites and where to place such a development, it was necessary to undertake consultation before finalising the outline business case for capital – a centre of excellence could be developed on a hospital site or in a high street - there were a range of options to explore;

- waiting time reductions on community alternative services had been demonstrated and the development would seek to extend this approach for a new Community Health and Wellbeing Centre;

- a report from the National Clinical Advisory Team supported the recommendations for Orpington Hospital/Orpington health services – there were clear conclusions to support the direction of travel. Outpatient services at Orpington Hospital should be transferred to the PRU or QMS in some cases. The use of the current hospital footprint

was no longer seen as appropriate, this has implications for hydrotherapy;

- for dermatology generally, 60% of new referrals are to community based clinics. The case mix is changing and theatre space is not adequate at Orpington Hospital and there is a desire to consolidate into one service;

- from a survey of 60 patients who had used an intermediate care services, a larger number of the patients preferred to have their care at home – intermediate care needs were to be supported at home under the proposed new arrangements;

- a clinical review of hydrotherapy did not provide evidence that this was clinically better than land based therapy although this was not to suggest there were no preferences for water based therapy;

- there are about 13 users of the Orpington pool with a learning disability – it was about providing alternative therapy for them in the best way, alternative pools are being explored including using QMS;

- a Community Health and Wellbeing Centre was the preferred option providing a larger collection of services, other investment directed at prevention and care at home;

- The hospital is not preferred as only a quarter or less of the Orpington hospital space was needed;

- it was necessary to find the right type of development (Community Health and Well Being Centre or a local health centre) in the right location.

In concluding her presentation, the Project Director sought clarification on when the Sub-Committee would like to consider the conclusions from the consultation. The consultation period would end on 29th October 2012 and following independent evaluation of feedback and public sharing of the report, recommendations from the Bromley Local Clinical Commissioning Committee would be made to the PCT Board on 29th November 2012.

In subsequent questions, Councillor Fookes asked whether a site had been found in Orpington High Street. The Chairman indicated that it was not possible to pre-judge the outcome of consultation - following consultation a business case was then necessary. The Chairman enquired of the time period necessary to produce a business case; the Project Director indicated that it was not possible to confirm until the future direction was known following consultation. Adding to the Project Director's comments, the Managing Director/Director of Public Health indicated that a business case would be produced as quickly as possible.

In reply to a further question on the consultation, the Project Director indicated that all residents in the borough would be leafleted. She would also be attending the Health Overview and Scrutiny Committee at Kent County Council later in the month. Consultation material would also be available at Orpington hospital.

In response to a concern that any future development would be left half empty, the Project Director referred to being more demanding of how people work together. The Managing Director/Director of Public Health explained that at Beckenham Beacon there had been a need, and more efforts were now being made, to be more specific in requirements for space. It was intended to learn further from Orpington on how space at Beckenham Beacon could be developed.

Councillor Jefferys referred to the linking of GP Surgeries to specialists for real time diagnosis, highlighting the use of such techniques for the future. The Managing Director/Director of Public Health indicated that much more of a similar nature could be undertaken and that efforts would be made to maximise such initiatives through the process.

It was necessary to look across Primary Care – health services and new ways of working were not limited to buildings. The Chairman questioned how far such approaches could be taken. There was a fear amongst residents about a loss of service and it seemed that there was less emphasis on delivery.

Concerning hydrotherapy, Councillor Mrs Manning had a sense that people were opting for this adding that hydrotherapy had its benefits. Members were advised of the availability of the children's pool at the Phoenix Centre and a hydrotherapy pool at QMS which currently has vacant sessions. A pool at Sevenoaks and the Riverside pool were also possibilities. Resolving hydrotherapy would be looked in individual clinical care plans as necessary. The Chairman noted the research had stated that there was no clinical evidence for hydrotherapy above land therapy. The matter was for the clinicians and it was necessary to have evidence to show that water based therapy should be prioritised above land based therapy. For people who wanted to make a choice for hydrotherapy, the option of attending QMS was available.

The Project Director also advised of a desire to speak with all hydrotherapy users and not just the 13 using Orpington hospital. However the recommendations look at maximum health gain for the population balanced against individual preferences for people.

Leslie Marks referred to money being raised by people for the Orpington pool. There were people who would self refer and she referred to block bookings. She suggested that there was no entrepreneurial approach to using the pool and if there are no referrals a service would cease. The Project Director indicated that there could have been more people to take more sessions and more use could be made of the pool but the problem they were trying to solve was how to make total resources work best for all of the population. She also

indicated that the matter had been raised with Mytime with enquiries made on what would make the greatest difference, and whether an injection of capital would make a big difference.

The Chairman suggested that the difficulty is meeting the costs of running a standalone pool. It was necessary to look at the best outcomes; the Committee would promote hydrotherapy if there was the evidence for this.

Concerning input to the consultation, the Managing Director/Director of Public Health was supportive of both the Committee making a combined response and individuals making a response. Councillor Ruth Bennett highlighted that the consultation leaflet could get mixed up with other material through the letter box; she also suggested using Resident Associations.

It was indicated that the Sub-Committee would respond to the consultation with the response based on comments made in the process so far with the Sub-Committee.

Councillor Adams felt that there should be emphasis on responding online in view of the cost of consultation. Councillor Ruth Bennett also suggested having a link on the Council website. Councillor Jefferys suggested that reference be made to encouraging responses electronically.

In concluding, the Chairman thanked the Health representatives for attending.

RESOLVED that the Sub-Committee support the readiness of proposals for consultation subject to the consideration of comments made in discussion.

7 LONDON AMBULANCE SERVICE WAITING TIMES - PRESENTATION

A presentation was given by Tracy Pidgeon, Ambulance Operations Manager for A&E Operations Bromley, Beckenham and Forest Hill and David Gibson-Stark, Duty Station Officer at Bromley Ambulance Station. A copy of information handed to Committee Members and Co-opted Members is at **Appendix B.**

In addition to information in the handout, a number of comments were made by the Ambulance representatives including those summarised below.

- On standards for patient waiting times, Category A includes cases regarded as life threatening.

- The Category A standard (75% within eight minutes) is difficult to achieve as it also takes account of the call.

- Categories C1 and C2 are not cases for immediate response.

- Category C3 and C4 telephone assessments are within 60 minutes and 20 minutes respectively.

- On data related to Bromley Patient Waiting Times April 2011 – March 2012 (page 2 of handout), Category A19 cases relate to occasions where an ambulance backs up.

- The total demand from April 2011 to March 2012 at 35,588 relates to the Bromley, Beckenham and Forest Hill A&E Operations area.

- The illnesses categories at the top of page 3 of the handout represented the ten most frequent requiring an ambulance response.

- The Cardiac Arrest Survival Rate (London) is expected to be at 30% when new figures are published.

- Bromley figures concerning Patient Return of Spontaneous Circulation at 41% for April and 21% for May (i.e. people getting to hospital after a cardiac arrest) are good given the extent of Bromley's elderly population.

In discussion it was indicated that Bromley Town Centre to Kings College Hospital could take some 25 minutes on an emergency "blue light" journey.

Referring to the Urgent Care Network of which all LAS services were a part, the Director of Public Health indicated that work was ongoing with LAS services on alternative pathways outside of A&E e.g. taking patients to Urgent Treatment Centres. It was necessary for people to be taken to the right place.

In further discussion, it was confirmed to Councillor Catherine Rideout that a triage could be undertaken by telephone and if appropriate urgent assistance provided by motor cycle with ambulance backup.

In response to a question from Councillor Fookes, it was indicated that highest demand was at the weekend, peaking from Thursday to Friday. In response to a further question, it was indicated to Councillor Fookes that an independent analysis of demand is undertaken and a prediction made of where calls for an ambulance are most likely to be made. The location of ambulances would then be fixed according to the predicted demand. If a crew was unavailable, the next nearest crew is sent out. Depending on the location, this could be a crew from a neighbouring A&E Operations area such as Greenwich.

Concerning hoax calls, it was explained that some might dial the emergency number out of panic and others might dial the number through lack of education.

Councillor Ruth Bennett felt that the cardiac survival rate was impressive; she suggested that it showed that specialist service in hospital is the way forward.

In response to a question from Councillor Catherine Rideout, it was explained that out of hours demand has always been rising; some call 999 as it is easiest. There was a need for “vomit buses” in places such as Waterloo or Soho in central London. Croydon also has such a bus. But the ambulance service was not called out so much for such incidents in Bromley.

Concerning use of an air ambulance, it was explained that if a serious trauma is identified then an air ambulance can be despatched. A car is also available at night.

Traffic calming measures such as road humps caused a problem for the ambulance service and some damage; a number of ambulance vehicles were not set up to go straight over road humps. The ambulance service had a policy on traffic calming.

Councillor Jefferys enquired of the percentage of cases where an assessment made by an ambulance crew did not result in going to hospital. It was indicated to Members that this information was not conveyed and so it was difficult to provide an accurate response.

A further question was asked about any policy to indicate where ambulances should be sited. It was explained that historic data was looked at every three to six months. Cars were sited at locations where places could be reached quickly – they were not sited at ambulance stations as it would take longer to respond.

Angela Harris enquired whether the ambulance service was content about responding to calls involving falls. It was indicated that crews were happy to respond to such calls and check those suffering a fall. Every fall was reported and details referred on to GP services.

Angela Harris also enquired whether there was any problem where people did not want to be admitted. It was explained that there were sometimes difficulties with mental health patients. Sometimes there could also be confusion with calls and people not expecting an ambulance crew.

A question was also asked on whether assaults on ambulance staff continued to be a problem. It was confirmed that this was continuing on a fairly regular basis either verbally or physically. Police would also attend if shouting was heard during the telephone call. The London Ambulance Service had stab vests. Crews also carried out risk assessments. Training helped e.g. with breakaway techniques. It was open for the service to write to individuals where there were serious concerns – there were some addresses that ambulance crews would not attend without police assistance.

In conclusion the Chairman thanked the LAS representatives and commended the number of cases attended. The Chairman also commended LAS performance in the borough associated with a return of spontaneous circulation following heart attack. However, the Chairman remained

concerned that the emergency 999 number was viewed by some to be a short cut to services. She suggested that the matter could perhaps be looked at by commissioners and the effectiveness of the new non emergency number considered. She suggested that the matter be looked at by the Sub-Committee at a later date.

8 NHS QUALITY, INNOVATION, PRODUCTIVITY& PREVENTION (QIPP) PROGRAMME UPDATE

All NHS organisations are required to develop a Quality, Innovation, Productivity and Prevention (QIPP) Plan describing how major national drivers towards shifts in the settings of care, improved quality of care, and greater productivity would be delivered locally. For Bromley this enabled resources to be identified and released which could be reinvested in innovation and improved quality.

To inform development of its QIPP Plan, Bromley Clinical Commissioning had undertaken a review of its strategy for the coming three years - the process being informed by the Joint Strategic Needs Assessment (JSNA), Health and Well Being Board priorities, Health Outcomes, and local provider risks and opportunities. A vision and Integrated Plan for the organisation had been developed defining strategic goals and strategic objectives.

To implement the strategic objectives, the following programmes of work had been formed:

- Planned Care
- Urgent Care
- Primary Care
- Long Term Conditions
- Women & Children
- Mental Health
- Corporate

The strategic programmes included the schemes set out in the QIPP Plan.

The QIPP programme for the current year at £9.24m was mainly predicated upon the Clinical Commissioning Group's (CCG) ability to make contractual changes through activity shifts out of secondary care, moving care into the community where appropriate or through efficiency savings (e.g. reduction in follow up outpatient appointments). This presented the CCG's main challenge and effective management of its acute contracts in the current financial year would be one of its main priorities.

Additionally, a number of new initiatives had been identified which would deliver improvements in clinical quality across a range of pathways, along with improved efficiency, and shifting care closer to home for many patients.

Work continued with the CCG's planned care programmes on shifting activity to more community based settings – for example, in Dermatology, Gynaecology and Musculoskeletal – and other pathways continued to be identified through work with stakeholder groups.

Bromley CCG's QIPP programme also described longer term measures which would become deliverable throughout the planning period described in the Integrated Plan, and which would demonstrate real improvements in patient outcome measures for Bromley residents. Some of the longer term plans would include the more transformational programmes, such as the CCG's ProMISE programme (Proactive Management and Integrated Services for the Elderly) which, when fully rolled out across the Bromley area, would, it was anticipated, contribute to high level savings through avoiding unplanned admissions for vulnerable and elderly patients. By working with Bexley and Greenwich colleagues additional synergy could be created which would help deliver some of the more challenging aspects of QIPP in the medium to long term e.g. redesign of patient pathways into more community based settings and decommissioning activity from acute providers. The Bromley, Bexley and Greenwich (BBG) Programme Board would continue to own and develop larger transformational QIPP programmes, specifically in planned and urgent care, and for some schemes within Long Term Conditions and other programmes.

A table was provided in the Director's report showing the 2012/13 QIPP Plan with identified schemes, their 2012/13 values and a short description of each scheme.

In his introductory comments, the Director of Healthcare System Reform, Bromley CCG referred to a QIPP Plan being about quality as well as resources. Money was often spent to secure a benefit in future years and there was a focus to ensure that sufficient change was being delivered. Reference was also made to re-investing e.g. provision of community based stroke services, completing the process for stroke patients coming out of hospital.

Highlighting the Urgent Care Centre Scheme, the Director referred to taking pressure off Accident and Emergency and looking at how more patient care could be managed through the Urgent Care Centres (at the PRUH and Beckenham Beacon) pending full procurement of the service.

The Director highlighted the CCG's ProMISE programme where it was intended to work with patients having a history of hospital admissions and to consider how other services could help prevent such patients going to hospital. Leslie Marks asked whether it was intended that every practice join the ProMISE programme. The Director explained that all practices have some links; seven practices had been identified and explanation could be provided to colleagues in other practices about how the service worked. Councillor Adams felt that it would be interesting to know the number of people benefiting and the Director indicated that he was happy to come back on specific details.

Concerning the Anti-Coagulation Scheme and responding to Councillor Jefferys, the Director indicated that it was possible to have a number of providers and that a patient has choice in respect of where they would like to access a service. The Director indicated that patient choice is the driver behind QIPP. The Chairman highlighted that some patients would prefer an appointment near their place of work and hoped that the process would widen out available choices. Councillor Fookes referred to scope for more joint working. The Director indicated that the Anti-Coagulation Scheme was a good example of working together.

Concerning the Urgent Care Centre Scheme, it was felt that information on the Urgent Care Centres is not always clear – for example the Beckenham Urgent Care Centre (UCC) was not the same as the PRUH UCC. The age restriction for children that can be taken to the Beckenham UCC differed from the age restriction at the PRUH UCC. The Chairman felt that a simple guide was needed and suggested that this type of information could be added to the MyLife website (accessed via the Council website).

RESOLVED that the paper from the Director of Healthcare System Reform, Bromley CCG be noted.

9 SLHT UPDATE ON THE OUTSTANDING ISSUES.

In providing an update on outstanding issues, the Deputy Chief Executive of the South London Health Trust (SLHT) addressed the Sub-Committee.

She advised on matters related to the provision of patient medication and prescriptions. Concerning delays, it was hoped to be able to provide prescriptions/medications to patients on ward rounds. Reference was made to being clear on what is prescribed and getting this to the patient as soon as possible. Sometimes A&E would dispense what is prescribed on discharge. A dossit box could take some time and for people such as the elderly, it was quite a prescriptive and complex process. The Deputy Chief Executive was comfortable that progress was being made although there was further work to be done.

A question was asked on the extent to which the Discharge Lounge was used by patients. It was indicated that the Lounge was a location where a patient could stay whilst waiting for an ambulance. It was a comfortable place to be and a bed was not being blocked. It was confirmed that the Lounge was not operative overnight. It was further explained that if a family provided a private car for transport, the patient could leave directly from the ward.

Concerning eye care, reference was made to implementing the largest NHS programme for change. Timescales were outlined for moving to the new system and receiving its full benefit.

Brief comments were also provided on matters associated with the SLHT's financial position and an anticipated announcement the next day that the Secretary of State for Health will have decided to put the Trust into administration. Members were advised that pressures for the Trust were around its financial position and not around the quality of service - infection control rates were three times less than the national average. Councillor Ruth Bennett suggested that the Sub-Committee hold a special meeting to consider the Trust.

In closing, the Chairman thanked the Deputy Chief Executive.

APPENDIX A

Please refer to attached pack.

APPENDIX B

Please refer to attached pack.

The Meeting ended at 6.21 pm

Chairman

Consultation on improvements to how health services are delivered in the Orpington area...

Better Health, Better Care, Better Value

Providing the right care in the right places:

Keeping services as they are is not an option

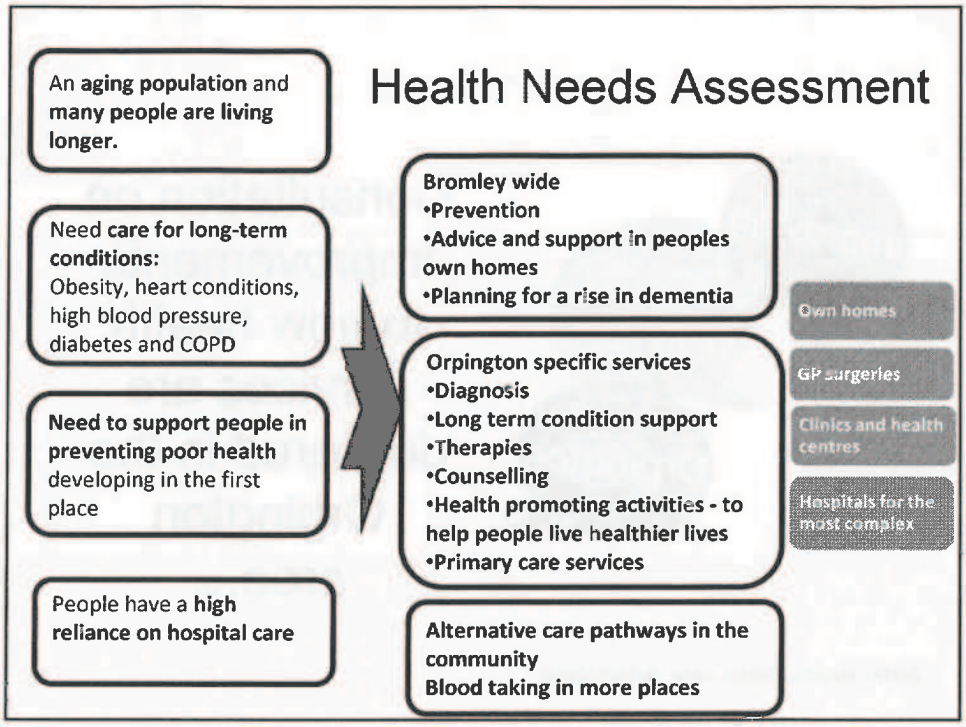
We need to provide the right kinds of healthcare in the best places, so people can live longer and healthier lives

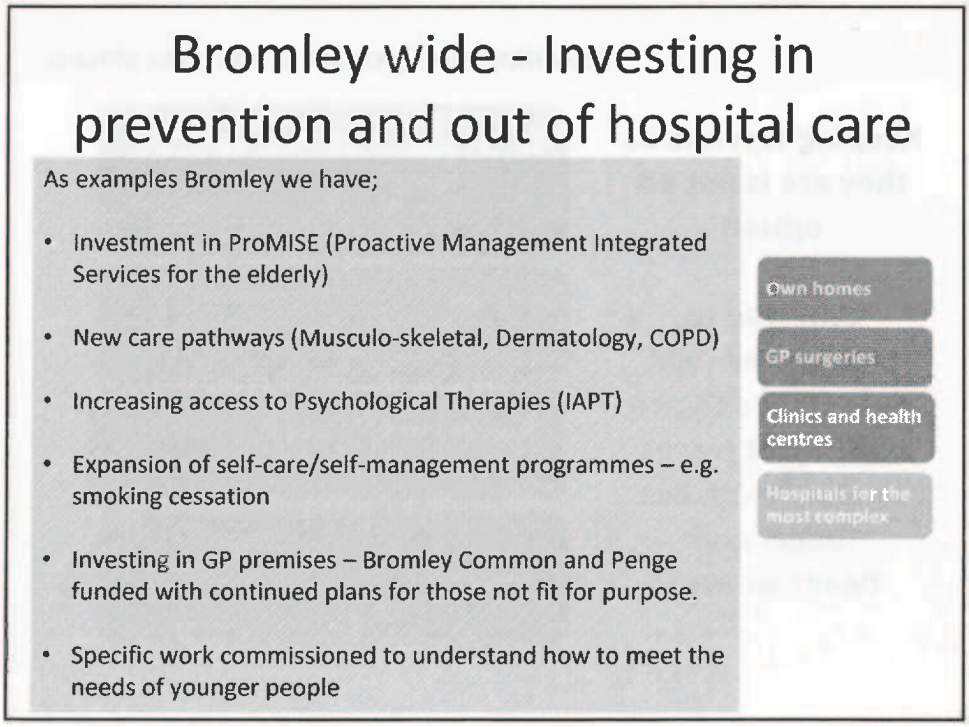
People's **own homes**, for rehabilitation, expert advice to manage your health and nursing care for housebound people

GP surgeries for family healthcare, regular check-ups and non-emergency health concerns

Clinics and health centres for ongoing healthcare tests, and wellbeing services

Hospitals for the most complex health needs and emergencies (alongside urgent care centres)


Health Needs Assessment
An aging population and many people are living longer.
Need care for long-term conditions: Obesity, heart conditions, high blood pressure, diabetes and COPD
Need to support people in preventing poor health developing in the first place
People have a high reliance on hospital care
Bromley wide
•Prevention
•Advice and support in peoples own homes
•Planning for a rise in dementia
Orpington specific services
•Diagnosis
•Long term condition support
•Therapies
•Counselling
•Health promoting activities - to help people live healthier lives
•Primary care services
Alternative care pathways in the community
Blood taking in more places
Own homes
GP surgeries
Clinics and health centres
Hospitals for the most complex


Bromley wide - Investing in prevention and out of hospital care
As examples Bromley we have;
• Investment in ProMISE (Proactive Management Integrated Services for the elderly)
• New care pathways (Musculo-skeletal, Dermatology, COPD)
• Increasing access to Psychological Therapies (IAPT)
• Expansion of self-care/self-management programmes – e.g. smoking cessation
• Investing in GP premises – Bromley Common and Penge funded with continued plans for those not fit for purpose.
• Specific work commissioned to understand how to meet the needs of younger people
Own homes
GP surgeries
Clinics and health centres
Hospitals for the most complex

Meeting Orpington residents health needs

Own homes

GP surgeries

Clinics and health centres

Orpington GP Practices

GP surgeries

- Move 3 GP practices - improving their facilities so they offer:
  - A wider range of services
  - Full accessibility for disabled people
  - Appropriate space for patient care
  - Improved patient experience.
- The Practices are Tubbenden Lane, Knoll Rise and Sevenoaks Road Surgeries (latter two merged on 1st July to be Knoll Practice).
- Potential for space available for all GP practices to use.

Community Health & Wellbeing Centre

Offers a comprehensive range of services and one-stop approach:

- Diabetes clinics
- Blood testing, x-rays and ultrasound
- Space for all Practices to use
- 3 x GP Practices requiring improved clinical space
- Physiotherapy (MSK/acute)
- Contraception services and colposcopy (non complex)
- Health promoting activities, voluntary sector advice
- Admission avoidance approaches.

Local Health Centre

Local Health Centre with the following services provided onsite:

- Diabetes clinics
- Blood testing
- Care for people with COPD
- 3 x GP Practices requiring improved clinical space
- Contraception services

Other services delivered from Hospital sites (Princess Royal mostly, Queen Mary's Sidcup) or Beckenham Beacon and dispersed through a mix of primary care, community and hospital services.

What's the difference between the two proposals and services currently offered at Orpington Hospital?

Both proposals offer local people all of the essential health services needed in the area.

However, the Community Health & Wellbeing Centre aims to bring many more out-of-hospital services together under one roof.

Must consult on the service shape BEFORE we can secure a location as otherwise pre-emptive - we have viable options.

Meeting Bromley residents needs for specialist healthcare

Under both proposals...

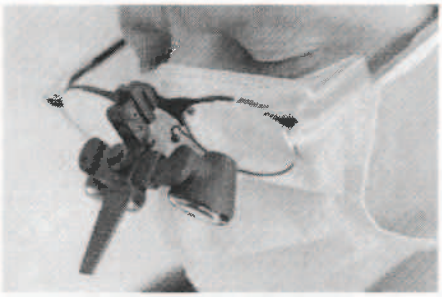
- Moving **hospital outpatient clinics from Orpington** Hospital to the PRUH, QMS or Beckenham Beacon
- Creating a specialist **Dermatology 'centre of excellence' at QMS** to deal with more complex skin conditions
- Moving **hydrotherapy to a range of suitable sites** (e.g. QMS, Phoenix Centre)
- Delivering more Intermediate Care in the community and reducing the number of **intermediate care beds from 62 to 42** to take account of this.

Outpatient Services

- **The hospital lacks all of the right equipment so some patients have to go to different places for the variety of tests and services they need.**
- **Specialists can't collaborate as they aren't co-located.**
- **Some services can now be offered outside of the hospital (e.g. community dermatology).**

- Better equipment (max-fax and colposcopy).
- More dignified setting – inadequate curtains and rooms not fit for purpose (colposcopy and max-fax).
- Need a hospital pharmacy on site so you can get the particular drugs (rheumatology).
- Less wasted trips for extra tests – Cardiology and max fax.
- Doctor, nurses and other clinicians making better use of their time.

Dermatology



WHY CHANGE??

- Only more complex cases need hospital-based care.
- Current hospital based service cannot offer all of the modern treatments needed.

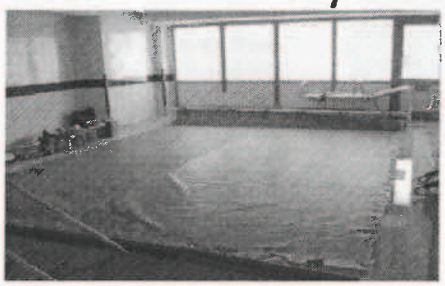
- **Creating a Centre of Excellence - pooling of nurse specialists and development of specialist services (currently goes to London).**
- **Rooms do not offer adequate theatre space and day treatment which is increasing.**
- **Cannot provide privacy and dignity or same sex accommodation.**
- **Clinic rooms cannot allow escorts, pushchairs, wheel chairs or teaching.**
- **60% of new referrals can use local community clinic provision.**

Intermediate Care

Patient Episodes 10/11

- As a result of improvements in community services – a large number of beds are no longer needed.
- 84.8% of users surveyed between Feb-Apr 2012 told us they preferred to be looked after at home.
- For those that do require bed-based care, a better environment is required to support privacy and dignity and infection control.

Hydrotherapy

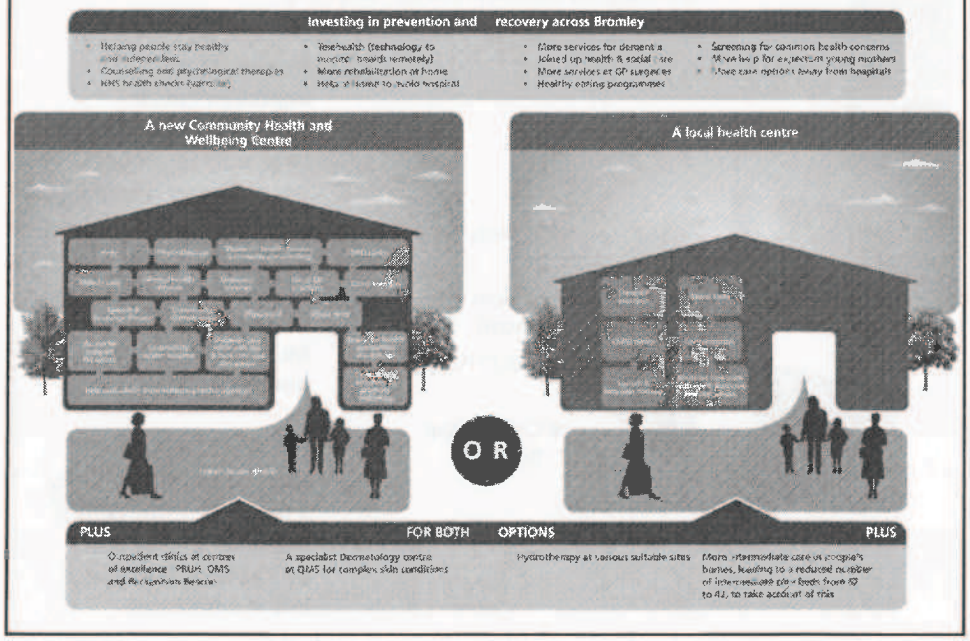


Why change:

- More physios are offering non-hospital clinics.
- Less people are using local hydrotherapy pools.
- Research evidence has shown that using land-based therapies have equally good recovery from their condition.

- There are alternative NHS sites (e.g. Queen Mary's and Phoenix Centre).
- Hydrotherapy will continue to be offered to patients where recommended by their physiotherapist.
- We will be working with learning disability users to offer individual solutions to ensure their needs continue to be met.

Our Proposals



Why not use the hospital?

- Must reshape the services - need less than 1/4 of the hospital space
- Refurbishment costs over £7 million
- There would be two floors of unutilised space
- Lease costs of vacant space unattractive
- SLHT has no access to capital to undertake refurbishment – expect the business case to fail
- £388k p.a. (Commissioning funds) needed above current level of funding to house services in Orpington Hospital.

Transport Implications for Outpatient Changes

- **PRUH – benefit for all transport users**
  - Parking is a known issue
  - Shorter journey for 78-81% of people using private transport and broadly neutral impact for public transport.
- **QMS – there are winners and losers; we need to understand more about anyone badly affected**
  - Average 8 minute increase
  - Greatest increase for private transport is 16 minutes and for public transport its 38 minutes.

Transport Implications for Community Health and Wellbeing Centre/ Local Health Centre Proposals

Viable site solutions include:

- Accessible High Street location in a new or existing building, OR
- Rebuilding a suitable sized facility on the Orpington Hospital site.
  - **Orpington High Street** – greatest number benefit from shorter journey times; plus more public transport and parking
  - **Orpington Hospital Site** – GP practice populations would be slightly affected (0.6 – 1.2 miles from current surgery location).

Exploration continues and will secure approval on the capital business case once the service model is agreed following consultation.

How to provide feedback – *when live*

- Read the full consultation document and complete the questionnaire in print or online
- Consultation period - 16 July to 29 October 2012
- Feedback received and evaluated independently by Opinion Leader
- Report to be shared publicly
- Bromley Local Clinical Commissioning Committee (LCCC) to consider implications and make recommendations to PCT board on 29 Nov 2012.

NHS Bromley

www.selondon.nhs.uk/orpingtonconsultation

From 16th July 2012

South London Healthcare NHS Trust

Bromley Healthcare better together

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Appendix B

Bromley Scrutiny Committee

11th July 2012

Who are we?

- Busiest ambulance service in the UK
- 1.6 million 999 calls last year
- More than 4,500 staff
- Just over 800 vehicles
- National ambulance demand is increasing by 6-7% per year

Call Categories

- Immediately life-threatening
- Not immediately life-threatening

Standards for patients waiting times

- Call connect: answering 999 calls within 5 seconds
- Cat A: 75% within 8 mins
  95% within 19 mins (transport)
- Cat C1: 93% within 20mins
- Cat C2: 93% within 30mins
- Cat C3 and 4: Telephone assessments (within 20 and 60 minutes)

Bromley Demand

	Cat A incidents	Cat A incidents one year ago	% difference
April 2012	1293	1138	13.62%
May 2012	1377	1117	23.28%
June 2012	1346	1108	Month

Bromley Patient Waiting Times

April 2011 – March 2012

	CAT A	CAT A 19	C1	C2
Bromley	**75.30**	**99.33**	**81.05**	**81.73**
LAS	**75.74**	**99.15**	**80.65**	**82.22**
Demand	**14988**		**1715**	**7947**

Additional demand – C1/ 3577 calls and C2 / 7361

Total demand –April 2011 – Mar 2012 = 35,588

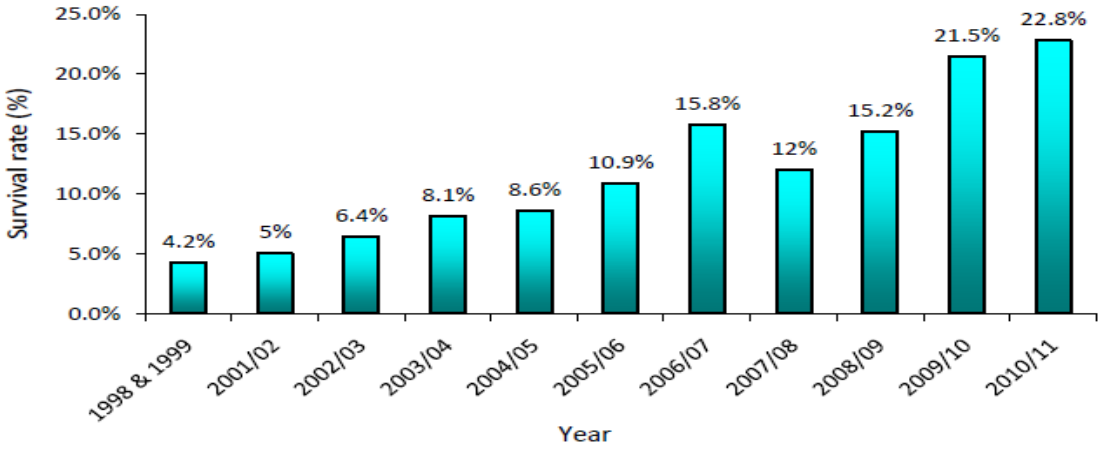
This year currently running at 76.4

Top 10 illness by PCT

Illness type	Bromley		
	Other medical conditions	824	11.5%
	Pain - Other	638	8.9%
	Abdominal pains	519	7.3%
	Generally unwell	483	6.8%
	Pain - Chest	446	6.2%
	No injury or illness	417	5.8%
	Dyspnoea	388	5.4%
	Head injury (minor)	349	4.9%
	Vomiting	307	4.3%
	Fracture/possible fracture	283	4.0%

Heart Attacks

- LAS have been bypassing A&E to convey STEMI patients to specialist cardiac centres since 2006
- Improved patient outcomes
    - Reduced length of stay
    - Reduction in occurrence of heart attacks
    - Reduced risk of stroke & major bleeding
    - Reduced incidence of death
- Associated long term cost saving



Cardiac Arrest Survival rate (London)

Bromley – Patient return of Spontaneous circulation – April 41% / May 21%

Tracy Pidgeon - Ambulance Operations Manager Bromley

David Gibson-Stark – Duty Station Officer Bromley