Adult and Community PDS Committee 2nd November 2010

Questions from Ms Jean Stout, Chairman, Community Care Protection Group

1. **The rationale stated in para.1 of this report for the proposal to halve the Orpington Hospital IC beds is 'the recent reviews of ICS'.**

   Please list:-
   (a) These 'reviews' with author and date;
   (b) The evidence of reduced need supporting this reduction in bed numbers.

   Reply

   (a) The reviews are:

   Acute Bed Utilisation and Capacity of Care Nearer to Home in Bromley – Report of Findings, The Balance of Care Group, 2008.

   The Care Quality Commission (CQC) Annual Performance Assessment for 2008/09 (Outcome 1 – Improved health and well-being) which confirms Bromley's comparative performance against other local authorities and CQC's views on the focus of intermediate care services within Bromley.

   (b) The evidence is provided in the above documents.
   The Bed Utilisation survey showed that at the point of admission, 35% of those admitted to Orpington might have received their care in their own home. This compared to just 5% of those admitted to Elmwood.

   The survey also showed that on the day of care, 70% of service users at Orpington could have received their care in their own home. The comparative figure for Elmwood was 47%. Overall 62% of people within Intermediate care beds on the day of the survey were assessed as suitable to receive intermediate care within their own home.

2. **Bromley PCT controls admission of patients to the ICS, whether home or bed-based, and the PACE Service. ICS was designated to provide intervention to avoid admission to Acute services, as well as rehabilitation and recovery after Acute Care.**

   Why have more patients not been referred to avoid Acute admissions?

   Reply

   Admission to the Intermediate Care service is managed by mangers within the Intermediate Care Service, one of whom is a PCT employee and the other an LBB ACS manager. Admissions are subject to service users meeting PCT/LBB agreed criteria.

When Intermediate Care services were introduced there was an emphasis on supporting earlier discharge from acute care. Over time Intermediate care has also been seen as useful in providing an intervention that can avoid the need for an acute admission. The balance between admission avoidance and supporting discharge is constantly kept under review and over the last 3 years there has been an increase in the numbers referred to avoid hospital admissions. There was also a significant increase in 2009/10 in the number of people being referred to community based intermediate care supported by the introduction of the PACE service.

3. **The 'Bed Utilisation Survey' took place over l July day. These results are not a reliable indicator of long-term needs during pressurised periods. BPCT controls the admissions and length of stay of patients in the Unit.**

   Why did they admit and retain patients who did not need the service?

   Reply

   The survey does not identify significant numbers of patients who did not need the service at all. Rather, it identifies patients who could have received their service in potential alternative care settings - whether they were currently available or not – instead of residential care settings such as Orpington hospital.

Questions from Ms Susan Sulis Secretary, Community Care Protection Group

1. **Bed-based IC is essential for those patients who lack the home environment, facilities, or support to enable them to undergo rehabilitation.**

   Are members satisfied that the results of the Bed Utilisation Survey over 1 day in summer provides adequate evidence of a permanent major reduction in need?

   Reply

   The report does not state that there will be a major reduction in need for Intermediate Care services, but that by further developing and investing in community based intermediate care services, there is a need for fewer intermediate care beds in the whole system. The findings from the Bed Utilisation Survey provide the evidence for this and the CQC Annual Performance Assessment for 2008/09 (Outcome 1 – Improved health and well-being) confirms Bromley's comparative performance against other local authorities.

2. **The provision of IC beds has enabled Bromley hospitals to reduce A&E waits and large-scale cancellation of elective surgery.**

   With cuts of 25% predicted, are Members confident that closure of 20 NHS IC beds will not risk additional costs for ACS at a time when services are under enormous pressure?

   Reply

   The proposals identified in the report will continue to contribute to the reduction in demand for hospital beds by avoiding admissions where possible. The proposed reduction in the number of intermediate care beds will enable additional investment in community based services to allow for any increase in demand for these services.

   In the challenging financial circumstances that we face in the coming years it will be even more important that the maximum benefit is being achieved for service users from investments in services such as intermediate care.

3. **Will Members ask for a detailed report with supporting data and future demographic trends, to ensure that a reduction in bed-based IC does not impact adversely on patient care, and contribute to greater pressure and costs for the ACS Homecare Service?**

   Reply

   Members will expect robust performance monitoring of the reconfigured intermediate care services, including a detailed evaluation of the service and its impacts after 6 months to be presented to the Policy Development and Scrutiny Committee.

Questions from Mr David Mott

Is this Committee aware that elderly patients admitted to PRUH and QEH may be transferred post surgery to QMS if there are bed capacity issues and that there will be no Critical Care Unit at QMS just Critical Care Support?

Reply

Thank you for your question. The Committee is interested in the issues that you have raised and as you know we have asked the Trust to come to the next meeting on 25th January 2011 to provide a health care update, including any issues in relation to post operative care.

Supplementary Question:

You state in an email sent to me on 29th October that the duty of the Trust is to notify this Committee of any service changes they intend to make and that it has fulfilled its duties regarding this.

Can you explain why this Committee was not informed during the verbal update given by the Trust representative at the last PDS meeting of imminent proposed service changes – the closure of A&E and Maternity at Queen Mary's the day after the PDS meeting – this would impact on Bromley patients – medically fit patients would be moved to Queen Mary's from 26th October and Ortho-Geriatrics from 27th October.

The Chairman responded that it was unfortunate that the date of the press release was the day after the last meeting (22nd September 2010). The Trust had informed the Committee of the proposed changes via the press release that had been issued. The chairman highlighted that the Trust did not have to inform the Committee before it publically issued information. The Committee regularly received press releases and could also received briefings from the Trust as and when necessary.

APoH consultation states that Elective Surgery be transferred to QMS in order to separate Planned and Emergency surgery thereby negating cross infection and yet we are now told that only non-complex cases will be dealt with at QMS – can the Committee tell the public how this complies with APoH ?

Reply

Thank you for your question as you know the Committee is interested in the issues that you have raised and has asked the Trust to report on any service implications in relation to post operative care at the next meeting on 25th January 2011. The Health Care Working Group raised these issues with the Trust at its last meeting on 28th October 2010 and Ms Jennie Hall agreed to provide a report to this Committee in January 2011 when she next attends.

Supplementary Question:

In a question I asked at the 27th July PDS meeting you stated that Ms Jennie Hall, Director of Nursing, attends every Committee meeting and has made herself available to respond to any issues that may arise that do not form part of the published agenda. I was informed on 29th October that Ms Hall would not be attending again until January 2011. Can the committee tell me why the answer you gave me has now changed – I also understand that the Chief Executive of the Trust is obliged to attend at least twice a year – can you tell me how many times he has attended during the last year please?

The Chairman confirmed that the Chief Executive had not attended a Committee meeting this year but that he had delegated this duty to Ms Jennie Hall. The Chairman agreed that it was important to hear from the Chief

Executive, especially as a number of health issues had emerged. The Chairman explained that as there was not a health based issue on the Committees agenda for this meeting Ms Hall had not attended.

Will this Committee ensure that the Trust guarantees that beds in the Stroke Unit are 'ring-fenced' solely for Stroke patients and that if there is a capacity crisis and there are available beds on the Stroke Unit they will not be used for emergency or planned admissions, barring, understandably, a major incident?

Reply
Thank you for your question as you know the Committee is interested in the issues that you have raised and has asked the Trust to report on any service implications in relation to stroke care at the next meeting on 25th January 2011.

As previously stated as the Committee has no powers to instruct the Trust as to the way in which they chose to deliver services all your questions have been passed to the Trust for them to respond directly to you.

Supplementary Question:

Your email of 29th October states that the remit of this Committee is to hear from the Trust about service implications arising from APoH in relation to post-operative and stroke care. My understanding of the Health and Social Care Act 2001 is that this Committee has much wider powers. Could you please explain to me what these powers are?

The Chairman responded that the Committee's main health scrutiny powers were

- *To review and scrutinise the planning, provision and operation of health services in the area*
- *To require officers of local NHS bodies to attend meetings and answer questions*
- *To make reports and recommendations to local NHS bodies and expect a response within 28 days*
- *To set up joint health scrutiny committees with other local authorities and delegate powers to another local authority*

Government guidance stated that:

"It is not the role of committees to performance manage the NHS. Other organisations exist to perform this role."

If there was another body set up to deal with formal complaints the committee should not look to duplicate that role and again should not get involved in the day to day activities.

The chairman clarified that APOH was an area that the Committee reviewed but the Health Scrutiny Powers were not limited to this as Health Scrutiny had been in existence for longer than the APOH proposals.

Questions from Mr Tom Williams

SLHT is outsourcing to four private providers - we now know that the Rapid Surgical contract was not subject to competitive tendering- were the other three provider contracts subject to competitive tendering?

Reply

SLHT have not been scheduled to attend this as Ms Hall provided an update to the Committee at its last meeting on 21st September and is due to attend the next meeting on 25th January 2011.

The question has been passed directly to the Trust for them to respond directly to you. SLHT have agreed to outline to the Committee the response that is sent to you at the next meeting on 25th January 2011.