healthwatch Redbridge

Care Closer to Home

Integrated Care in Redbridge

October 2014

Introduction

In December 2013 Healthwatch Redbridge released a report regarding Integrated Care in Redbridge which suggested the following follow ups need to be looked at :-

- Ensure the services are publicised and promoted appropriately
- Ensure adequate levels of staffing are maintained as the service becomes more popular
- Ensure continuity of care for users
- Users must not be left without appropriate support at the end of the service
- Review the pilot and provide updates to interested organisations and individuals

Figure 1 People listen intently as the proposals are explain

A consultation document was produced before the extension regarding the proposed changes to intermediate care by the Barking and Dagenham, Havering and Redbridge Clinical Commissions Groups

Trials of the proposed changes were implicated by the CCG to make sure that the health and social care system is 'future proof' and that there is a system that will care better for people now and can also care for more people in years to come.

Following the trial the consultation deadline was extended from the 1st of October 2014 to the 15th of October 2014. This was due to concerns that many people had about the proposal.

The CCG came up with five options that were possible for the future of intermediate care.

-Option One. Stay as they are now:

Community Treatment Team (CTT) and Intensive Rehabilitation Services (IRS) - Same number of beds (104) - beds on three sites

-Option Two. Go back to before the trial:

No CTT in Redbridge and reduce CTT hours in Barking and Dagenham and Havering - same number of beds (104) - beds on three sites

-Option Three. New services and three sites:

CTT and IRS - fewer beds (41-61) - beds on three sites

-Option Four. New services and two sites:

CTT and IRS - fewer beds (41-61) - beds on two sites

-Option Five. New services on one site:

CTT and IRS - fewer beds (41-61) - beds on one site at King George Hospital

The CCG made it clear that they favoured option five.

Method

- A consultation was held at Wanstead Library on the 13th of October 2014 to discuss these proposed changes.
- Everyone was invited to this consultation, including patients, carers, councillors and general members of the public.
- Tara-Lee Baohm (Deputy Director and Strategic Deliverer for the BHR CCGs) and Carol White (Deputy Director, Integrated Care, NELFT) were invited along to the consultation.
- Tara-Lee Baohm then spoke on behalf of the CCG about the proposed changes to intermediate care.

Figure 2 Tara-Lee Baohm explains the proposals

- Following this presentation, the floor was then opened for questions and comments to be answered and received by Tara-Lee and Carol (these questions, comments and answered can be seen in the following section).
- This was then followed by a presentation which included questions from the questionnaire given by the CCG regarding the intermediate care
- Healthwatch Redbridge added a choice six to the power point which was "none of the above, but look at other options"
- Comments were then given from the floor regarding their answers and their worries about the questioning itself.

Questions and Comments

The following is a summary of the questions/comments from the floor and responses given.

Question (Q) 1. CCG claim there was good transport in the area, this is disputed by those who have to use it.

Answer (A) 1. If the proposed changes were to go ahead, we take into considering that we would have to have talks with TFL.

Q2. How much consultation has taken place?

A2. Barts has submitted a formal response to CCG supporting the proposals.

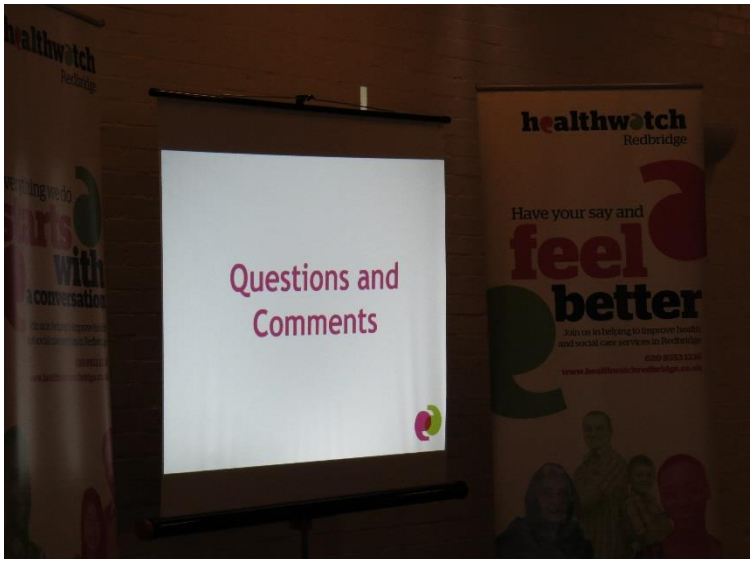

Figure 3 The Powerpoint used as a tool to spark discussion

Q3. (Councillor Cummins) How will home care be provided out of hours?

A3. General Practitioners (GPs) have said it will be considered as emergency care, the London Ambulance Service (LAS) will have to intervene.

Q4. What if a user needs help with extensive soiling in the middle of the night? Particularly if there were no beds available.

A4. As this is not a health crisis but a care crisis and therefore a social care issue, the user will have to contact the out of hours service, it will have been assessed and be part of the care package.
Beds have always been available at Heronwood and Galleon Wards.

Q5. It is understood that patients can no longer self-refer.

A5. CCG encourages self-referral and the assertion about self-referrals no longer being available is wrong.

Q6. (Vivian Nathan) the transport to King George Hospital (KGH) from the Wanstead area is nigh on impossible, the 396 bus from Ilford is every 40 minutes.

A6. Again, the CCG have noted that a conversation with TFL is needed to arrange for a bus to travel from Wanstead to KGH.

Q7. CCGs and their roles are not well understood, even by GPs, further GPs are not sufficiently familiar with entitlements to make appropriate referrals.

Figure 4 A question being asked by a local resident

A7. CCGs are not responsible for GP services, that is for NHS England. There are strict standards that are monitored.

Q8. 98% of ordinary people and GPs included are not aware of the exact role of CCGs.

A8. There are representative GPs on CCG associated boards.

Q9. I was admitted to Royal London for hip surgery after which I needed rehab but told there were no beds available, however because I could not be discharged was admitted to Whipps and never found more than 17 beds out of 24 occupied.

A9. If a patient needs a rehab bed, it will be available.

Q10. If one is bed bound due to illness or surgery, how does one go to the toilet in the middle of the night?

A10. That will be a matter concerning the assessment of the care plan.

Q11. A well-known case of a patient who had to be readmitted to Whipps Cross from rehab was told that there was no bed.

A11. An investigation found this not to be true. (The answer was challenged by a number of attendees).

Q12. This consultation is not well known as even the Clinical director in Waltham Forest appeared to be aware of it. There was great difficulty I discharging from acute wards – a closed ward had to be re-opened.

A12. Cannot comment for Waltham Forest but NELFT was closely monitored.

Q13. What modelling of future transport and staffing was undertaken? What will it look like in the future after 5 years with an ageing population? What contingency plans are there if more than 61 beds are needed?

Figure 5 Healthwatch's Lorraine Silver asks a question

A13. The (Windsor) Review suggests 1 nurse to 6-8 patients but this is not obligatory or agreed yet. We have Advanced Nurse Practitioners and a range of professional mix teams totalling 80 staff and their use depends on need.

Q14. The winter pressures means a higher bed uptake, how will CCG cope?

A14. I hope to make sure there are enough beds.

Q15. This is not consultation but a presentation. It is not about patient care but an exercise in saving money by closing wards.

A15. CCG does not own NHS Estates, we are just commissioners. (This was not believed by attendees).

Q16. (Sally Edwards) As a carer I want to know if you have altered the criteria for admissions as the population profile is changing? It feels as if you have changed the criteria to ration services.

A16. The criteria has not changed, this is evidenced by more people using rehab.

Q17. You are prematurely cutting beds because we have had a mild winter. Redbridge Intermediate Care Service (RICS) not mentioned in the consultation document, how does it dovetail?

A17. This is a short sharp intervention and patients will be referred on to RICS. Have new model to increase beds/services by 5-10%. The increase is because of the ageing population and equate to 2 extra beds.

Q18. Not heard about this consultation until about two weeks ago – you are not consulting but telling us.

Q19. How did you come to the conclusion that reducing beds was seen as a positive choice by patients?

Figure 6 Attendees listen on to the answers being given

A19. Councillor Wes Streeting has been reported to have said that it was okay to point out what CCG's preferred option was but no decision has been undertaken as yet. We carry out exit questionnaires of patients being discharged that ask where they would like to be cared for and care in the home is preferred.

REGISTERED SPEAKER

Registered speaker Helen Zammet from Wanstead and Snaresbrook Residents Association (WASRA) delivered a prepared statement from WASRA members, it reads:

We welcome the development of the two teams but do not believe that the work of these two teams can compensate for the loss of 40 – 60 beds. The lack of beds is the heart of our rejection.

Figure 7 Helen Zammet gives her speech

In spite of what the RCCG says, we are not over provided for with intermediate care beds. The 2013 National Audit of Intermediate Care says that 26.3 beds ought to be provided per 100,000 people, which means that the 700,000 people who live in Redbridge, Barking and Dagenham and Havering, need 184 beds. (The full speech can be seen at the end of the report)

A show of hands indicated that no one supported the reduction in beds from the present levels.

Q20. What will happen to Whipps Cross patients needing medical attention for long term who upon discharge need intermediate care but then require medical attention again if the proposal to centralise intermediate care at KGH?

A20. They will go to Foxglove ward at KGH but final details have not been worked out yet.

Q21. Did the modelling take into account closed beds?

A21. Bed modelling took into account closed wards and empty beds.

Q22. There is evidence that people are often told that beds are not available. This could be to justify cuts.

A22. Will look at the matter outside the meeting.

Q23. Where will norovirus patients be sent as KGH wards are not norovirus wards?

A23. Will take advice when required.

Q24. Have GPs been consulted over Option 5 proposals? What awareness of it do they have of the proposals?

A24. Yes, all GPs have been consulted and PPGs too. There are GPs on various CCG associated bodies.

COMMENTS
Comments on the questionnaire.

Question 1

"The NHS should permanently run the new home based services that have been trialled (the community treatment teams and the intensive rehabilitation service) because they help people to get better more quickly and to stay independent."

Comment (c) 1. It is a statement, therefore the question is irrelevant as everyone agrees the existing services should continue.

C2. It seems the proposals have not looked further than 5 years as it is envisaged that needs are going to rise exponentially with an ageing population.

Figure 8 Another attendee gives his comment

C3. The two statements ask for a single reply, this may not be possible if respondents agree with one statement but disagree with the other.

C4. The title is misleading, it gives the impression that more resources are going in.

C5. There is a clear need for an independent review of the service.

Question 2

"The NHS should reduce the numbers of community rehabilitation beds if it can be shown that they are not used and are not needed."

C6. Have no doubt that figures will be massaged to justify the outcome – how are the figures arrived at?

C7. What is worrying is that no account seems to have been taken of different circumstances, such as the weather, particularly the winter.

C8. Foxglove ward alone will not be able to cope with a crisis.

C9. It is easy to close wards/beds, much more difficult to reopen.

C10. A major incident situation scenario has not been taken into account.

C11. If Heronwood and Galleon wards are inflexible to care for people's needs now, it will become difficult for those discharged to cope.

Response to comment 11. Care plans for rehab ought to take care of this and there is an offer of STEP UP which is part of the Safe Discharge Policy. (This was disputed by attendees).

C12. This is like saying if we shut Wanstead Station for a month, we can prove we don't need Wanstead Station after a month.

Figure 9 An attendee gives her comment on the proposals

Question 3.

"The NHS should reduce the number of community rehabilitation units because this is the best way to provide high quality, safe care."

C13. The two statements do not go together, same as for Q1.

C14. The statement is wrong, it is a total misnomer.
C15. The proposals are based on presumptions that better care can be delivered centrally.

A show of hands indicated that no one thought this was to include a reduction in the number of beds.

THE OPTIONS SUMMARISED.

C16. Have problems with the questions set, they are poorly formulated. What does 'where possible' mean?

C17. What is the difference between Options 1 and 3?
A17 (Offered by HWR) – the difference is:

Option 1 - Stay as they are with 104 beds.
Option 3 – Reduce to 40-61 beds.

Figure 10 Attendees look on as another question is asked

C18. How will people get to KGH from Snaresbrook by public transport?
A18. Will take the concern on board.

C19. All questions are Double questions, Ambiguous or Leading – these are three basic rules taught at elementary sociology to avoid as they are bad practice.

C20. It is felt that the GP leads on various boards are not representative of their colleagues.

C21. (Councillor Littlewood) Should start the consultation process again from scratch.

C22. The bus services to KGH are very poor from many parts of the catchment area – say Woodford.

C23. ReconfiguratioPanel should be called in to look at the CCG proposals.

C24. There is a huge bed shortage at present, before the proposals – nowhere to admit people to. NELFT and BRHUT should work together.

C25. Option 1 is not a real option. There is an election coming up and all political parties are promising more money for the NHS, so CCG's response earlier mentioning affordability should not be a factor.
A25. Everyone (including CCG) agreed QIPP has become jargon for cuts.

C26. Proposals should be in addition to and not in place of existing services.

C27. Should there not be a rolling programme of mothballing to allow future flexibility?

Response to comment 27. Mothballing still incurs some costs and quoted Health & Safety reasons not mothballing for some ward closures where there was insufficient uptake of beds. Also said CCG will spot purchase additional beds if need arose.

C28. CCG should extend the trials for a further six months to gain the lost trust.

C29. Bureaucrats will do what they have made their minds up to do.

Figure 11 Attendees look on as more questions are answered

C30. Failure of the system because of placing psychiatric patients in the community without adequate infrastructure to support them there.

C31. Where are the MPs and Councillors?

A31. (HWR) there are three Councillors present. Mike Gapes MP sent apologies due to Parliamentary business. No reply received to invite from Lee Scott MP. It was agreed by HWR and Councillors present that the matters being discussed are not and should not be politicised.

C32. What will happen to the comments being made at this meeting?

A32. (HWR) they will be sent to CCG by Wednesday 15 October 2014. CCG then confirmed that all feedback received during the consultation period will be reported at the Business Case meeting in mid-December 2014.

C33. There is a need for more consultation with GPs. If the exercise is not about saving money then why is it being discussed in the context of 'business case'?

Recommendations

-If there are any more consultations about the document these need to be advertised to the public better and more clearly to patients, councillors, carers and service users etc.

-In regards to the consultation document

- A better explanation of who was involved in the decision making who lead in July was needed
- A better explanation as to how the decision was made
- The business plan strategy needed to be made aware of as some of the document was based on this strategy
- A strategic plan consulting around the staff needed to

Figure 12 A full room attended the event and braved the poor weather

be arranged as it is suggested that Heronwood/Galleon are currently showing low staffing levels
- The consultation document needed to be reworded so that readers felt they were being told of a suggestion rather than an outcome already
- Better strategy if more beds are needed following the proposals
- There needs to be thought as to integrated services, so that patients can receive care after the set times.

-The Questionnaire needs to be redesigned. There were too many misleading and bias statements included in the questionnaire. There were also double questions which is against good practice in regards to questionnaires.

-Whilst there have been good reactions to the trial period, the implications of said period need to be drawn out which would result in the trial period being extended.

- Using the anecdotal evidence gained from the consultation, the relationship between the CCG and GPs needs to be stronger as GPs feel less empowered, with some not agreeing with the proposed changes.

-If these services were moved to King George Hospital, communication with TFL must be held to make it easier for people from Wanstead and surrounding to be able to get to the hospital via public transport.

Conclusion

Healthwatch Redbridge seeks a meeting with the CCG to clarify issues of the following:-

-The evidential case of the reduction of beds

-The evidential case of needing a centre of excellence

-The evidential case of why Heronwood and Gallions ward were shut down before the results of the consultation

Healthwatch Redbridge believes that the CCG have failed in the eyes of the public to discover the way to gain the patients trust.

TALK TO HEALTHWATCH ON INTERMEDIATE CARE

ON BEHALF OF THE WANSTEAD AND SNARESBROOK RESIDENTS' ALLIANCE [WASRA]

MONDAY 13 OCTOBER 2014

WASRA's view on the proposal.

We welcome the development of the two teams but do not believe that the work of these two teams can compensate for the loss of 40 – 60 beds. The lack of beds is the heart of our rejection.

In spite of what the RCCG says, we are not over provided for with intermediate care beds. The 2013 National Audit of Intermediate Care says that 26.3 beds ought to be provided per 100,000 people, which means that the 700,000 people who live in Redbridge, Barking and Dagenham and Havering, need 184 beds.

Twice we have asked what they base their calculations on and the best we can get is that they have looked at comparable borough's provision, but will not name these boroughs.

We have it on good authority that their bed modelling is not sound. They say it has been independently verified by NHS England. As NHS England is backing the proposals, we do not feel they are independent. Look where NHS London's verification of the Health4NEL has landed BHRUT – in special measures.

Deliberately keeping beds empty at Wanstead Hospital.

At our meeting on 17 September, in addition to the evidence provided by two family members who wanted their relative treated at Wanstead Hospital, members of staff confirmed what some of our residents have

told us - which patients are finding it hard to be referred to Wanstead Hospital. They are either sent to KGH or held at Whipps Cross Hospital. The Mid-Staffs culture of fear of victimisation after 'whistle blowing' continues here, as no staff will give their names.

At the debate in the House on 4 September, John Cryer said: *"I am being told stories - off the record - nobody has gone on the record - by NHS staff and constituents that people are being turned away from Wanstead Hospital and sent to King George in Ilford in order, I can only imagine, to massage the figures. I am also told by doctors and nurses who work for the health service that it is quite difficult to get into Wanstead hospital. Again, that will bring down the bed occupancy figures, adding grist to the mill of the senior health managers who are keen on getting bed occupancy down, so that they have a perfect justification for closing Grays Court and Wanstead hospitals."*

If these proposals were adopted, there would be negative consequences on healthcare in Redbridge:

Population Pressure

These proposals are in denial of the fact that Redbridge's population is rising more than anticipated – current estimates are an increase of 58 – 80,000 by 2030, while the 'baby boomer' generation is reaching 65 years of age. Population pressure is the reason why BHRUT have announced that they are doing a "major piece of work" on whether or not it is possible to close King George Hospital's A+E at all.

Pressure on A+E

The two teams only work from 8:00 am to 10:00 pm. Many intermediate care patients need urgent medical care at night, many fall going to the toilet – we have the 4th highest number of falls in

London. The only option would be A+E, which the CQC has shown is in difficulties locally, being bottom nationally at the end of August 2014.

Also the RCCG proposals rely on reducing the length of stay which intermediate patients would have in a bed from the current 29 days to 21 days, with the national average being 27 days. BHRUT has failed to shorten its length of stay, which is still a factor in its poor performance.

Providing new intermediate care beds elsewhere destroys their clinical argument

The RCCG says that one reason for putting all intermediate care beds into one place is to improve the quality of care. However, its pre-consultation business case says it is considering providing new intermediate care beds in a new health centre in Hornchurch.

Why close 48 well regarded beds in Wanstead and spend money on building new ones elsewhere?

The Reconfiguration Panel

This is a panel of senior independent experts in all the fields of healthcare – none of whom will have any personal involvement in the proposal. The IRP specialises in investigating controversial proposals for changes in health services.

They investigate in depth, study all the written material, visit the sites involved, speak to staff and NHS officials and hold meetings with the Clinical Commissioning Groups involved, MPs, local councils etc as well as interested parties like resident groups all of whom can give evidence and discuss with the Panel. They then write a

recommendation - advice which is sent directly to the Secretary of State for Health for his decision.

Conclusion

On behalf of WASRA I am here to ask if Healthwatch will support us in asking Redbridge Local Authority to write to the Secretary of State for Health, requesting that he ask the Independent Reconfiguration Panel to investigate these RCCG proposals.