

Tower Hamlets Involvement Network

Annual Report April 2010-March 2011



A vehicle for change in Tower Hamlet's health and social care services

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Making an impact

Introduction

Amjad Rahi
Co-Chair of Tower Hamlet LINK



On behalf of the members and the Steering Group of Tower Hamlets Involvement Network(THINK), it gives me great pleasure in presenting our third Annual Report. It outlines our increased membership, the diversity of their affiliations and interests, their input into community involvement, participation in Enter and View visits and their contribution to our engagement exercise with the commissioners and providers of health and social care services.

Our focus in early years, inevitably, was on developing governance and accountability arrangements, refining engagement and participation mechanisms, mapping local involvement activity and training members for Enter and View visits. We have since progressed towards making a real impact on commissioning and delivery of care services, contributing effectively to health and wellbeing strategies and supporting fully our local community to have real choice and fair access to services.

As we progress and soon metamorphose into Local HealthWatch we would like to be seen as a stable community reference point while there is unprecedented change in the NHS and adult social care. Our resolve is to create a culture of mutual respect and transparency while questioning vigorously and debating constructively relevant community issues. This is strengthened by the perception of THINK by commissioners and providers of health and social care services as ensuring that patients, carers and service users concerns will be raised until there is a solution and that a user-centred approach is sustained which with time will inevitably reflect on decision making.

In these times of financial constraints our real challenge will be to help the community to be continuously and constructively involved in decisions around health and social care, to contribute to the building of their understanding of changing health and social care options and resources trade-offs and to help resolve their concerns and complaints. Fortunately our membership comprises very committed, competent, well informed, diverse and independent individuals who are well supported by the Director of Urban Inclusion and her very dedicated staff and therefore there is no doubt we will succeed irrespective of the enormously difficult task ahead.

Amjad Rahi (Co-Chair)

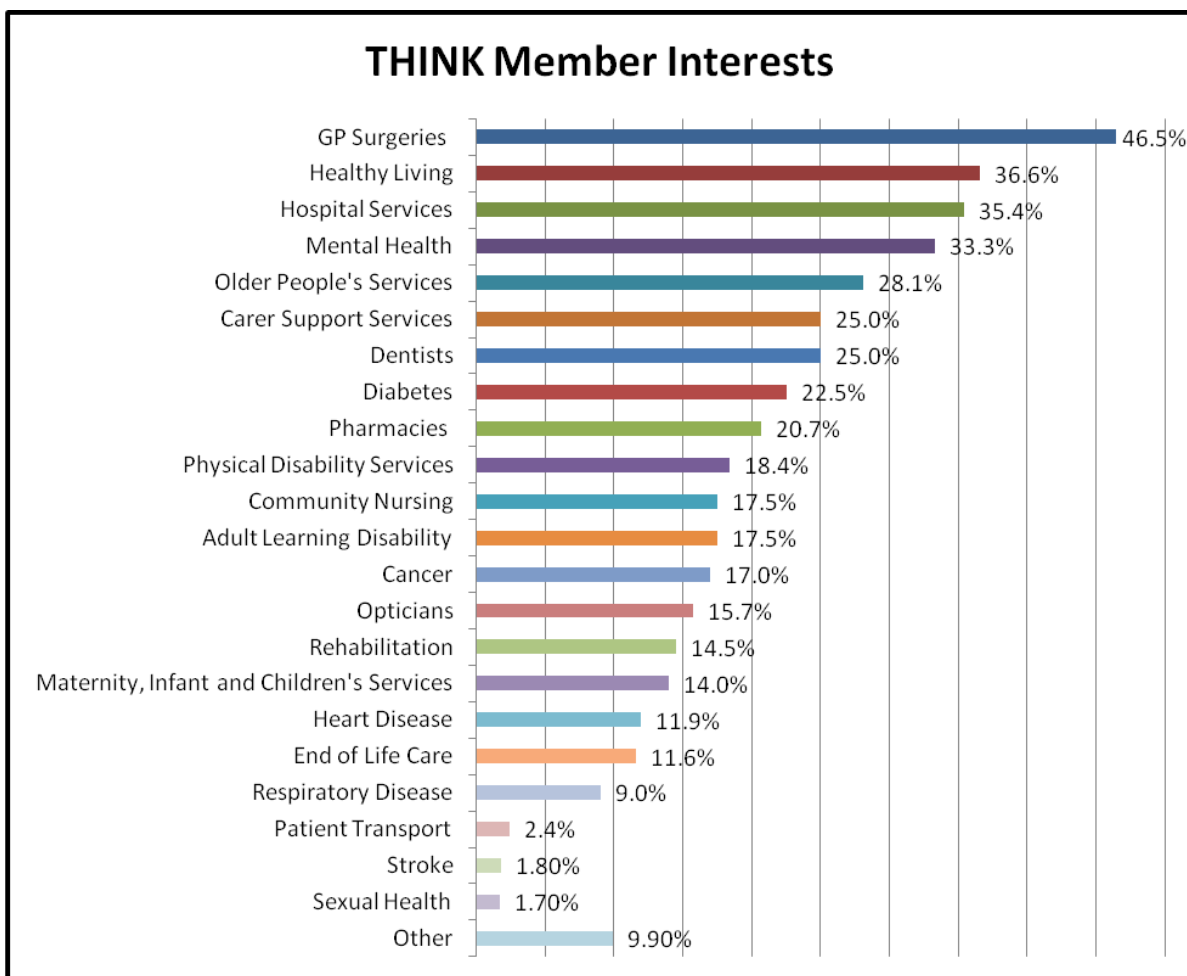
What is THINK?

THINK is the Local Involvement Network, or LINK, for Tower Hamlets. LINKs have been set up in every area of England, funded by the Department of Health and supported by an independent organisation, known as a Host. The Host in Tower Hamlets is Urban Inclusion Community. In practical terms THINK is a network of more than 900 local people and groups who believe that the users of local health and social care services often have the best ideas on how they can be improved. The role of THINK staff and volunteers is to gather those ideas and make sure that they are considered when services are being designed or their performance is being assessed.

The basis of THINKs' work is to gather community intelligence through direct outreach. THINK has gathered over 2,000 comments from its members, including community groups and members of the public. This has been achieved through attending 34 community events and 38 GP Practice Outreach Sessions and by members completing 216 surveys and online comments forms.

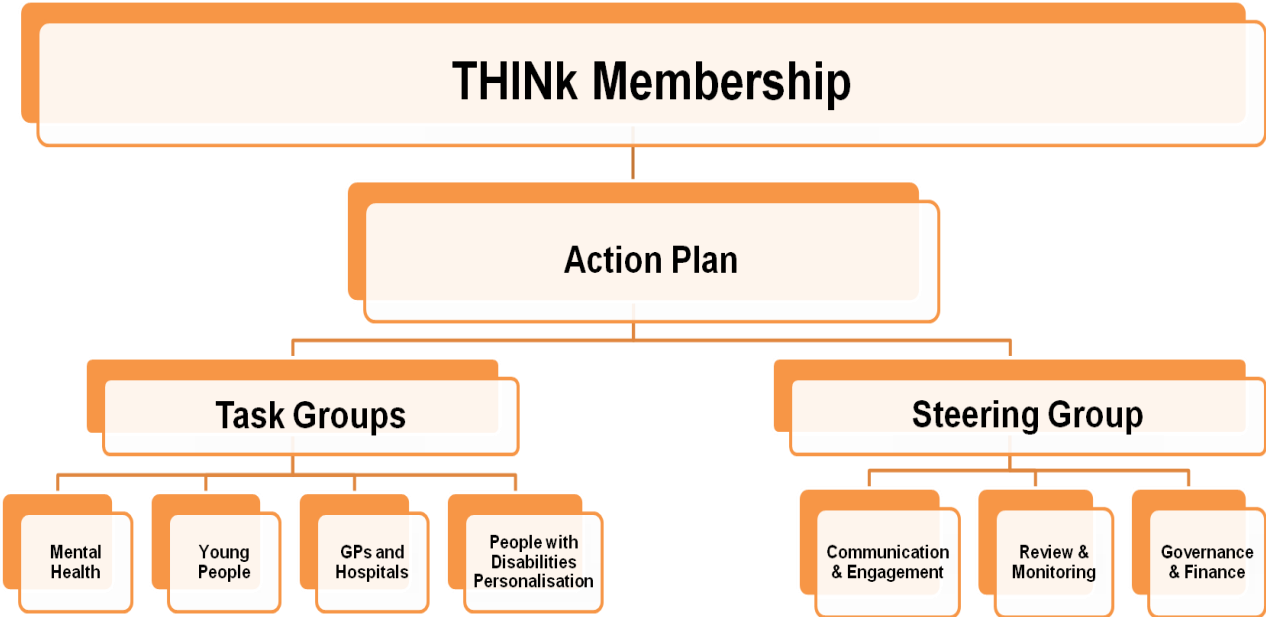
THINK Members

The most important part of the THINK structure is its members. THINK firmly believes that the only way to come up with effective ways of tackling health inequalities is to engage the wider community in identifying and designing the solutions. It is crucial therefore that we are able to engage with a significant number of local people who fairly reflect the experience and views of the local community. In order for those members to have an impact it is essential that we have strong and collaborative relationships with our public sector partners.



*Please note the above graph is based on the responses of 759 members as not all members identified their interests.

Members are encouraged to provide monthly feedback of their experiences of care services, get involved in leading work around specific task group areas, become Steering Group members, and volunteer across a range of engagement, outreach, and research areas.



THINK Steering Group members

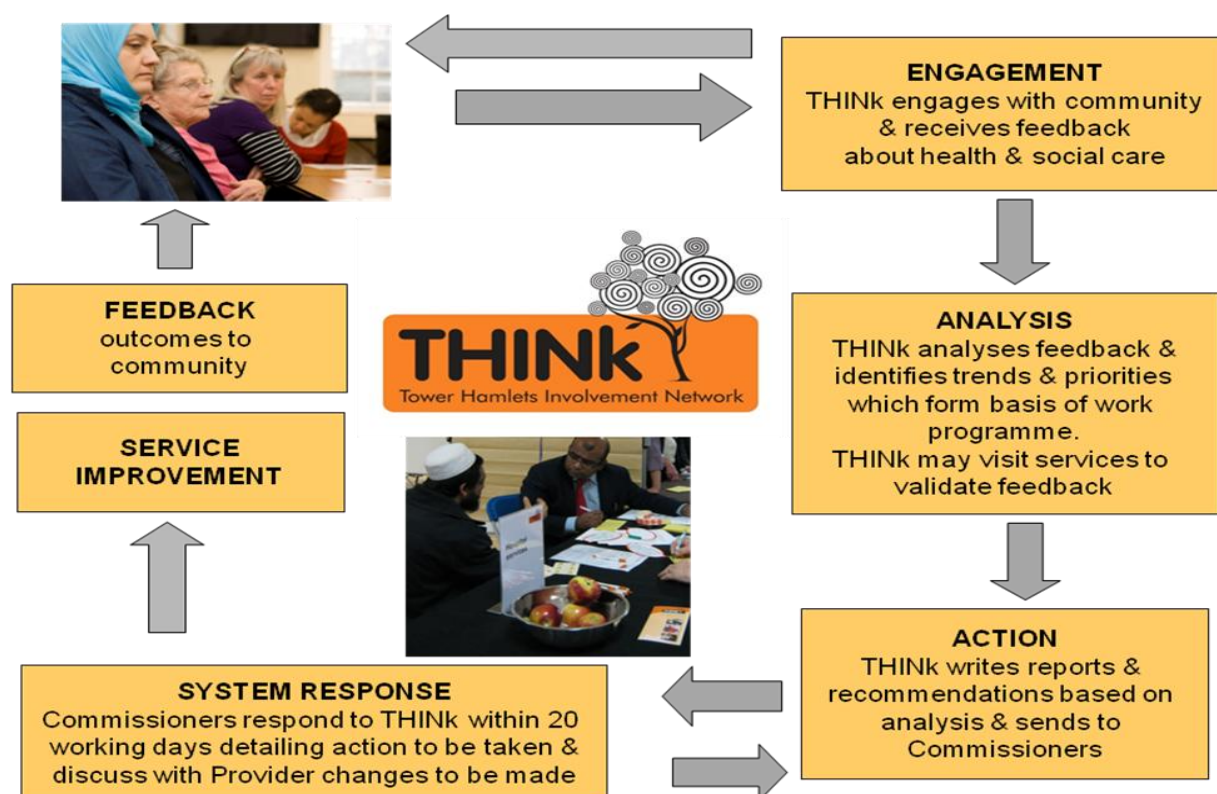
The Steering Group helps to gather and analyse information from members, patients and the public and to represent the views of THINK on decision making bodies. It is made up of ten local residents, five representatives from user groups and five representatives from voluntary and community organisations. All THINK members were invited to put themselves forward to become Steering Group members in July 2009. The Steering Group also co-opts non-voting representatives from the major health and social care commissioners and providers in the Borough.

THINK Steering Group	
Ten local residents	
David Burbidge	Bill Colverson
Peter Cobb	Amjad Rahi (Co Chair)
Myra Garrett	Kate Melvin
Indu Naik	Sybil Yates
Peter Nichol	Mike Elston
Five User Groups	
Gulrook Begum	Bangladeshi Mental Health Forum
Rita Dove	Bow Haven
Charlene Elliot/Zaheen Mehtab	Community Options
Ian Fincher	HIV/AIDS and Sexual Health
Five Voluntary and Community Organisations	
Sharon Hanooman	Social Action For Health
Lynne Overend	Mental Health Service Users and Carers of East London NHS Foundation Trust
Christine Sheppard (Co Chair)	Age UK Tower Hamlets (formerly Age Concern Tower Hamlets)
Mike Smith	Disability Coalition
Jo Weller	Women's Health and Family Services

Non voting Co-optees	
Joanne Starkie	LBTH Adult Health and Well Being
Motin Uz-Zaman/ Jane Canny	Patient Engagement BLT
Sandra Cater	THPCT
Clive Denton	East London Foundation Trust
Shanara Matin	Tower Hamlets Partnership
Abbas Mirza	Community Health Services
Members who can do Enter and View Visits	
David Burbidge	Bill Colverson
Amjad Rahi	Myra Garrett
Sybil Yates	Mike Elston
Peter Nichol	Christine Sheppard
Lesley Pavitt	Jean Taylor
John Scholes	

Our Steering Group is frequently called upon by commissioners and providers to provide feedback on strategic programmes and proposed changes in commissioning. The Steering Group is often able to give advice on the level of patient and public engagement that is needed and the best mechanisms for engaging users.¹

How we do it?



All of the comments we gather through our engagement activities are compiled into patient and user comments reports and circulated to all of the lead commissioners within the relevant commissioning agencies. THINK then undertakes analyses of the comments to come up with

¹ THINK has all relevant policies and procedures including: Terms of Reference, Code of Conduct, Declaration of Interest, Financial Procedures, and an enter and view code of conduct. All of these can be viewed on the THINK website www.thinknetwork.org.uk.

key requests for information, suggestions, and recommendations that are sent to the commissioners for response. We use our statutory power to make requests for information and recommendations to commissioners and get a response within 20 working days to ask for a response to our questions and recommendations. Recommendations we submit are taken as constructive opportunities to use patient and user experience to improve services.

Why THINK's work is needed

Population

There are around 242,000 people living in Tower Hamlets, with an unusually young age profile. In 2010 just 7.1% of the total Tower Hamlets population is thought to be aged 65 and over (between 15,000-18,000 people)² compared to 18.9% nationally. The population is expected to increase by over 23,000 people between 2010 and 2015, an increase of about 10%. Analysis conducted at London level suggests a population churn (combined inflow and outflow) in Tower Hamlets of nearly 19% of the population. If movement within the Borough is added, this equates to 24% of the population per year³.

50% of the population is classified as white and 33% Bangladeshi. This distribution varies substantially across different age groups with 59% of the 0-20 age range being Bangladeshi, decreasing to 25% of the 20-64 age range (adult) population and just 22% of the 65 years and over population. The Somali population has been recently estimated to be between 2.3%⁴ and 3%⁵.

Health headlines

Overall mortality in Tower Hamlets for males and females combined is the highest in London and significantly higher than the national average; 717 per 100,000 in Tower Hamlets, compared to 582 per 100,000 in England. Tower Hamlets has the highest rate in London of mortality from all causes amenable to healthcare in under 75s (151 per 100,000 compared to a London average of 104)⁶. The Borough has the highest or second highest mortality in London for the three major killers: cardiovascular disease, cancer and chronic respiratory disease (COPD).

Cardiovascular disease and cancer are the leading causes of death contributing to overall mortality. Cardiovascular disease mortality has particularly high inequalities across the Borough. Four wards (Mile End East, Whitechapel, Bethnal Green North and Shadwell) have mortality rates that are close to twice the national average.

Tower Hamlets has the highest cancer mortality in London. This is driven to a significant extent by high incidence and mortality from lung cancer, and reflects the high prevalence of smoking in the borough. One year survival from cancer is in the bottom 10% nationally and is particularly poor for breast, colorectal and prostate cancer. Evidence indicates that late diagnosis is a significant contributor to poorer survival. Bow East and West (and St Dunstan's and Stepney Green in the case of males) have by far the highest mortality (around 50% higher than national averages)⁷.

Chronic Obstructive Pulmonary Disease (COPD) is the third biggest driver of higher mortality and Tower Hamlets has by far the highest mortality in London (a mortality ratio of 172 compared to a London average of 98)⁸, which is likely due to levels of deprivation and other socioeconomic factors, and higher smoking rates in some population groups.

² Mayhew Harper Associates, 2009.

³ London Borough Migration 2001-2006 - DMAG briefing 2008-10, Greater London Authority.

⁴ NKM Population count, 2009

⁵ Tower Hamlets Health & Lifestyle Survey 2009, (note this was a survey for adults)

⁶ Mortality from causes considered amenable to health care in all persons in London boroughs and England. 2006-2008. Directly age-standardised rates (DSR) per 100,000 population (Various cause-specific ages). National Statistics.

⁷ CVD mortality in under 75 Persons by Tower Hamlets Wards, 2003-07, London Health Observatory.

⁸ Mortality from COPD, all persons, London boroughs and England. 2006-2008, National Statistics.

Age adjusted mortality rates are significantly higher in the white population compared to the Bangladeshi population for deaths from all causes, cardiovascular disease (under 75) and cancer (under 75). The life expectancy gap between men and women in Tower Hamlets is 5 years, compared to 4 years nationally. This is consistent with a higher gap in areas of high deprivation.

In 2007, 16 out of 17 Tower Hamlets wards were ranked in the 20% most deprived in the country and 12 were ranked in the 5% most deprived. 78.5% of Tower Hamlets residents live in the 20% most deprived areas in England, compared to around 26% of London residents.

According to the ONS Annual Population Survey, in 2009/10 Tower Hamlets had an unemployment rate of 14.5% (the highest in London)⁹. 56% of 'Tower Hamlets Homes' properties are classed as non-decent (the second highest proportion in the country)¹⁰. The overall over-occupation level (whereby a dwelling does not have sufficient bedrooms to meet the requirement according to age and gender of occupants) in Tower Hamlets is 16.4%, or 15,752 implied households, with the majority of overcrowding found in BME households¹¹. In the quarter April – June 2010, 156 households were assessed as being homeless and in priority need. This represents 1.8 per 1,000 households being homeless and in priority need, compared with a London average of 0.7 households per 1,000 population. Forty six percent of residents in Tower Hamlets perceive anti social behaviour to be a problem in the local area (the second highest percentage of all London boroughs)¹².

How THINK can help address these needs?

In a budgetary environment where services are likely to be decommissioned it is essential that commissioners are directly engaging with communities and users to

- identify their needs
- make decisions about the most appropriate use of resources, and
- inform them if services are not safe or of a good quality.

We need to move from a passive user/consumer approach to health and social care and encourage an active citizen/community-based approach. There is a need to identify and make use of the existing capacity and resources within the community, which could both complement and enhance the impact of statutory services.

There is an issue with disjointed engagement with residents, whereby individual commissioners or service providers are consulting on issues without linking to previous consultations or other current engagement processes within the same community. This doesn't allow the community to build up the knowledge and skills to participate effectively and frustrates residents who feel they're being asked the same questions again and again without feeling there's any real progress being made.

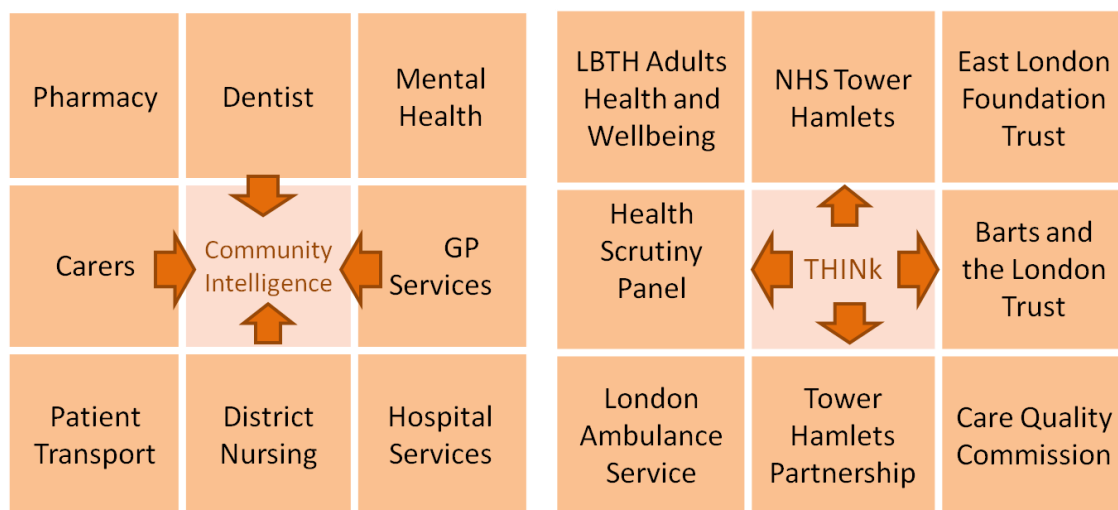
THINK are able to look at the person rather than the individual services that they're using and in the course of talking to them we can gather information on a wide range of interactions they may have from a multitude of service providers. It's our job, not theirs, to figure out where or to whom the information should be fed back to in order to influence change.

⁹ ONS Annual Population Survey, 2009/10, extracted from Nomis. Percentage is a proportion of economically active.

¹⁰ 'Business Plan Statistical Appendix (BPSA)- Annual Monitoring 2010, from www.communities.gov.uk.

¹¹ Tower Hamlets Overcrowding Reduction Strategy, 2009-12.

¹² Place Survey, 2008.



What benefits does THINK bring?

- A one-stop-shop for residents to feedback their comments on health and wellbeing.
- A more systematic approach that builds up community capacity, knowledge and expertise with ongoing support and individual development rather than one-off consultations that lead to stop-start engagement.
- An independent body to make negative comments to without fear that it will impact on services they may be receiving.
- Avoids consultation fatigue and frustration as information gathered at a ward level can be used for local input but at the same time people can feed into borough-wide health and wellbeing issues.
- Capitalises on community word of mouth.
- Maximizes volunteering opportunities and gives people a broad range of ways of getting involved.

Often people don't want to make a formal complaint but there are lots of things they'd like to say – not necessarily serious things but small things that would have made their experience better. It is this low level information that can really help to improve the quality and cost effectiveness of services. People are very reluctant to make negative comments to service providers for fear that it will impact on the service they receive in the future and THINKs independence is crucial to our success.

What THINK did in 2010/11

Engagement – getting people's views	Number
New THINK Members	432
THINK members actively involved in the Steering Group, Task Groups, and other interest-based groups within THINK	75
THINK Volunteers	14
Number of comments received from THINK members, community group members and members of the public on 2010/11	951
THINK Events	4
GP practice outreach sessions	38
Community Events	34
THINK Steering Group and Task Group Meetings	22

Activity	Evidence
Independent evaluation of THINK	THINK Evaluation Report
Pilot GP Network citizens engagement project across two wards	Pilot Strategy and Work Programme
Development of Patient Engagement Strategy for GP practices and the GP Consortium	GP Engagement Strategy
Event for Somali Community to identify health and social care needs and any gaps in service	Report to PCT Community Access Working Group
Input into the development of a new management structure for Community Health Services	Public consultation event report.
Engaged members in the PCT Commissioning Strategic Plan process	Steering Group minutes
Developed action plan for the implementation of Health Watch	Response to Department of Health on HealthWatch Consultation.
Engaging people who may not have a voice	
Research into the barriers to self management for people with Long-term conditions	Report due August 2011
Chinese communities health and social care concerns	Report with Women's Health and Family Services
Somali communities health and social care concerns	Report with Ocean Somali Community Association
Consultations undertaken with THINK Steering Group	
Barts and the London Trust Choose and Book process and roll out Quality Account	
East London Foundation Trust Mental Health - interface between primary care and secondary mental health services Quality Account	
Tower Hamlets Primary Care Trust Tower Hamlets Healthy Borough Programme - Evaluation Care Closer to Home Validation of Commissioning Strategic Plan Decommissioning process Urgent Care Strategy Presenting GP performance data Primary Care Investment Programme	
London Borough of Tower Hamlets Adults Health and Wellbeing Joint Strategic Needs Assessment Supporting People Strategy Transformation of Adult Social Care Public Health White Paper	
Care Quality Commission	
NHS London Health for North East London	
City University, London Adult user involvement in nurse education	
Health White Paper and local HealthWatch Proposals	

Analyses – of people's views		Evidence
Comments on health and social care services circulated to commissioners and key providers	Patient and User Comments report	
Analysed patient and user comments and compiled a table of recommendations and requests for information to key commissioners and providers.	Reports to NHS Tower Hamlets, Adults and Health and Wellbeing LBTH, and Barts and the London Trust.	
Consultation event reports that gathered user comments on health and social care services and feedback on key strategic policies of commissioners	Your Health Your Say June 2010	
THINK Statement provided to the Quality Accounts for Barts and the London Trust, East London Foundation Trust, PCT Commissioning and PCT Delivery.	Statements within providers Quality Accounts June 2010	
Detailed report into patient experience of GP practices and health centres	GP report to NHS Tower Hamlets Sept 2010	
Detailed report into services at Royal London Hospital	Royal London Hospital report to Barts and the London Trust Nov 2010	
Consultation on Health for North East London proposals	THINK submission on Health for North East London	
Input into Joint Strategic Needs Assessment	Community Perspectives Chapter Joint Strategic Needs Assessment (JSNA)	
Input into Learning Disabilities Needs Assessment and Carers Needs Assessment	Needs Assessment Reports	
Influence – using the analyses to make improvements		
Requests for information made by THINK to commissioners and providers as a result of comments received		33
Recommendations made by THINK to commissioners and providers as a result of comments received		73
Responses from commissioners and providers		48
Number of THINK members supported to represent users and the public on decision-making bodies		21
Number of procurement panels THINK were a member of		4
Decision making groups of which THINK representatives are active members		
Community Health Services End State Working Group	Community Health Services Procurement Panel	
Tower Hamlets NHS Board	Healthy Community Plan Delivery Group (LBTH)	
East London Foundation Trust Board	Clinical Effectiveness Board (PCT)	
Practice Based Commissioning Executive (PCT)	Health Scrutiny Panel (LBTH)	
Integrated Care Board (PCT)	Health for North East London Peoples Platform (NHS)	
Integrated Care Communications & Patient Public Engagement Group (PCT)	Voice and Representation Working Group (LBTH)	
Joint Strategic Needs Assessment	Joint Strategic Needs Assessment	

Operational Group (PCT/LBTH)	Programme Board (PCT/LBTH)
Diabetes Local Implementation Team (PCT)	Patient Public Involvement in Commissioning Group (PCT)
CBD Local Implementation Team (PCT)	Adult Health and Wellbeing Quality Board (AHWB)
CHD Lit (PCT)	Transformation of Adult Social Care Programme Board (AHWB)
Maternity Review & Maternity Services Liaison Committee (PCT)	Older People's Partnership Board: LBTH
Dental Clinical Governance Group (PCT)	TH Working Together Group - ELFT
Pan Disability Panel Transport Group	London Ambulance Service Tower Hamlets Project Steering Group
Access Strategy Group – Community Engagement & Dialogue Workstream (PCT)	Community Health Services End State Steering Group (PCT)
Transformed Customer Journey for Carers Project Group - AHWB	Long Term Conditions Reference Group (PCT)
Compassionate Care Project (BLT)	Patient and Carers Engagement group (BLT)
Scrutiny – keeping an eye on safety and quality	
Enter and View Visits	Royal London Hospital <ul style="list-style-type: none"> - Mary Ward - George Ward - Accident and Emergency - Talbot Ward - Follow the food Barts Hospital new cancer wards Crisis House
Third Party Commentary on commissioners and providers' Quality Accounts	Barts and the London Trust East London Foundation Trust Primary Care Trust – Commissioning Primary Care Trust – Delivery
Reports to the Care Quality Commission	4
THINK members on Health Scrutiny Panel	2
Presentations and updates to LBTH Health Scrutiny Panel	2
Feedback to members – letting you know you've had an impact	
Copy of Annual Report 2009/10 sent to all members	
Annual General Meeting – Your Health, Your Say July 2010	
Regular email updates provided to all members	
All members notified and given access to Comments Reports and recommendations	
Members provided with summary of: What people said, what THINK did and what happened.	
All THINK reports as outlined above are available on the website together with policies and procedures and minutes of Steering Group meetings, sub committees and Task Groups	

Copies of all reports can be found at www.thinknetwork.org.uk

What was the impact?

All of the comments we gathered through our engagement activities were compiled into patient and user comments reports and circulated to all of the lead commissioners or providers. THINK then undertook analyses of the comments to come up with key requests for information, suggestions, and recommendations that were sent to the service commissioners or providers for response. The responses we receive are fed back to our members to demonstrate their impact on improving services for their community.

How did this influence change?

GPs and Health Centres			
What you were worried about	How you think services could be improved	What THINK did	What was the impact?
Length of appointments, quality of GP consultations, continuity of care, attitude of front line staff, interpreters, waiting times.	More flexible appointment times/types, clearer patient focused information, training for GPs and frontline staff, better information on choices.	Completed report on patient perspective of GP Practices including 29 requests for information and recommendations. Undertook pilot project in Network 6 to engage the community in improving GP Practices.	Working group established with PCT to work on THINK recommendations. Sam Everington Chair NHS Tower Hamlets (GP Consortium) said <i>“Excellent survey on GP services and access. Encouraged great reflection “</i> THINK is a voting member of the Tower Hamlets GP Consortium. PCT Network pilot is seen as best practice and expanding.
Royal London Hospital			
What you were worried about	How you think services could be improved	What THINK did	What was the impact?
Staff attitude and communication, appointments processes, information on what to expect, maternity, treatment of older people and cleanliness.	Better patient, carer and community engagement in bringing about improvements to staff attitude, communication and information. Better relationships with primary and intermediate care.	Completed report on patient perspective of Royal London including 5 enter and view visits 38 requests for information and recommendations. Met with Chief Nurse and Chair of BLT. Engaged in key projects within the Trust.	BLT responded to all our recs and made environmental and procedural changes as a result. See Appendix for detail. Jane Canny Head of Patient Quality said <i>I think the key impact of THINK is that they ensure that the issues and concerns of patients continue to be raised until there is an answer or solution. This tenacity helps us to continue to focus on patient concerns in the current context of change.</i>
Mental Health			
What you were worried about	How you think services could be improved	What THINK did	What was the impact?
Variability and co-ordination of services, weak person centred care, capacity of GPs, attitude and high inpatient staff turnover use of bank staff; lack of	A more holistic approach with more non-medical treatments, decisions being made with, rather than for, better links to housing, employment, social needs, benefits and physical health.	Enter and view visit to Crisis House. Mental Health Task Group met with senior staff from ELFT on a regular basis. 3 meetings with members on the ELFT Quality Account. Development of a	The 2010/11 Quality Account prioritised our issues from the 2009/10 QA around quality of staff and patient experience. Whole Systems Review is now undertaking more detailed work in areas users highlighted.

activities for inpatients.	Ask users where efficiencies can be made with the least impact on user outcomes. Better support and training of GPs	Complementary Therapies project with voluntary and user groups working with ELFT across secondary and primary care. Facilitated input into Whole Systems Review.	
Older People			
What you were worried about	How you think services could be improved	What THINK did	What was the impact?
Transformation of Adult Social Care, Housing, dignity in care, home based services, transport, social isolation and safe guarding.	GP home visits scheme, access to a wider range of services through personalisation, compassionate care standards for OP, more joined up services, better monitoring of home care services.	Worked with Age UK Older People's Reference Group. Planning to review barriers affecting older people as part of LTC work and undertake a systematic review of OP services across commissioners and providers.	THINK hope to use LTC research to impact on commissioning and provision of services for OP in relation to NHS Borough Plan for cancer, long-term conditions, dementia, reablement, end of life, CHS and BLT, personalisation and residential care.
Social Care			
What you were worried about	How you think services could be improved	What THINK did	What was the impact?
Lack of knowledge of personalisation, fear of being forced into change, not feeling confident to manage financial requirements.	Clear information, positive case studies, gentle incremental steps approach, support for groups to develop own services, don't force change.	THINK held an event for service users and carers in early 2010 to explore people's views on social care and the personalisation agenda. Raised user views at Transformation of Adult Social Care Board.	Joanne Starkie, Strategy, Quality and Involvement Manager, <i>Throughout the transformation of adult social care programme, THINK representation on and input into the Transformation Programme Board has ensured that a customer focus has been sustained. This, in turn, has been reflected in decision-making.</i>
Carers			
What you were worried about	How you think services could be improved	What THINK did	What was the impact?
The number of unidentified carers in Tower Hamlets that are not accessing support. The lack of stable funding to support voluntary and community groups who support carers. Un-coordinated carer support across providers.	Better awareness of who is a carer, public education campaigns to raise awareness and promote: Carers Assessments; financial assistance such as the Carers Allowance and respite care;, home help and daycentres. A campaign aimed at employers regarding carers needs for flexible working conditions etc.	Provided input into the Carers Needs Assessment. Lobbied for continued funding for the Mental Health Carers Support Worker at Tower Hamlets Carers Centre. Raised information request on carers respite funding allocated to the Primary Care Trust. Provided carer input into the customer journey work	Joanne Starkie <i>THINK</i> input into work to develop a new and better quality "customer journey" for carers has been integral in confirming what we suspected to be some of the key issues and barriers for carers in the social care system. Secured continued funding for the Mental Health Carers Support Worker. Working on pilot project for respite care with PCT and LBTH.

		stream for the transformation of adult social care.	
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What commissioners and providers say about our impact?

Jane Canny, Head of Patient Quality – Barts and the London Trust

Firstly we thank THINK for the support and assistance they have given us over the last year. In particular, the support provided with the reviews and inspections such as the PEAT Audit and a review of the food and food tasting.

The feedback from the visit to the new building at Barts gave us very useful insight into the signage and some of the limitations of fixtures and fittings from a patients view.

LINKs members have assisted us with reviewing patient information and ensured that we have a patient’s perspective to a number of service improvement initiatives such as Safety Express, Out Patient Transformation and the developing Compassionate Care project.

THINK have been very helpful in expediting improvements to the environment such as installation of new showers and refurbishment of the bathrooms on Mary ward

We hope that our work with THINK will develop this year to include work to improve patient experience through expanding volunteer roles and engagement projects.

Two projects in the early stages of planning are In-patient information and Hospital experiences of BME patients

Joanne Starkie, Strategy, Quality and Involvement Manager, LBTH Adults Health and Wellbeing

Impact on adult social care services in the AHWB Directorate

Impact on the quality of services

THINK’s independent role has been crucial in enabling the AHWB Directorate to better understand the views and experiences of people who use social care, and we have used this information to help drive up the quality of our services.

THINK held an event for service users and carers in early 2010 to explore people’s views on social care and the personalisation agenda. The findings from this event helped us to understand some of the public perceptions of social care, the nature of which highlighted the importance of having an independent group asking the questions (for example, some people were worried about contacting social care for fear of “rocking the boat” and having services removed). The findings from this formed the basis of a programme of organisational development work, aiming ultimately to improve staff practice. A set of Directorate service values based around accountability, working collaboratively and being empowering were agreed in late 2010. These, in turn, are now starting to be used in the performance management of all Directorate staff to drive up the quality of staff practice in line THINK findings.

Another key element of the transformation of adult social care programme that THINK has impacted on is around the experience of unpaid carers. THINK input into work to develop a new and better quality “customer journey” for carers has been integral in confirming what we suspected to be some of the key issues and barriers for carers in the social care system. For example, THINK members have confirmed how important it is for carers to be able to easily access information on social care that is consistent and up-to-date. This has been built into

the “vision” for the carer customer journey in social care, and actions to meet this vision are now underway.

Throughout the transformation of adult social care programme, THINK representation on and input into the Transformation Programme Board has ensured that a customer focus has been sustained. This, in turn, has been reflected in decision-making.

Impact on the commissioning of services

Both the results of direct consultation with THINK members and the results of wider THINK engagement work have been used to inform commissioning in the Adults Health and Wellbeing Directorate.

THINK have direct input into commissioning intentions via membership on decision-making structures such as the Transformation Programme Board, and through consultation with members at THINK Steering Group meetings. In addition, every six months, the AHWB Directorate carries out an analysis of the findings of all THINK’s engagement work in order to assess the key messages for adult social care. This ensures we are capturing and utilising information that may still be relevant to us, whilst not being directly applicable. In 2010-11, two of the key commissioning strategies developed and significantly informed by the findings of THINK are the “Information, Advice and Advocacy” strategy and the “Prevention” Strategy. For example, the importance of social contact and healthy lifestyles to keep people well have been built into the Prevention Strategy, which in turn is now being used to inform commissioning decisions.

THINK representation on the Transformation Programme Board has directly shaped the commissioning of services, including most recently the proposal to develop “experts by experience” in adult social care services.

Impact on services via monitoring and scrutiny functions

THINK membership on the AHWB Directorate Transformation Programme Board, Quality Board, and Communication and Engagement Project group over the last year have all helped to ensure that adult social care services are accountable and scrutinised by an independent source able to provide a customer perspective. One of the key impacts on this over the last year has been to help ensure that the results of all customer engagement work are fully utilised to inform the quality and commissioning of services.

Margaret O'Donovan, *Quality Assurance & Clinical Governance Manager, NHS East London and the City*

THINK’s very helpful “*User Comments Reports*” provide useful information that the PCT can review for users’ perspective on their experience with the quality of care/service they have received. The reports also provide a structured outline of concerns by:

- Themes
- Specialties
- Location

The PCT uses the above information to assist with informing any potential Quality Assurance Visit from the PCT.

THINK’s regular “*Comments and Recommendation Reports*” also provide a helpful outline of provider service themed recommendations that assist the PCT Commissioners/Quality Assurance leads with a focus for ensuring these are reviewed and acted upon in the relevant provider service.

THINK’s regular “*Enter and View Visit Reports*” compliment the PCT’s programme of Quality Assurance Visits to provider services and highlight areas that are in need of performance and clinical quality management review.

The PCT uses THINK's reports to assist with triangulating our own information for quality assurance.

THINK has been instrumental in providing expert advice to the PCT in contributing towards the PCT's:

- Quality Summit (June 2010)
- Development of the Quality Assurance Framework
- Working in partnership with the development of the "tell us what you think" leaflet
- Being a valued member of the PCT's Patient and Public Involvement Work Group

Somen Banerjee, Co-Director of Public Health (Tower Hamlets)

Patient and public perspectives are integral to getting local insight into the needs of the population. I can't state enough how fantastic the input of THINK to the joint strategic needs assessment has been. This has been through

- a. representation on the JSNA Programme Board feeding in community intelligence, sense checking findings and informing priorities for focus of the JSNA
- b. THINK's contribution to specific health needs assessments (eg carers, mental health and older people, learning disabilities and others.)
- c. THINKs role in gathering community perspectives on healthy lives and services to address them

I think it has been a mixture of confirming what we already suspected (and therefore validating other data) as well raising issues which are important for local people but not always a national priority reflected in targets (eg carers).

Esther Trenchard-Mabere, Co-Director of Public Health (Tower Hamlets)

THINK has generally played an important role in ensuring that patient involvement and feedback is kept high on the agenda with respect to commissioning and strategic planning and has provided useful specific feedback on maternity and cancer services that have contributed to ongoing service improvement.

Natalia Clifford, Public Health Strategist, NHS Tower Hamlets

THINK add an important objective questioning voice on commissioning decisions and budget allocations (e.g. Carers breaks) and in helping to keep an agenda live.

Abigail Knight, Senior Public Health Strategist, NHS Tower Hamlets

THINK provide key patient representation on PCT governance boards and key community networks to support evaluations with relevant sub-groups in the population. THINK's input into a number of needs assessments has enabled us to develop strategic priorities for programme areas, and shape Public Health campaigns.

Chris Lovitt, Associate Director of Tower Hamlets Public Health,

THINK played an important role for our work areas in the following ways:-

1. Facilitated and presented community engagement for recommissioning of Health Trainers and took part in the procurement process
2. During decommissioning and cost reduction programme last year undertook community engagement and representation
3. Regular surveys of THINK members enabled a cross section of health issues to be presented on a regular basis to commissioners.

John Wardell, Chief Operating Officer, NHS Tower Hamlets Consortium

Areas where THINK have had an influence;

- Ensuring that the patients voice is heard during commissioning discussions
- Giving expert advice on how to engage patient and service users views
- Providing feedback from forums and interactions on the views of local residents
- Delivering master classes on participation and engagement in partnership with the leads from the PCT

Dental procurement at the PCT

Providing a specific localized patient/community knowledge in relation to barriers to dental health supported tendering processes. The development of bidder questions ensured bidders developed real localised plans rather than the normal pat response of 'yes we will work with local community groups'. Provided challenge to commissioning projects.

How we spent our money

	Total
<u>Staff Costs</u>	
	£148,407
<u>Participant Costs</u>	
Carers costs	£200
Representative reimbursements	£1,458
<u>Other Costs</u>	
Research and surveys	£7,000
Events/meetings	£5,039
Outreach & communication	£7,967
Training & specialist advice	£2,300
Running Costs	£2,945
Stationary & postage	£3,983
Rent and utilities	£11,132
UIC overhead	£20,800
TOTAL REVENUE	£211,231

INCOME	
LBTH	£208,000
LBTH Davenant Centre	£2,132
Peoples Platform	£1,099
TOTAL INCOME	£211,231

What we are doing next

As a result of our engagement this year we have identified the following key issues for 2011/12.

1. Citizen's Engagement and Empowerment

There is an opportunity to use THINK in a more systematic and formalised way as a citizens' engagement panel for health and wellbeing in Tower Hamlets.

There is an issue with disjointed engagement with residents, whereby individual commissioners or service providers are consulting on issues without linking to previous consultations or other current engagement processes within the same community. This doesn't allow the community to build up the knowledge and skills to participate effectively and frustrates residents who feel they're being asked the same questions again and again without feeling there's any real progress being made

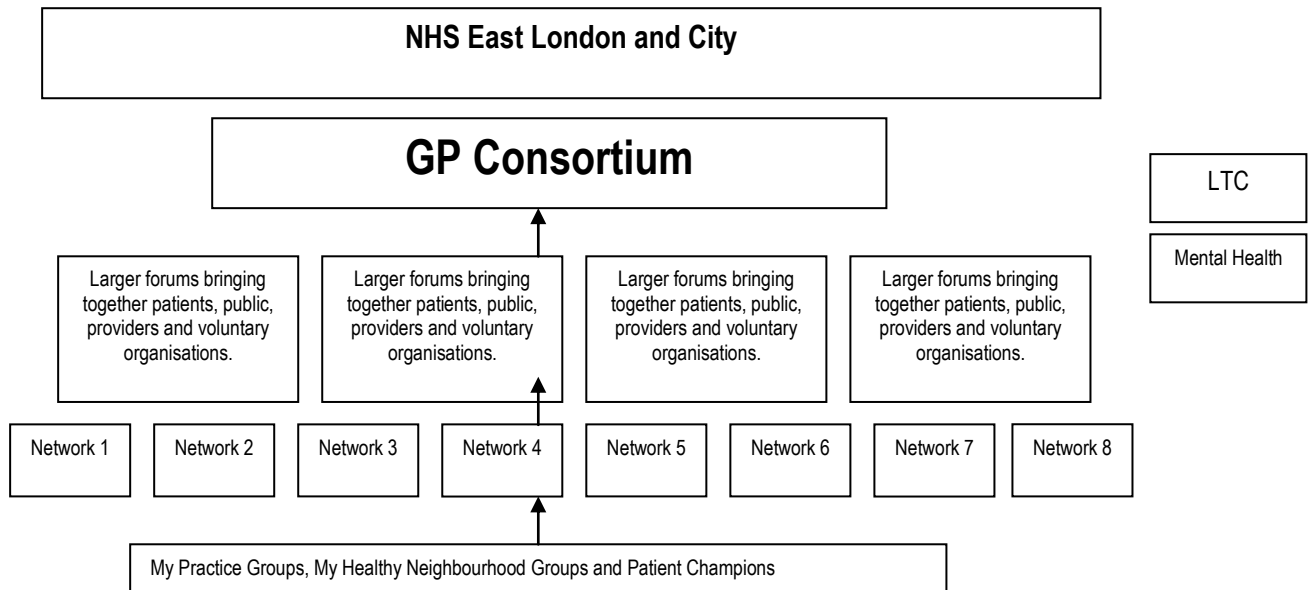
What benefits might it bring?

- A more systematic approach that builds up community capacity, knowledge and expertise with ongoing support and individual development rather than one-off consultations that lead to stop-start engagement.
- Avoids consultation fatigue and frustration as information gathered at a Network level can be used for local input but at the same time people can feed into borough-wide health and wellbeing issues.
- Capitalises on community word of mouth.
- Maximizes volunteering opportunities and gives people a broad range of ways of getting involved.
- Doesn't require people to attend a lot of meetings and gives people the opportunity to find an option that suits their capacity and interests.

Using GP Practices and community groups as bottom up access points for engagement the project aims to work with partners within each of the 8 Primary Care Network (made up of four wards) to engage 100 local people within their network to:

- become real partners in service commissioning, development and delivery, and performance management,
- develop more positive, healthy behaviours,
- be able to confidently navigate the health and social care system,
- have a better understanding of health and social care issues and be able to educate others;
- take a stronger role themselves in working with agencies to support other vulnerable people in their own communities.

We see this as an opportunity to have real bottom up engagement in the GP Consortium and the commissioning process.



This is a long-term project and what THINK is currently doing is piloting the project in the Mile End East and Bromley by Bow (MEEBB) Network. The aim is to continue the capacity building work for a further six months if THINK funding allows and then that the project is handed over to the Network to sustain. Ideally we would like to see the programme rolled out across the other Networks in Tower Hamlets but with current resources THINK can only work with one NHS Network every six months.

Another option is for THINK to work with two Networks over the next year as a pilot project. THINK could draft up the findings and lessons learnt; fine tune the model and hand it over to the other GP Networks to deliver internally.

2. Long-term Conditions (LTC)

A key focus will be ensuring our LTC research with 125 people has an impact on the NHS Borough Plan. This will support:

- ongoing engagement of participants in integrated care at a Network level,
- an informed enter and view programme and ongoing research into services for Older People
- empowering patients to have more control and develop their capacity to self manage their condition
- empowering patients to take an active role in commissioning processes.

3. Mental Health

Whole Systems Review, reconfiguration of in-patient services for people with dementia, support complementary therapies & recovery model.

4. Enter and View Programme

We plan 20 visits in the next 10 months including older people's services across provider organisations, GPs, Dentists and other areas as identified by patient feedback during the course of the year.

5. Royal London

Patient, carer and community engagement in improving patient experience. Monitoring outcomes of CHS transfer and merger with Whipps Cross and Newham.

6. Social Care

Supporting service user involvement and feedback through developing experts by experience" in adult social care services.

7. Carers

Working with PCT and LBTH to ensure appropriate funding of carers support programme.

8. Preparing for HealthWatch

THINK will need to transition into Local HealthWatch (LHW) by October 2012. This may involve taking on the new functions of

Choice: helping people to make choices about their care, particularly those people “who lack the capacity” to do so.

Advocacy: LBTH could commission Local HealthWatch to provide a complaints advocacy service to help people complain about a service. It does not have to be provided by Local HealthWatch staff or volunteers and THINK are asking for Pathfinder status to test out a model in partnership with the Independent Complaints Service (ICAS) delivered by POhWER.

Structure: Local HealthWatch is to be structured below HealthWatch England an entirely new consumer champion structured within the CQC.

Health and Wellbeing Boards: Local HealthWatch will have a seat on the local Health and Wellbeing Board a committee of the local authority, which will have a duty to encourage integrated working in the provision of health and social care services.

The THINK SG has set up a sub group to look at possible legal structures for HealthWatch.

How to get involved?

It's really important that if you experience or see services that you feel are not of good quality that you let somebody know. If you feel comfortable talking to somebody who is independent and who will keep your identity private then THINK might be the right organisation to contact. You leave your comments on the THINK website www.thinknetwork.org.uk in the Have Your Say section.

If you want to get involved in any of THINKs work like helping us with visits, going out to talk to other members of the public about their health experience, or getting involved in the Steering Group of Task Groups we'd love to hear from you.

THINK Support Team

Shafina Akter or Shamsur Choudhury
Urban Inclusion Community
Room 12, Block 1
Mile End Hospital
London E1 4DG
www.thinknetwork.org.uk

Appendix: Recommendations and responses

Barts and the London Trust

THINK provided a detailed report on services at the Royal London Hospital that can be downloaded from the THINK website. Below is a list of our request for information and recommendations and their responses.

Royal London Hospital Recommendation	Response
1. THINK would like to formally request that BLT include a patient representative on the BLT Board.	The request was denied. It was suggested that THINK feed in through attending public meetings of the Board. Follow up has led to a suggestion that we work more closely with the Non Executive members of the Board.
<p>2. The toilet and bathroom facilities in Mary Ward do not enable the hospital to ensure that patient dignity can be maintained. At the very minimum:</p> <p>3. The female and male bays should be swapped over (so that the appropriate toilets are available)</p> <p>4. The toilets should be thoroughly cleaned and maintenance undertaken to ensure that all mechanisms work effectively. It may be necessary to schedule more regular cleaning given the nature of the ward.</p> <p>5. A new shower should be fitted in Mary A.</p>	<p>The ablution areas were converted to allow for patients to close the door whilst attending to there personal needs.</p> <p>The ward has not yet been able to swap the bays so that they to align with the toilets. This is due to high bed occupancy. However, the toilet signage has been changed</p> <p>The cleaning standards have improved and in the recent audit the ward received a 100% compliance with the standard</p> <p>Two new showers have been installed including a new toilet. The current shower bath area has been refurbished</p>
<p>6. Is there a process for clearly identifying the staff that has a problem providing compassionate care in Mary Northcliff?</p> <p>7. Has the rotation of night duty staff with day staff led to any recognisable improvements in the experience of mothers?</p> <p>8. Is there any chance of increasing the number of maternity support workers and is there funding to take on the trained maternity support workers from South Bank University funded by NHS London?</p>	<p>Yes, all staff receive ongoing review, direct and indirect supervision by their manager and if concerns are raised these are addressed with the individual</p> <p>Yes all staff now rotate, and there is no permanent night staff. Significant improvements have been made with regards to the quality of care. Staff have been able to access training during the day and acquire new skills. They have been able to work more in a team during the day, because there is more activity. Everyone has been able share the workload more as a result this change.</p> <p>The recent Birth Reflection Survey carried out by the department has shown significant change and improvement in patient experience. A PCT survey from January 2011 has also shown improvements in all areas.</p> <p>There are no plans to increase maternity support workers at present due to budget restrictions. However, their will be development of a transitional care team of support staff in 2011</p> <p>The transitional care and support staff provide specialist support and additional care for Babies. For example a baby requiring tube feeding or antibiotic</p> <p>Currently putting together a business case for additional</p>

<p>9. Do UCH have the same staffing ratios, if so how are they managing to do it better?</p> <p>10. Has there been a local community midwifery recruitment campaign.</p> <p>11. Does midwife training include feedback from mothers about what good and poor care entails?</p> <p>12. Is there information on particular cultural issues regarding giving birth? Could the Maternity Services Liaison Committee feed in to this?</p> <p>13. It is crucial that parents are welcomed on to the ward and receive a Welcome Pack explaining what would generally happen between arriving and being discharged. Who does this? How often does it happen?</p> <p>14. Could the ward provide education sessions for first time parents?</p> <p>15. How might the issue of lack of breastfeeding support at night time be tackled by the ward?</p> <p>16. Are there alternatives to using language line for woman in labour?</p>	<p>staff.</p> <p>All maternity ratios are assessed using birth-rate + so will be similar throughout maternity units. RLH has the added benefit of breast feeding support workers which many units do not have. The Head of Nursing across London meet and informally share good practices. Recently, NHS Institute for Improvement and Innovation has been looking at improving the number of births given normally and reducing Caesarean Section. Staff have been sharing and learning via Community of Practice, which is web based tool kit for all clinical staff to share good practice.</p> <p>Yes we have recently taken on 8 new maternity care assistants from the local community.</p> <p>Yes the maternity unit use feedback from the birth reflections report/complaints and discussions to inform changes in practice.</p> <p>Women Information Group (WIG) has patient representatives, who are able to comment on draft leaflets before they are approved.</p> <p>All midwives are given training regarding this – it is possible that more work could be done and we would be interested in the MSLC supporting this</p> <p>This is currently part of the MCA or midwifery role – a short leaflet about the ward is available. However, a new brochure is being developed to improve postnatal information given to women.</p> <p>Yes following feedback an afternoon session is planned daily</p> <p>The breast feeding support workers do not work at night. Information and advice is provided to help support women breast feeding at night. The new maternity unit will also allow partners to stay when requested.</p> <p>Breast Feeding unit at Barts and the London has recently entered the World Health Organisation Award and achieved 2nd Stage. They are now going for stage three and if achieved, will be the only Hospital in London to have achieved this level.</p> <p>The advocacy service is under review at present and the maternity unit is also introducing the Doula project. At this time the scope of the review is about internal management and business arrangements of the service. We are using feedback from patients and staff who use the service about the quality of the systems and would be grateful for THINKs views.</p>
<p>17. Can patients be provided with information before they come in to the hospital on what is likely to happen?</p>	<p>Since THINK visited the ward reconfigurations have taken place and there is now a dedicated day care and same day admission unit on Croft ward. George Ward is now a surgical ward incorporating short stay beds and a surgical assessment unit. Dedicated patient information booklets that detail what patients can expect and how their care and treatment will proceed, are provided from pre-assessment,</p>

<p>18. Once in hospital can whiteboards or information inform patients if things are not happening as normal today and why (e.g there's been a major trauma, or one of the consultants is sick, or they are short staffed) and what the impact is likely to be.</p> <p>19. People should be given information on when they can eat following surgery. Tell people that the surgeons are not going to get around to giving them an update until after they complete all their surgery.</p> <p>20. How can better communication between doctors and nurses be facilitated to enable more rapid feedback to patients?</p>	<p>for all patients.</p> <p>18. Day care staff have close links with theatre and access the information needed to keep patients informed of changes to schedules. Any changes in planned care, such as list progressions or changes in list order are communicated to staff on Croft so that patients can be kept fully updated and informed.</p> <p>19. We are in the process of updating and improving our post-operative information leaflets so that patients have written specific and general post op instructions, including eating and drinking following surgery.</p> <p>Patient Information Reference Group (PIRG) considers draft leaflets prior to them being approved by Patient Information Validation Committee.</p> <p>20. We now have dedicated staff for Croft ward who link more closely with the surgical teams looking after the patients. This enables nurse-led discharges following surgery and clear information to patients about follow-up appointments, and further care with their GP.</p>
<p>21. Can some form of cushioning be used on the seating in the waiting area if people are waiting up to four hours in A&E?</p> <p>22. Can patient feedback screens be more prominently located and patients proactively engaged to record their experience.</p> <p>23. Is there the possibility for patient held records to fast track frequent visitors to A&E?</p>	<p>It is the Trust's intention to buy upholstered seating for the A&E department in the new RLH</p> <p>The positioning of our feedback screens is being reviewed in all areas to maximise publicity and use. We are designing new posters to encourage people to participate and there is greater engagement of staff teams as they begin to see the results and use the feedback to improve services</p> <p>Each attendance at A&E has to be logged in the system to enable test and investigation requests. Each attendance is different and needs to be assessed at the time. Although a patients' history is important it would not necessarily lead to them being fast tracked. Clinicians have access to patient electronic records if the patient is being seen in the Trust. We are using patient held records to enhance care - for example in the care of patient's with learning disabilities the patient passport is used to enable rapid assessment.</p>
<p>24. Cleanliness standards and schedules should be posted throughout the hospital with specific contact points for complaints on each ward or area.</p>	<p>All wards and departments have cleaning schedules highlighting the service to the area. A blue cleaning schedule should be visual at all times on the patient information board.</p> <p>Information on how to complain is provided in leaflets and on posters displayed in patient areas. The supply and display of the posters are reviewed by Matrons and complaints staff</p>
<p>25. Signage should be developed to inform patients about the 'untidy state' of the hospital and the impending move.</p>	<p>Directional signs have been improved and this is an ongoing programme. PEAT inspections along with weekly site visits manage the untidiness which is gradually improving.</p> <p>There are no plans to develop additional signs to inform patients about the move. We have information available about the new building at the main reception area.</p>
<p>26. Where ever possible patients should be provided with information before they enter hospital on what is likely to happen.</p>	<p>Outpatients All patients referred to the Trust receive information with their appointment letter; this includes a comprehensive leaflet with an insert on text messaging. Patients attending certain clinics e.g. Urology One Stop, receive additional,</p>

	<p>more service specific information.</p> <p>As part of the work undertaken within the outpatient service transformation, all patient correspondence is being reviewed. This includes the proper use of letter preps which are pieces of information that are automatically inserted into the text of letters and relate specifically to the appointment at hand, in order to give the patients more information. The review is to be completed by March 2011.</p> <p>Patient Information Reference Group has been consulted on the format of letters and information leaflets prior to their final approval by the Patient Information Validation Committee.</p>
<p>27. What systems are in place to improve communication between staff, particularly between doctors and nurses on wards?</p>	<p>Different wards and departments operate different systems to facilitate good communications. Many areas have multi disciplinary team meetings every week, such as in the Orthopaedics, These meetings will include Doctors, Nurses, Managers and the Physiotherapists and other health professionals.</p> <p>When people have complex discharge or continuing care arrangements, case conferences that include the health professionals, carers and patients and/or relatives are arranged to ensure all the parties are informed of the issues and arrangements.</p> <p>Day to day communication regarding clinical care is achieved through ward rounds, ward diaries and instructions/entries made in the care records. There are handovers of information and care instructions for nurses at the change of each shift.</p> <p>Each Clinical Academic Unit holds monthly meeting to review complaints and serious incidents, decide on actions and next steps and identify points for learning from these.</p> <p>All maternity wards have daily multi-disciplinary ward rounds and a midwife is present at the follow up reviews of women. All care plans are communicated verbally between midwife, doctors and other relevant professional and written in the woman's record.</p>
<p>28. Can we ensure that patient feedback is heard by managers and linked into the performance management system with a clear action plan implemented to bring about change</p>	<p>Patient complaints are discussed with staff and managers during the course of the investigation.</p> <p>The CAU and Divisional governance teams report monthly to the CAU and Divisional boards. The Boards are made up of senior medical health professional and management staff.</p> <p>The reports include information on patient feedback/complaints and PALS information; Actions plans and changes implemented in response.</p> <p>Complaints numbers and themes of complaint are presented in report format to the Quality and Safety committee.</p> <p>Results from the real time feedback project will also be presented to these groups with examples of what is being done in response.</p>

<p>29. Are there staff competencies in relation to treating patients with respect and dignity?</p>	<p>We have patients on some of our Boards, which includes, Out Patient Transformation Board, Patient Express Committee and on panels as and when required.</p> <p>There are core competencies for maintaining respect and dignity for all levels of nursing staff.</p>
<p>30. Are there clear processes for patient feedback to be taken into account in staff appraisals? Do staff reflection sessions happen at the moment?</p>	<p>If a particular member of staff is named within a complaint or specific feedback about the staff member is received from a patients about their performance it may be recorded as part of a professional portfolio and/or used as part of performance review during appraisal</p> <p>Staff reflection and review happens routinely as part of complaint and incident investigations</p> <p>There have been 9 incidents where people have undergone disciplinary due to their conduct with patients and investigations have been carried out as a result. We are unable to say if any resulted in dismissal.</p> <p>Reflective practice is undertaken in different ways, by different staff groups throughout the Trust. Clinical and case supervision is used by health professionals. Staff use patient feedback in their portfolios and staff are beginning to use feedback from the RTF to focus improvements in areas that matter to patients</p> <p>Overall patients experience is improving in many clinical areas evident in the type of reports we are having now. Last year the patient satisfaction scores were very low in most areas but this year higher scores are being registered in many areas eg Lawrence Ward (3A and Bedford Fenwick).</p>
<p>31. Could patients have a small white board at the end of their beds or a card to go with patient notes where they could note down any questions they have for staff or concerns about their treatment?</p>	<p>Thank you for the suggestion. We encourage our patients to write down questions or concerns they have in order to help them remember. However, we do not have plans to issues patients with cards or white boards at this time.</p>
<p>32. Care for Older People standards should be presented to all nursing and frontline staff and made a performance management priority for supervisions.</p>	<p>Care standards do form the basis for performance management for clinical staff -</p>
<p>33. Is it possible to look at developing a system for patient held records for frequent hospital users?</p>	<p>We are currently utilising patient held records to enhance care for some groups e.g. in the care of patient's with learning disabilities we utilise the patient passport. Increasing information that patients have to keep as their own record is being implemented gradually through initiatives such as copies of discharge letters sent to the patients.</p>
<p>34. How often does the hospital use language line for the Somali community and is this cost effective?</p>	<p>In the last quarter the language line was used 8 times for the Somali Community. The total cost to the Trust for this service was £137.50.</p>
<p>35. Is it possible to develop a system for sessional Somali interpreters to be available as needed for appointments?</p>	<p>There is an advocacy review underway to further develop the way advocacy is provided in the Trust. We do operate a booking system for appointments and interpreters are booked in advance whenever the need is known. Some of this need is met.by the in-house service and some is met.by external companies. This includes Somali interpreters.</p> <p>The review of advocacy services, at this time the scope of the review is about internal management and business</p>

	<p>arrangements of the service. We are using feedback from patients and staff who use the service about the quality of the systems and would be grateful for THINKs views.</p>
<p>36. Are nursing staff required to attend equalities and diversity training with Compassionate Care standards linked to cultural sensitivity training?</p>	<p>Equalities training is now mandatory for nurses</p>
<p>37. There is a need for increased support and signposting by patient advocates and volunteers. We understand that a Doula volunteer project is commencing with Maternity services and it would be good to see the impact of this. Would it be possible to develop a kind of 'meet and greet' volunteer service on some of the more problematic wards? Can THINK work with BLT staff to further develop the Volunteer Programme?</p>	<p>We have volunteer welcomers based in outpatients and the dental hospital and some that work across the whole site. The Doula project has been organised by Women's Health and Family Services based in The Brady Centre. The initiative will work with women in the community in conjunction with Maternity Services. We have volunteers who befriend patients working on some of the wards. Their role is to keep patients company, shop for them and make drinks and encourage patients to use the real-time feedback touch screen.</p> <p>Voluntary Services would be more than happy to discuss with THINK any ideas they may have to improve patient experience in our hospital.</p>
<p>38. What are the proposed changes in relation to the Choose and Book system? The appointments process still appears to be a major problem and more information is needed on how this is being resolved. When will GPs be able to book at the time of appointment? Why does there seem to be a problem with appointments being cancelled so frequently?</p>	<p>Many outpatient services can now be booked direct from the GP surgery, approximately 65% of BLT outpatient services can be booked in this way. There continue to be some issues with using the service for example</p> <ul style="list-style-type: none"> • The GP is not aware/chose not to use the CAB system • The specialty they needed to be referred to was not available on CAB and so the traditional paper route had to be followed • The patient asked to make the booking at a later time <p>Plans are in place to have all outpatient services available on Choose and Book for direct booking from GPs by March 2011. Leading up to this there will be a number of communications to GPs to ensure they are aware of the increased service.</p> <p>With regard to the clinic cancellations, these do sometimes happen and recently there has been an increase in the number of cancellations. This is due to clinical services rearranging the clinic templates and schedules in order to meet capacity standards. This work is nearing completion and we expect that the number of appointment cancellations will reduce.</p> <p>In relation to reducing clinic cancellations, this is an ongoing target for the Trust and progress has been made in some areas eg receiving adequate notice, actioning requests quickly and way in advance etc; but the current clinic capacity re-profiling work aimed at offering patients increased choice and less crowded clinics, has taken longer than anticipated and is still ongoing.</p> <p>However, Choose and Book work has progressed very well, and now all OPD services have clinics available on Choose and Book for GPs and patients to book into.</p> <p>In terms of DNAs, these continue to reduce as a result of text message reminders. Month on Month data suggest reductions by as much as 30% in some clinics. Once the</p>

GP Services

THINK provided a detailed report on GP based health services in Tower Hamlets that can be download from the website. Below is a list of our request for information and recommendations.

GP Questions

- a) Has there been any improvement in the number of unanswered calls to GP Practices? A survey carried out by the NHS Tower Hamlets PCT between November 2009 and February 2010 showed that 13% of calls went unanswered.
- b) Could we have an update on the adoption of the Virtual Ward model in Tower Hamlets?
- c) Why do practices fully book appointments? Could they not just book 50 minutes of appointments every hour knowing that there is always some over run?
- d) What are the financial consequences of practices booking fewer appointments per hour? Are GPs paid by the number of appointments? Are email and phone consultations considered appointments in terms of payments?
- e) When does the PCT think they will abolish GP boundaries? What do they see as some of the major issues concerning the opening of practice boundaries in Tower Hamlets?
- f) Will the new three digit access number be able to provide a type of triage service?
- g) How do we make it easier for patients to change GPs? Is this going to be difficult if they are working more collaboratively in a network?
- h) Could we consider a Somali focused practice that was open to anyone in the Borough as a pilot project to see if this type of practice addresses community identified needs?
- i) Can we have an update of the new interpreting tender that is about to be commissioned in Tower Hamlets? Have patients been involved in developing this? Does it include a network based model?
- j) Are there plans to have dedicated Home Visit GPs?

GP Recommendations

Short term

- a) Flexible appointment times should be offered where patients have a say in the length of their appointment time and extra time is given for people with particular needs such as interpreters, people with multiple disabilities and others with more complex needs. Evening and weekend appointments should be available to all patients who need them.
- b) Practices should develop effective telephone and email systems to enable patients to discuss issues with clinical staff and agree the best course of action. GP and Health Centre phone systems should be regularly monitored and capable of handling the appropriate volume of calls. Patients should be able to book appointments online.
- c) Practice websites should be improved to enable communication on clinical issues between patients and primary care staff. Could this be done on a network level?
- d) Clear information signposting patients to the appropriate health care provider should be provided in both written and electronic formats. This should be available to patients on the website, via email, by phone and at the surgery or centre. Frontline staff should be trained to direct patients to the most appropriate service and/or staff. Patients need to know the skills and training of every member of the primary care team, including pharmacists, so that they can make appointments based on their assessment of their needs to fit in with the skills and expertise of an appropriate member of the primary health care team.
- e) Offer follow up and test results appointments over the phone where the patient agrees for this to happen.

- f) Promote and use the Make it Happen website.
- g) Health care providers, particularly GPs, should be offering more training and development around patient care 'soft skills'.
- h) Continuity of care could be encouraged through a practitioner 'buddy system' so that patients see the same two doctors and they are able to share patient information and knowledge.
- i) Attitudes of frontline staff should be a priority management issue for surgeries and health centres; with performance standards related to patient-centred focus being a high priority. Customer care training should be closely evaluated to ensure that both uptake and quality are of a high standard.
- j) Patients should be actively encouraged by staff to use the touch screens for evaluating services and to name health care providers specifically. Third party contacts for feedback should also be publicised at the surgeries.
- k) A public education campaign is needed related to the Choose and Book system and how it works. All GPs should have information fact sheets available on how to use the system as well.

Long term

- a) An evaluation should be commissioned related to ESOL referrals from practices and whether or not this reduces the need for interpreters.
- b) Investigate the need for a dedicated time or clinic for young people or separate appointment times where clinicians are specially trained in issues relevant to young people.
- c) Clear policies should be developed and standards agreed as to how to handle latecomers and late running appointments. Patients should be given clear indications of how long their wait will be, ideally through a number system.
- d) Local quality care strategies should be developed and there should be dialogue to address the gaps in understanding and agree quality standards for GPs and health centres.
- e) Self-help groups should be established to support patients with chronic illness/long term conditions, and to enable them to participate in the design of network services systems. This approach should be linked to the development of 'expert patients' at practice level.
- f) Practice boundaries should not be used to limit the aspirations of patients to access the primary care services they need, but the loosening of practice boundaries should be managed to prevent competition between practices.
- g) Consider a dedicated information area/patient information library within practices including a computer set up for people to easily access NHS Choices, the PCT website and information under key preventative, self care programmes and long term conditions support and networks as well as feedback mechanisms such as THINK.
- h) Primary Care Networks with significant older populations should develop a strategy for home visits and how to address the needs.