BROMLEY CLINICAL COMMISSIONING GROUP - GOVERNING BODY MEETING
– MONDAY 21 JULY 2014
PUBLIC QUESTIONS AND ANSWERS

QUESTIONS RAISED AT THE PUBLIC FORUM PRIOR TO THE MEETING ON
21 JULY

WRITTEN QUESTIONS FROM THOSE PRESENT

From Tom Williams

Question 1: I read that some patients come into hospital with Pressure Ulcers/ Bed Sores whilst some patients acquire them whilst in hospital. Does the CCG know, which one has the bigger percentage, the former or the latter? If there is no knowledge of this statistic do you not think there should be?

Response:
It is correct that some patients acquire pressure ulcers at home and some whilst they are under hospital or community care. This can be for a variety of reasons as outlined in question 2. It is often difficult to pinpoint where a pressure ulcer originated as patients, particularly those who are unwell or elderly, can move across many parts of the health community. However, it is our experience in Bromley that the majority of pressure ulcers being identified for the first time are related to patients coming from their own homes.

Pressure ulcer prevalence is monitored closely both on a local level and national level and there are a number of sources of information on pressure ulcers available to the public and to commissioners.

The providers’ own websites contain quality information including information on pressure ulcers acquired under their care. Information on the number of hospital acquired pressure ulcers is nationally reportable and it is also published each quarter in the CCG’s Integrated Governance Committee papers (which come to the Governing Body meeting).

NHS England also conduct a 'snapshot' of all pressure ulcers in what is known as the Safety Thermometer - a description of this snapshot audit can be found at: http://harmfreecare.org/measurement/nhs-safety-thermometer/

Question 2: Can the CCG explain what is the cause of Pressure Ulcers/ Bed Sores?

Response: Pressure ulcers are caused by sustained pressure being placed on a particular part of the body. This pressure interrupts the blood supply to the affected area of skin. Blood contains oxygen and other nutrients that are needed to help keep tissue healthy. Without a constant blood supply, tissue is damaged and will eventually die.

The lack of blood supply also means that the skin no longer receives infection-fighting white blood cells. Once an ulcer has developed, it can become infected by bacteria.
People with normal mobility do not develop pressure ulcers, as their body automatically makes hundreds of regular movements that prevent pressure building up on any part of their body. For example, while you are asleep you may think you are lying still, but you may shift position up to 20 times a night.

Pressure ulcers can be caused by:

- pressure from a hard surface, such as a bed or wheelchair
- pressure that is placed on the skin through involuntary muscle movements, such as muscle spasms
- moisture, which can break down the outer layer of the skin (epidermis)

The time it takes for a pressure ulcer to form will depend on the amount of pressure and how vulnerable a person’s skin is to damage

Grade three or four pressure ulcers can develop over short time periods. For example, in susceptible people, a full-thickness pressure ulcer can sometimes develop in just one or two hours. However, in some cases the damage will only become apparent a few days after the injury has occurred.

There are several factors that increase the risk of developing pressure ulcers. These include:

- mobility problems – anything that affects your ability to move some or all of your body
- poor nutrition – for your skin to remain healthy, it requires nutrients that can only be supplied by eating a nutritious diet
- an underlying health condition that disrupts your blood supply or makes your skin more vulnerable to injury and damage
- being over 70 years old
- urinary incontinence and/or bowel incontinence
- serious mental health conditions

Further information is available on NHS Choices at: http://www.nhs.uk/Conditions/Pressure-ulcers/Pages/Causes.aspx

Supplementary Question: If keeping mobile makes pressure ulcers avoidable then should they be happening in hospital?

Response: Unfortunately they do happen and work is done on a ward by ward basis at the PRUH to reduce the occurrence of pressure ulcers. There is an expert Tissue Viability Team who work with staff on how to best prevent them. We certainly want to see the numbers reduced.

Question 3: At a recent Kings public meeting Tim Smart the CEO stated that 93% of the beds at the PRUE are taken up with emergency patients. This to me shows that more beds are needed and not less as is often told to the public by medical personal. What is the honest opinion of Bromley CCG. If the CCG does not agree with me how can they convince me that they are right and I am wrong?
It is worth noting that when the PRUH was built many members of the public at public meetings complained to Mark Rees and his cronies that to build the hospital with 700 beds would not meet demand. The public also voiced that the car park was too small and should be a two story building. As is the norm, in my opinion, the public were right, out voiced by a minority.

Response: Occupancy figures do vary and Tim Smart may have been referring to Denmark Hill as well as the PRUH. Generally the PRUH has between 93% and 95% occupancy overall, which includes emergency admissions as well as patients who are there for planned procedures. Emergency admissions can account for as much as 80% in winter but reduce in proportion during the summer. We are putting in measures, such as the Ambulatory Emergency Care Unit and the Clinical Decision Unit (CDU) to avoid emergency admissions and although a 9% increase has been reported nationally this is not reflected in Bromley which last year saw a fall of over 10%. This year, the rate has been more variable and we are reviewing why emergency admissions are not reducing as much as expected.

We do review the number of beds and whether we can flex up and down to fit demand. In October 2013 a demand and capacity study was done for the six SE London CCGs which concluded that we had about the right number of acute beds for the population, based on current usage and practice. We do however need to continue to reduce the average length of time patients stay in hospital and improve the flow through the system so that patients can be discharged promptly. Bromley health and social services are working well together to help patients out of hospital but there can be problems discharging patients from the PRUH to other boroughs.

Clinical practice has changed enormously in the 15 years or so since the PRUH was planned. For example, patients with appendicitis used to stay in hospital for three weeks but now they return home the next day. Keyhole surgery has meant that some colorectal and urology surgery can be done as a day treatment instead of the previous nine day stay. Long stays can be detrimental for a patient and the practice now is to keep patients in hospital for as short a time as possible and provide more community services and facilities so that people can keep mobile and receive their care from home.

OTHER QUESTIONS FROM THOSE PRESENT

From Penny Dale
Q. Do we have walk in emergency and / or walk in GP services in the borough? There is one at Peckham that relieves the pressure on A & E.

Response: We do have a walk in centre at Beckenham Beacon and the Urgent Care Centre there has GP cover provided by the practice which is on the same site. Bromley’s Out of Hours service is also staffed by GPs. There are walk in centres throughout the country but evidence is uncertain as to whether they reduce A & E demand and some are now being closed. There are other things that might be done to improve access to a GP; for example, 8am to 8pm opening hours are being piloted, although not all practices can necessarily offer this. There are also support services, like the community Rapid Medical Response Team, which visit people who need urgent help.
A campaign is planned for the autumn/winter which will publicise the NHS 111 service and to help people find the type of service they need.

From Pat Wade

Q: What time scale is foreseen for GPs to introduce longer opening hours?

Response: We may see some GP practices trialling longer hours this year and an extension of this next year. The CCG however does not drive this as Primary Care services (eg: GPs, Dentists and Opticians) are commissioned by NHS England, who also hold the GP contracts. Recently all CCGs have been invited to express interest in ‘co-commissioning’ primary care services and this may give them more say over how things are run locally.

There are many questions to be resolved regarding longer opening hours for GP practices. They are already open from 8am to 7pm Monday to Friday. Increasing to 7 days a week would require extra staff and care must be taken to make sure the quality of staff remains high. Longer hours are particularly difficult for small practices where there may be only one partner.

Practices are beginning to work together to make the most of available resources and share clinical expertise. A balance needs to be found between having quick access to a GP if needed and having the continuity of seeing the same doctor each time.

From Tom Williams

Q. Are telephone consultations available with GPs?

Response: Most practices do offer consultations by telephone and also by email.

From John Howard

Q: What monitoring of privatised contracts is being done? eg Specsavers / Boots.

Response: Private providers who deliver NHS services are bound by the National NHS contract. There are clear standards that they are expected to meet and regular contract monitoring is carried out, either directly by the CCG or by the contracts team in the regional Commissioning Support Unit (CSU). The two companies in question are monitored directly by the CCG.

As well as finance and quality factors, which are reported on a monthly basis, the CCG also draws information from GPs, Healthwatch and patients themselves. All GPs are encouraged to use a GP alert system so that the CCG can pick up issues or trends and investigate any areas of concern. Information from these various sources are pulled together and reviewed at regular Quality Review Group meetings.

From Tom Williams

I have heard about a hospital fraud of £600k through the finance department. What control does the CCG have in place to make sure this does not happen here?

Response: Sadly fraud does exist. We use the services of professional counter fraud officers to help us minimise the risk and all staff have had training to raise their
awareness and know what to look out for. CCG finances are scrutinised by both internal and external auditors and the Audit committee reviews the processes each year in order to learn lessons and plug any gaps. It is unlikely that all fraud can be prevented.