Joint Health Overview and Scrutiny Committee: Update

Report of the Director of Law and Governance

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Summary:
This report updates the Health and Adult Services Select Committee (HASSC) on the issues that were discussed at the last meeting of the Joint Health Overview and Scrutiny Committee (JHOSC), held on 17 January 2017 at Redbridge Town Hall.

Recommendations
The HASSC is recommended to note the update.

Reason
To keep the HASSC updated on issues discussed at JHOSC meetings.

1. Introduction and background

1.1 The Outer North East London JHOSC is a discretionary joint committee made up of three health scrutiny members of the following local authorities to scrutinise health matters that cross local authority boundaries:
   - Barking & Dagenham
   - Havering
   - Redbridge and
   - Waltham Forest.

(The Essex County Council Health Overview and Scrutiny Committee is permitted to appoint one member to the JHOSC).

1.2 As agreed by the HASSC at the meeting on 9 June 2016, the London Borough of Barking and Dagenham’s representatives on the JHOSC for 2016/17 are Councillors Chand, Zanitchkhah and Jones.

1.3 Four JHOSC meetings are usually held per municipal year and are chaired and hosted by each constituent authority on a rota basis. This report covers the matters that were discussed at the third meeting of this municipal year, on 17 January. The final meeting of this municipal year has been scheduled for 4.00pm on 18 April 2017 at Waltham Forest Town Hall.
2. Matters discussed at the last meeting of the JHOSC

2.1 The last JHOSC meeting was held on 17 January 2017 Redbridge Town Hall and was chaired by Councillor Dev Sharma. An outline of the matters discussed at the meeting is provided below.

2.2 Sustainability and Transformation Plan

2.2.1 The JHOSC was addressed by two representatives from the Save Our NHS group who raised a number of concerns regarding the North-East London Sustainability and Transformation Plan (STP). These related to the prospective closure of the A&E department at King George Hospital (KGH), as well as the closure of acute beds there. Concerns were also raised around what was viewed as ‘secrecy’, lack of democratic accountability and public engagement around the STP, and the feeling that key financial details were being withheld. Further concerns were raised that the STP would be devastating for the local area where a lot of new housing had been proposed but no details around where new health facilities would be located, and that GP surgeries were forming into larger networks but that there were insufficient GPs to support this model.

2.2.2 The STP officers’ response to some of the above points, as well as questions from JHOSC members, included an acceptance that there been challenges in the STP process, but assurance that the overall aim of the STP, was a positive one, which was to create a new way of working based on a partnership model to deliver a health service which was fit for the future. The decision to close the A&E at KGH had been made by the Secretary of State rather than the Barking, Havering and Redbridge Hospitals NHS Trust. Bed modelling data was likely to be available by the end of April but officers would confirm the timescale for this. It was accepted that Queen’s Hospital A&E was extremely busy and a lot of capital would be required to expand the department; however, some 50-60% of current A&E cases at KGH could still be treated at a planned enhanced urgent care centre. Work to expand the A&E at Queen’s would take over a year and depended on capital availability. The effect of the Private Finance Initiative process for Queen’s Hospital would be fed into an estates strategy. The impact on Whipps’ Cross on any closure of A&E at King George would also be considered. Furthermore, revised figures for population growth in the local area would be factored into the STP plans and there were further plans for public engagement. It was felt that the STP could be implemented and a more accessible document would be produced explain the differences the STP would make to health services.

2.3 Results of Open Dialogue Trial

2.3.1 The Associate Medical Director at North East London Foundation Trust (NELFT) explained that Open Dialogue was a new approach to that utilised the close networks of people with mental health issues in their treatment. It was based on the considerable rises in discharge rates from mental health services that had used the approach in Finland and the USA. NELFT had submitted a grant application for the evaluation of pilots of the technique that it planned to run in Havering and Waltham Forest. It was hoped that the funding would enable the largest single trial of Open Dialogue to be carried out, followed by evaluation over the next 3-4 years to show that Open Dialogue could produce marked reductions in the relapse rate and re-admission to mental health services. Confirmation of grant funding was hoped to be received by March with pilot teams starting work from mid-2017. Havering and Waltham Forest had been chosen as pilot sites as consultants from these areas had expressed most interest in Open Dialogue. Teams would be based in the Community Recovery Team offices but would also carry out home visits with a 24-hour target response time. If the funding was not
received, other sources of funds would be considered. It was also hoped that local CCGs would fund one to two consultant posts specialising in Open Dialogue.

2.4 **Great Ormond Street Hospital**

2.4.1 Unfortunately, for the second meeting in succession, Great Ormond Street Hospital had to send apologies and could not send a representative to the meeting.

2.5 **London Ambulance Service**

2.5.1 Officers from London Ambulance Service NHS Trust (LAS) stated that it had been a challenging time for the Trust with rising numbers of category A calls being received across all Outer North East London boroughs. Growth in demand was due to several factors including more referrals from both GPs and the NHS 111 service. Work was in progress to seek to manage this demand including work with other partner organisations, efforts to reduce demand via social media and, intelligent conveyancing was being introduced, whereby patients could be taken to less busy A&Es. The LAS computer aided dispatch system had failed for some hours on 1 January 2017 and officers apologised for the long patient waits during this time. One patient was known to have died during this period and this matter was currently being investigated.

2.5.2 A quality improvement plan had been published on the LAS website and the purchase of 160 replacement ambulances had been funded. A new monitoring system had been introduced for medicines management and around 700 front line staff had been recruited in the last year. There were, however, some local shortfalls in recruitment and these were being addressed. It was acknowledged that there were sometimes delays at Queen’s Hospital in handing an ambulance patient over to a clinical member of staff; however, it was not usually possible to divert ambulances elsewhere as there were similar pressures at the closest hospitals in other areas. The LAS fleet tended to move considerable distances around London over the course of a shift and there was not a shortage of ambulances themselves.

2.6 **Whipps Cross University Hospital**

2.6.1 Officers from Barts Health NHS Trust reported that, following an inspection by the Care Quality Commission (CQC) in March 2015, Whipps Cross had been rated as ‘inadequate’ and the Trust had been put into special measures. Since then, the CQC had re-inspected Whipps Cross in July 2016 and issued its report on 15 December 2016. This had shown significant improvements at Whipps Cross although the Hospital’s overall rating had remained at ‘inadequate’. Services at the hospital for children and older people were now as ‘good’ and the A&E department was now rated as ‘requires improvement’ rather than ‘inadequate’.

3. **Implications**

3.1 There are no legal or financial implications arising directly from this information report.

**Background Papers Used in the Preparation of the Report:**


**List of appendices:** None.