HEALTH SCRUTINY COMMITTEE

18 December 2018

Title: Joint Health Overview and Scrutiny Committee: Update	
Report of the Director of Law and Governance	
Open Report	**For Information**
Wards Affected: None	**Key Decision:** No
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Accountable Strategic Leadership Director: Fiona Taylor, Director of Law and Governance	
Summary This report updates the Health Scrutiny Committee (HSC) on the issues that were discussed at the last meeting of the Joint Health Overview and Scrutiny Committee (JHOSC), held on 2 October 2018, at Barking Town Hall.	
Recommendation(s) The HSC is recommended to note the update.	
Reason(s) To keep the HSC 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 HSC at its meeting on 11 September 2018, the London Borough of Barking and Dagenham's representatives on the JHOSC for 2018/19 are Councillors Keller, P Robinson and E Rodwell.

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 second meeting of this municipal year, on 2 October 2018. The next meeting will be held at 4.00pm on Tuesday 15 January 2018 at Redbrige Town Hall.

2. Matters discussed at the last meeting of the JHOSC

2.1 The last JHOSC meeting was held on 2 October 2018 and was chaired by Councillor Eilleen Keller. An outline of the matters discussed at the meeting is provided below.

2.2 BHRUT – Improving Cancer Care

The Committee received a report explaining that the Trust provided one of the largest oncology departments in the UK and offered care for patients during the acute phase of treatment as well as beyond this. The Trust had met the national 62 day cancer treatment standard for the last 13 months. Initiatives such as the Enhanced Supportive Care Team and the EMPOWER Programme – a course on dealing with cancer treatment, had been nominated for awards. The Trust also offered a state of the art radiotherapy facility at Queen's Hospital and the introduction of two halcyon machines had halved treatment times as well as making radiotherapy treatments more accurate. The Trust covered a catchment area of more than one million people and expected a 6% yearly increase in patient numbers. Current treatments offered included radiotherapy at Queen's, chemotherapy at Queen's and King George, an inpatient ward at Queen's and outpatient facilities at both sites. The Trust wished to centralise chemotherapy treatment at Queen's to improve efficiency, care and experience due to the access to specialised medical cover and the removal of the need to transport chemotherapy drugs between sites. This would allow better access to clinical trials and would offer better outcomes for patients requiring chemotherapy and radiotherapy. Current treatment pathways meant that more complex cases were seen at Queen's whilst all preassessment and clinical trials also took place at Queen's.

Some 600 patients per month were given chemotherapy at the Sunflower Suite at Queen's (compared to 450 previously) and 150 patients at the Cedar Centre at King George (comparted to 200 previously). More choice of appointment times could be offered at the Queen's unit which was open six days per week. There was also a dedicated pharmacy production unit at Queen's whereas chemotherapy had to be transported four times a day to King George. The Trust therefore felt that just having chemotherapy at Queen's would reduce patient delays. Longer term plans included a phone triage service for chemotherapy patients which would allow those patients needing urgent help to go straight to the cancer unit, rather than wait in A & E.

Some 20% of patients receiving chemotherapy at BHRUT would be affected by the proposed change. The expected rise in more complex cases over time (which would be seen at Queen's) was likely to reduce this figure. It was accepted that some people would experience increased travel times but officers felt that the better patient experience would outweigh this. Hospital transport would continue to be provided as necessary and there remained a dedicated free car park at Queen's for

oncology patients during treatment. Reduced waiting times would mean that car park capacity was unlikely to be an issue.

The Trust wished to implement the changes by the end of October and BHRUT officers did not feel that this was a significant change to how services were delivered. Engagement had been undertaken with patient groups and, once the changes were agreed, leaflets about the changes would be distributed across both hospitals and a frequently asked questions page placed on the Trust website. All members of the Trust's Patient Partnership Council (PPC) supported having chemotherapy services on one site and it was felt that there would be capacity for this at Queen's with the possibility of chemotherapy being available on Sundays in the future.

2.3 Health Based Places of Safety

Offices explained the role of s. 136 health based places of safety which allowed the assessment of people detained with mental health problems to take place in a more appropriate environment. Currently, not all such places of safety were open 24:7 or allowed enough privacy and there were also some shortages of trained staff.

It was proposed to close the s. 136 suite at the Royal London Hospital which, being located next to the A & E department, was not considered fit for purpose. Extra staff would be allocated to the suite at the Homerton Hospital and the suite at Goodmayes Hospital (Sunflowers Court) would also retained. The future of the suite at Newham Hospital would be decided after a further year of operation.

The lead officer for mental health at the Metropolitan Police stated that police received over 4,000 calls a year relating to mental health issues. The detainment of a person under s. 136 arrangements could police offices for a full shift although it was wholly accepted that mental health issues were a core part of policing. Police currently found difficulties in transferring people to a place of safety and needed confidence that they could take people at any time to well managed and fully staffed suites with less waiting time for police officers.

The Deputy Director of Quality and Nursing at London Ambulance Service (LAS) accepted that patients in a mental health crisis often received a very poor service. The LAS received around 400 calls a day from people in mental health crisis and there were cases of people with a mental health crisis waiting 12-14 hours to access a place of safety. The LAS wished to see a reduction in the number of places of safety but an increase in their capacity, opening hours etc. It was felt there had been a very good consultation on the issue with many people engaged. It was felt that the changes would free up ambulances but would also be better for patients. There would be some increases in travel time but it was noted that people could already often not obtain space in their local units. The LAS therefore supported the proposals.

It was felt that a better built environment would offer patients safety, privacy and dignity. The recruitment of more staff in places of safety would lead to reduced waiting times. Department of Health funding had been secured for two more rooms at Homerton and one more room at Goodmayes Hospital. Further modelling would be undertaken with the CCGs around whether to increase staffing at the Goodmayes suite.

It was felt that 40-50% of people taken to places of safety were not previously known to mental health services. There was good cooperation between the police and the NHS and work on assessing the street triage service was continuing both across London and nationally. It was felt however that telephone triage services were more cost effective in many areas. The NELFT mental health helpline was available to patients (and police) on a 24:7 basis. It was suggested that an update from NELFT could on the Trust's street triage service could be taken at a future meeting of the Committee. Mental health nurses had also now been introduced to the LAS which allowed better linkage of patients to mental health services.

Whilst the suite at the Royal London Hospital was not proposed to be kept due to a lack of space on the site, cost issues were also an important factor. It was not affordable for commissioners to staff a s. 1236 unit at the Royal London and officers wished to see fewer but better units across London. Individual configurations of service were the decision of the East London Health and Care Partnership. It was accepted that increased patient travel times posed a risk but the enhanced quality of care and patient experience outweighed this.

A travel time analysis from the Tower Hamlets area to the unit at Homerton Hospital had been undertaken and had shown that there would not be a huge increase in travel time. There was no hard and fast rule on border issues for s. 136 calls. The Police were reliant on health services to say place of safety a patient should be taken to. It was wished to phase out the use of police cells as places of safety although it was accepted cells were used more often in Essex than they were in London. Detailed data on mental health-related calls by borough was kept by the LAS and it was expected that there would be an average of two s. 136 admittances each day. The representative from the Police added that the Police accepted the need for rationalisation and that the proposals did not reduce the overall number of beds

2.4 Healthwatch Havering – Services for People who have a visual disability

A director Healthwatch Havering explained that the organisation's report on services for people with a visual disability focussed on Havering but it was felt that many of the problems and issues scrutinised may well also apply elsewhere in Outer North East London. The report had previously been well received by the North East London eye health group. It was felt that the clinical pathway in Havering fir visual impairment was very confusing with ophthalmologists often being unable to refer patients direct to hospital. In addition the Queen's Hospital ophthalmology department operated from a very cramped building with poor patient communications often via an electronic board that many patients were unable to see clearly.

A Royal National Institute for the Blind eye clinic liaison officer had now been reinstated at Queen's Hospital as some office accommodation had been made available. Healthwatch had found that fewer Certificates of Visual Impairment, which allowed access to services from the Local Authority etc, had been issued than expected. BHRUT could not however confirm how many certificates had been issued and to which boroughs. Healthwatch Havering was therefore concerned at the lack of data available with which to plan services.

It was noted that, since the publication of the report in June 2018, BHRUT had made a bid for capita funding to improve the ophthalmology department at Queen's Hospital. The Healthwatch director agreed that eye services across London were often somewhat piecemeal in nature. There was no overall plan for eye health services across London although this could of course change in the future

Public Background Papers Used in the Preparation of the Report: None

List of appendices: None