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JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

4.00 pm	**Tuesday 9 April 2019**	**Council Chamber, Redbridge Town Hall, 128-142, High Road, Ilford, Essex IG1 2DD**

COUNCILLORS:

LONDON BOROUGH OF BARKING & DAGENHAM

Councillor Eileen Keller
Councillor Paul Robinson
Councillor Emily Rodwell

LONDON BOROUGH OF WALTHAM FOREST

Councillor Richard Sweden
Councillor Saima Mahmud
Councillor Catherine Saumarez

LONDON BOROUGH OF HAVERING

Councillor Nic Dodin
Councillor Nisha Patel
Councillor Ciaran White

ESSEX COUNTY COUNCIL

Councillor Chris Pond

LONDON BOROUGH OF REDBRIDGE

Councillor Stuart Bellwood
Councillor Beverley Brewer
Councillor Neil Zammett (Chairman)

EPPING FOREST DISTRICT COUNCIL

Councillor Aniket Patel (Observer Member)

CO-OPTED MEMBERS:

Ian Buckmaster, Healthwatch Havering
Mike New, Healthwatch Redbridge
Richard Vann, Healthwatch Barking & Dagenham

For information about the meeting please contact:
Anthony Clements, anthony.clements@oneSource.co.uk 01708 433065

Protocol for members of the public wishing to report on meetings of the London Borough of Havering

Members of the public are entitled to report on meetings of Council, Committees and Cabinet, except in circumstances where the public have been excluded as permitted by law.

Reporting means:-

- filming, photographing or making an audio recording of the proceedings of the meeting;
- using any other means for enabling persons not present to see or hear proceedings at a meeting as it takes place or later; or
- reporting or providing commentary on proceedings at a meeting, orally or in writing, so that the report or commentary is available as the meeting takes place or later if the person is not present.

Anyone present at a meeting as it takes place is not permitted to carry out an oral commentary or report. This is to prevent the business of the meeting being disrupted.

Anyone attending a meeting is asked to advise Democratic Services staff on 01708 433076 that they wish to report on the meeting and how they wish to do so. This is to enable employees to guide anyone choosing to report on proceedings to an appropriate place from which to be able to report effectively.

Members of the public are asked to remain seated throughout the meeting as standing up and walking around could distract from the business in hand.

Essex County Council

Waltham Forest

Havering LONDON BOROUGH

London Borough of Redbridge

London Borough of Barking & Dagenham lbbd.gov.uk

NOTES ABOUT THE MEETING

1. HEALTH AND SAFETY

The Joint Committee is committed to protecting the health and safety of everyone who attends its meetings.

At the beginning of the meeting, there will be an announcement about what you should do if there is an emergency during its course. **For your own safety and that of others at the meeting, please comply with any instructions given to you about evacuation of the building, or any other safety related matters.**

2. CONDUCT AT THE MEETING

Although members of the public are welcome to attend meetings of the Joint Committee, they have no right to speak at them. Seating for the public is, however, limited and the Joint Committee cannot guarantee that everyone who wants to be present in the meeting room can be accommodated. When it is known in advance that there is likely to be particular public interest in an item the Joint Committee will endeavour to provide an overspill room in which, by use of television links, members of the public will be able to see and hear most of the proceedings.

The Chairman of the meeting has discretion, however, to invite members of the public to ask questions or to respond to points raised by Members. Those who wish to do that may find it helpful to advise the Clerk before the meeting so that the Chairman is aware that someone wishes to ask a question.

PLEASE REMEMBER THAT THE CHAIRMAN MAY REQUIRE ANYONE WHO ACTS IN A DISRUPTIVE MANNER TO LEAVE THE MEETING AND THAT THE MEETING MAY BE ADJOURNED IF NECESSARY WHILE THAT IS ARRANGED.

If you need to leave the meeting before its end, please remember that others present have the right to listen to the proceedings without disruption. Please leave quietly and do not engage others in conversation until you have left the meeting room.

AGENDA ITEMS

1 CHAIRMAN'S ANNOUNCEMENTS

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.

Apologies have been received from Councillor Nisha Patel, London Borough of Havering.

3 DISCLOSURE OF INTERESTS

Members are invited to disclose any interests in any of the items on the agenda at this point of the meeting. Members may still disclose an interest in an item at any point prior to the consideration of the matter.

4 MINUTES OF PREVIOUS MEETING (Pages 1 - 6)

To agree as a correct record the minutes of the meeting held on 15 January 2019 (attached) and to authorise the Chairman to sign them.

5 NHS LONG TERM PLAN (Pages 7 - 18)

Report and presentation attached.

6 NELFT STREET TRIAGE SERVICE (Pages 19 - 36)

Report and presentation attached.

7 ACCESS TO HEALTHCARE BY VULUNERABLE MIGRANTS (Pages 37 - 44)

Healthwatch Redbridge report attached.

8 JOINT COMMITTEE'S WORK PLAN

The Joint Committee is asked to suggest any further items for scrutiny at future meetings.

Anthony Clements
Clerk to the Joint Committee

MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Waltham Forest Town Hall
15 January 2019 (4.00 - 5.30 pm)

Present:

COUNCILLORS

London Borough of Barking & Dagenham	Eileen Keller
London Borough of Havering	Nic Dodin and Nisha Patel
London Borough of Redbridge	Stuart Bellwood, Beverley Brewer and Neil Zammett
London Borough of Waltham Forest	Saima Mahmud (Chairman) Richard Sweden, and Catherine Saumarez
Essex County Council	Chris Pond
Epping Forest District Councillor	Aniket Patel (Observer Member)
Co-opted Members	Cathy Turland, Healthwatch Redbridge (substituting for Mike New)

Apologies were received for the absence of Ian Buckmaster, Healthwatch Havering and Richard Vann, Healthwatch Barking and Dagenham.

The Chairman reminded Members of the action to be taken in an emergency.

17 **APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.**

Apologies were received from Ian Buckmaster, co-opted member, Healthwatch Havering and Richard Vann, co-opted member, Healthwatch Barking & Dagenham.

18 **DISCLOSURE OF INTERESTS**

Agenda Item 7 - JOINT COMMITTEE'S WORK PLAN.

Councillor Richard Sweden, Personal Interest - managed, though not employed by, North East London NHS Foundation Trust.

19 **MINUTES OF PREVIOUS MEETING**

The minutes of the meeting of the Sub-Committee held on 2 October 2018 were agreed as a correct record and signed by the Chairman.

A request was made for the clerk to seek to obtain figures for the numbers of Essex patients using the Cedar Centre at King George Hospital.

20 **BHRUT - CANCER SERVICES UPDATE**

BHRUT officers addressed the Committee and stated that they wished to improve outcomes for patients and sought to develop a world class cancer centre based in Romford. The 62-day target for cancer treatment had now been met by the Trust for 17 months in a row and Queen's Hospital now offered state of the art radiotherapy services. Change had been driven by clinical need of the rising population in North East London.

King George Hospital was unable to offer as good cancer care as Queen's and there was not any radiotherapy available at King George. Queen's Hospital offered a dedicated teenage cancer unit and could also cater better for patients with disabilities. Queen's also offered longer opening hours for its services including Saturdays as well as the ability to run patient trials for cancer treatments.

Patient and staff safety was a challenge at King George as well as staffing shortfalls which were also an issue nationally. Two vacancies had recently been recruited to with another two currently being interviewed for. Chemotherapy services had moved from King George to Queen's which had allowed the opening of a Living with Cancer Hub at King George in December 2017. This had been attended by 60 people thus far (27% from Redbridge) and had received very positive feedback from service users.

It was confirmed that all King George chemotherapy patients had transferred successfully to the Sunflowers Suite at Queen's and patient transport was available if required.

BHRUT officers accepted that they should communicate more with all stakeholders and agreed that they would work with Healthwatch on the changes. A dedicated Patient Partner was also available to give the patient's viewpoint.

A Member from Redbridge stated that legal advice he had received was that the services should be subject to consultation and felt that BHRUT or the Clinical Commissioning Groups (CCGs) should therefore consult on this matter. The Member felt that this had been agreed at the Committee's

previous meeting and that Healthwatch should also be involved in any consultation.

Officers from BHRUT added that staff shortages had made it untenable to stay at King George and agreed with a Member's statement that it would be for the CCGs to lead on any consultation. The Trust was happy to work with Healthwatch and accepted that Healthwatch did not necessarily endorse the service changes.

Members accepted that patient safety should be a priority but also raised the point that it was not credible that the staffing issues should arise so quickly after the last meeting had taken place and that the behaviour of BHRUT around the issue may not have been befitting of a partnership. A representative of Healthwatch Redbridge confirmed the organisation been involved in the engagement work but also felt that the closure of the service at King George had been very quick. It was planned that Healthwatch engagement work with patients would commence by March 2019. BHRUT supported the involvement of Healthwatch but felt that full public consultation was not the right approach and that cost issues would also be involved.

Officers confirmed that transport would be offered to patients who became unwell during the course of their treatment. It was emphasised that the Cedar Centre was not closing and would continue to offer post-treatment support to cancer patients – a very important area. Members felt however that this could not be compared with the chemotherapy service and, whilst the scope of consultation could be discussed, this should be agreed in principle. Members also felt that there had been a fault in the process and that the extra demand on services at Queen's was also a concern.

Trust officers responded that the opening of the chemotherapy unit at Queen's for longer hours and on Saturdays meant that it would be able to cope with the additional demand. It was possible that the unit would open 7 days per week in the future.

The Joint Committee **AGREED** unanimously (with one abstention) that the clerk should draft a letter requesting the CCGs organise consultation of some kind on the recent changes to cancer services.

21 KING GEORGE HOSPITAL UPDATE

Work at King George Hospital to enable the opening of the Living Beyond Cancer hub had now been completed and the new facility had opened. A replacement CT scanner had also recently been installed at King George.

It was accepted that the previous Health for North East London plans from 2011 were now outdated and that a new approach was needed for healthcare in the local area. No additional capital funds were available and

so it had been necessary to review the strategy for health services across the local boroughs. A new position statement for the future of both King George and Queen's Hospitals was therefore expected to be released by the CCGs in early February 2019.

Officers accepted that there were recruitment challenges but this was common across the UK and internationally and these needed to be addressed if safety issues were to be avoided.

King George Hospital received around 70 ambulances per day and this was evidence of the need for emergency care across the area. BHRUT would work with clinicians on the exact configuration of these services. The Trust Chief Executive felt it would not be a viable option to close King George A & E and move those services to Queen's.

Members agreed that there needed to be a strategy across the BHR area as a whole but requested more details of e.g. the strategy for cancer services. Officers accepted that the rising population of the area needed to be taken into account and much of the complex work on strategies would need to be undertaken by the East London Health and Care Partnership, with the support of the CCGs.

A request was made that the Essex Health Overview and Scrutiny Committee be kept informed of any new BHRUT clinical plan. Daily information was kept by the Trust on readmission rates of discharged patients but these were relatively low. Further information on readmissions could be provided to the Committee.

The establishment at the Trust of a School of Surgery had assisted with overseas recruitment to surgery vacancies although there remained many incidences where locum staff had to be used. The possibility of developing a medical school on the King George site would also help with recruitment difficulties. It was suggested that the Committee could consider the wider determinants of health at a future meeting with the assistance of CCG and Public Health colleagues.

The Trust stated that it was anticipated that any public consultation on proposed changes at King George would take place in early 2020. If capital funding was required, this would have to be applied for via NHS processes and failure to obtain the required funding could lead to further closures of facilities at the site. It was anticipated that options for the future of King George Hospital would be available by late 2019.

The Joint Committee **NOTED** the update.

22 **JOINT COMMITTEE'S WORK PLAN**

Suggestions for future work programmes included determinants of public health, the proposed relocation of Moorfields Eye Hospital and the closure of Moore Ward at Goodmayes Hospital which catered for patients with disabilities from across Outer North East London.

The representative from Healthwatch Redbridge added that the Committee may also wish to receive a report the organisation had compiled with the Refugee and Migrant Forum for East London regarding the experiences of migrants when receiving medical care. Healthwatch Redbridge would supply further details to the clerk of the Committee.

Chairman

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Havering
LONDON BOROUGH

OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 9 APRIL 2019

Subject Heading:	Delivering on the NHS Long Term Plan Commitments in North East London
Report Author and contact details:	**Anthony Clements, Principal Democratic Services Officer, London Borough of Havering**
Policy context:	**The information presented gives initial details of the impact of the NHS Long Term Plan on North East London**
Financial summary:	**No impact of presenting information itself.**

SUMMARY

NHS officers will present to the Joint Committee details of how it is planned to deliver commitments outlined in the NHS Long Term Plan in North East London.

RECOMMENDATIONS

1. That the Joint Committee considers the frequency of updates that it would like on progress with the implementation of the NHS Long Term Plan and notes that these issues could also be scrutinised jointly with the equivalent Committee for Inner North East London.
2. That the Joint Committee considers the information presented and takes any action it considers appropriate.

REPORT DETAIL

The new Long Term Plan for the NHS was agreed and launched at national level in early 2019. NHS officers will present to the Joint Committee (presentation attached) a summary of the commitments in the plan and local work planned to implement these. The process of engagement as the Plan is fully developed will also be outlined.

Members may wish to note that it may be more productive for future detailed scrutiny of this issue to be undertaken on a joint basis with the Inner North East London Joint Health Overview and Scrutiny Committee. As Members are aware, an initial joint meeting with that Committee has been provisionally arranged for 18 September 2019 at 4 pm.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

East London Health & Care Partnership

Towards Integrated Care: Delivering on the NHS Long Term Plan Commitments in North East London

Simon Hall
Director of Transformation, ELHCP
March 2019

Who we are – North East London

East London Health & Care Partnership

We are:

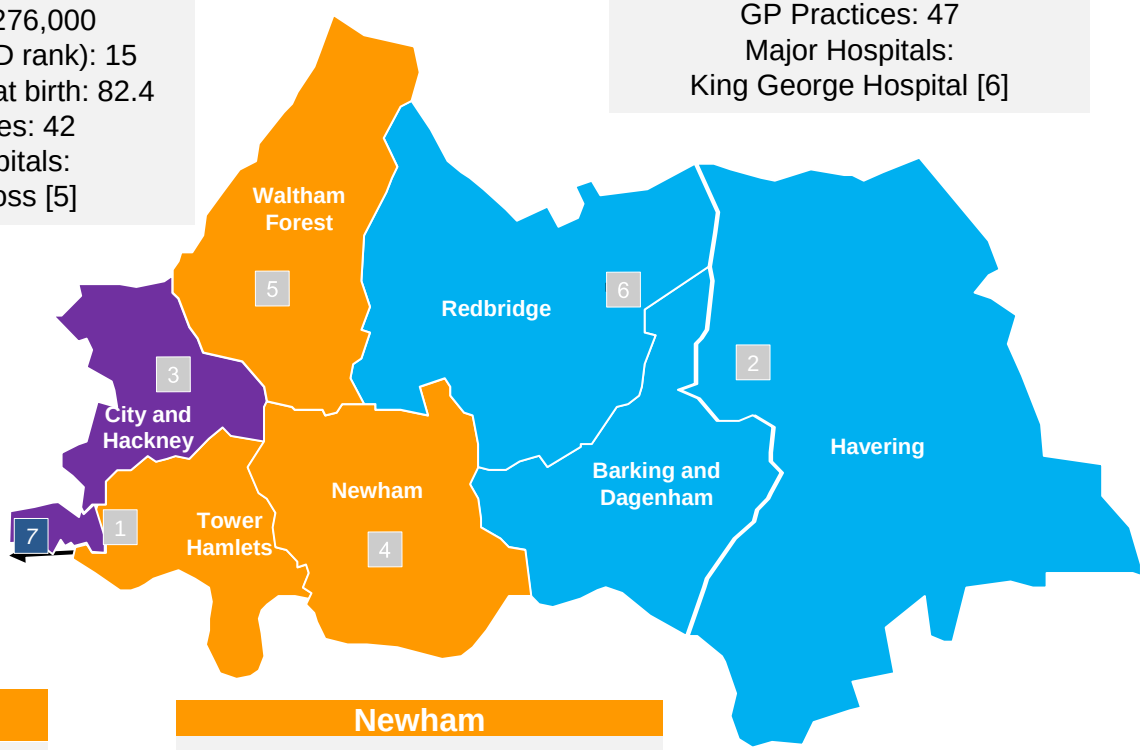
- **7 CCGs**
- **8 London Councils**
- **5 NHS Trusts – 3 acute and 2 community**
- **304 GP Practices**

Waltham Forest

Population: 276,000
Deprivation (IMD rank): 15
Life Expectancy at birth: 82.4
GP Practices: 42
Major Hospitals:
Whipps Cross [5]

Redbridge

Population: 300,600
Deprivation (IMD rank): 119
Life Expectancy at birth: 82.7
GP Practices: 47
Major Hospitals:
King George Hospital [6]



City and Hackney

Population: 277,000
Deprivation (IMD rank): 2 (Hackney) & 226 (City of London)
Life Expectancy at birth: 80.9 (Hackney)
GP Practices: 44
Major Hospitals
Homerton[3]
St Bartholomew's [7]

Havering

Population: 250,500
Deprivation (IMD rank): 166
Life Expectancy at birth: 81.9
GP Practices: 40
Major Hospitals:
Queen's Hospital [2]

Tower Hamlets

Population: 296,300
Deprivation (IMD rank): 6
Life Expectancy at birth: 81.0
GP Practices: 41
Major Hospitals
Royal London [1]

Newham

Population: 338,600
Deprivation (IMD rank): 8
Life Expectancy at birth: 81.3
GP Practices: 50
Major Hospitals
Newham University Hospital [4]

Barking and Dagenham

Population: 206,700
Deprivation (IMD rank): 3
Life Expectancy at birth: 80.0
GP Practices: 40

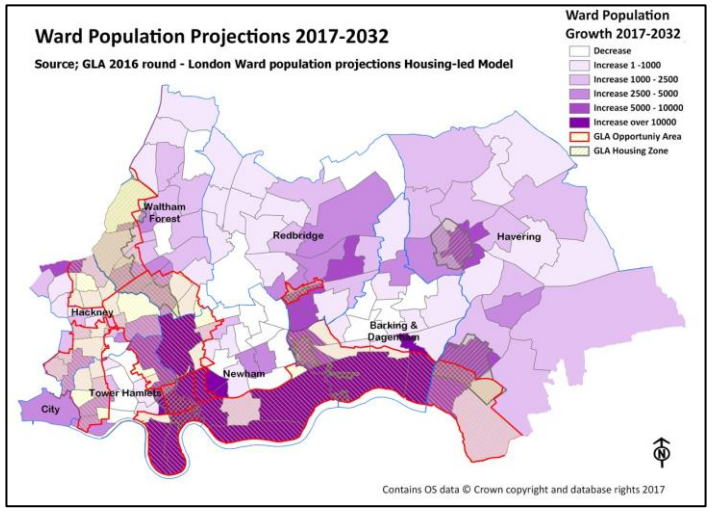
Our Challenges:

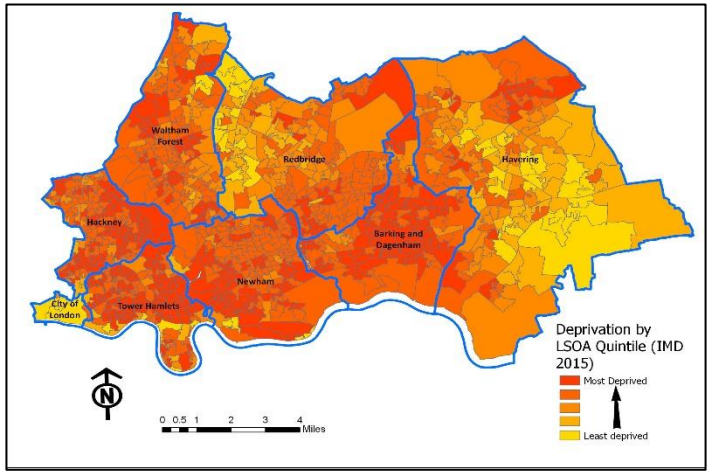
East London Health & Care Partnership

We have

- the highest population growth in London – equivalent to a new borough in the next 15 years
- Poor health outcomes for local people including obesity, cancer, mental health, dementia
- A changing population with increasing diversity, people living longer especially with 1 or more health issues and a high reliance on health and care services
- High deprivation with high proportions relying on benefits, experiencing fuel poverty, unemployment and poor housing and environments
- Service quality issues including a high reliance on emergency services, late diagnoses and treatment and access to services particularly primary care
- Health and care workforce with a high turnover, recruitment difficulties and high reliance on temporary agency workers
- Funding – there is a gap between the demand and cost of services with the resources available - if we do nothing. This is estimated at £1.2bn over the next 5 years

We also recognise that there is significant variation between each borough – health and care outcomes, population, services and quality, relationships between organisations and resources





The NHS Long Term Plan sets out the ambitions to transform our health and social care over the next 10 years

East London Health & Care Partnership

Making sure everyone gets the best start in life

- reducing stillbirths and mother and child deaths during birth by 50%
- ensuring most women can benefit from continuity of carer
- providing extra support for expectant mothers at risk of premature birth
- expanding support for perinatal mental health conditions
- taking further action on childhood obesity
- increasing funding for children and young people's mental health
- bringing down waiting times for autism assessments
- providing the right care for children with a learning disability
- delivering the best treatments available for children with cancer.

Delivering world-class care for major health problems

- preventing 150,000 heart attacks, strokes and dementia cases
- preventing 14,000 premature deaths through education and exercise to patients with heart problems
- saving 55,000 more lives a year by diagnosing more cancers early
- investing in spotting and treating lung conditions early to prevent 80,000 stays in hospital
- spending at least £2.3bn more a year on mental health care
- helping 380,000 more people get therapy for depression and anxiety by 2023/24
- delivering community-based care for 370,000 people with severe mental illness a year by 2023/24.

Supporting people to age well

- increasing funding for primary and community care by at least £4.5bn
- bringing together different professionals to coordinate care better
- helping more people to live independently at home for longer
- with more rapid community response teams to prevent unnecessary hospital spells and speed up discharges
- upgrading NHS staff support to people living in care homes.
- improving the recognition of carers and support they receive
- making further progress on care for people with dementia
- giving more people more say about the care they receive and where they receive it

We will do this by:

- **Doing things differently** – giving people more control of their care, joining services up, more care closer to home
- **Preventing ill health** – increasing health prevention initiatives
- **Increasing the workforce** – making the NHS a better place to work, creating more routes into the NHS, and recruiting more professionals
- **Increasing digital** – make accessing the NHS more convenient, better digital services and patient records, improved use of data for planning
- **Value for money** – reduce duplication, and spend on administration

Our System Achievements since 2016

East London Health & Care Partnership

Improvements in Quality and Performance

- Significant improvements in Care Quality Commission ratings across all Trusts: ELFT – Outstanding; Homerton & NELFT – Good; BHRUT & Barts have exited special measures.
- Of our 7 CCGs, 1 is rated Outstanding and a further 3 are rated Good.
- Improvements in primary care, with the proportion of good or Outstanding GP practices improving in all CCGs – with 1 CCG now having only Good or Outstanding practices.
- Improvements in cancer services, with the 62-day treatment standard achieved for the last 18 months consistently.
- 100% coverage of 7-day primary care access.

Progression to Integrated Care

- Development of strong place based delivery systems building on Devolution Pilots (City/Hackney and BHR) and Tower Hamlets Vanguard.
- ELPR (East London Patient Record) rolled out in WEL and C&H and underway in BHR. Usage doubled in 1 year (current 112,000 views per month)
- ELHCP health analytics programme (Discovery) adopted as a core component of the London Health Care Record programme.
- Personalised care programme agreed for STP building on significant progress made in TH on personal budgets.

Developing our local Workforce

- International GP recruitment, 8 GPs in 18/19
- Successful medical student expansion scheme, 32 additional places in 19/20
- 21 Physician Associates graduating through ELHCP scheme (on target to have more PAs than rest of London combined)
- GP retention initiatives enabled more GPs to stay living and working in east London.
- Medical student expansion scheme
- Good progress in apprenticeships made, particularly at Barts
- Healthy Workplace Charter adopted by all Councils and majority of Trusts.

Innovation and Service Development

- £5.2m secured for a cancer early diagnostic centre.
- Improved NHS 111 service successfully implemented
- Development of a first cut Estates Strategy for the NHS across ELHCP.
- Direct booking for GP hub and home visiting services enabled on-line.
- £7.5m London wide digital infrastructure capital funding secured, £3.5m in 2018/19.
- ERS (Electronic Records) programme delivered and paper switch off achieved for outpatient referrals to hospitals.

We already have major programmes addressing many of the commitments in the Long Term Plan

East London Health & Care Partnership

Area	ELHCP Programme	Gaps / Areas to address
Cancer	☑	• Targeting specific groups incl CYP and older men • Lung cancer
End of Life	☑	• Consistency - training and CYP
Maternity	☑	• Consistency - digital records, care plans and Saving babies Lives care bundle
Personalisation	☒	• Integrate work on social prescribing, personal health budgets, care plans
Urgent and Emergency Care	☑	• Consistency – UTCs, frailty
Mental Health	☑	• Consistency - investment in primary and community services
Children & Young People	☒	• Consistency - LD / autism / SEND • Transition arrangements – child – adult
Primary Care	☑	• Consistency - working at scale (Networks) • Enhanced role – prevention, care homes, digital services
Digital	☑	• Consistency - digital apps and care records, remote monitoring • Integrated child protection
Workforce	☑	• Expanded and integrated recruitment and retention • Focus on leadership, involvement and OD • New ways of working including digital and flexible workforce,
System Reform, Estates and Resources	☑	• Resources to support transformation and investment in community / primary • At scale delivery where effective • ICS and system approaches to sustainability incl. contracting

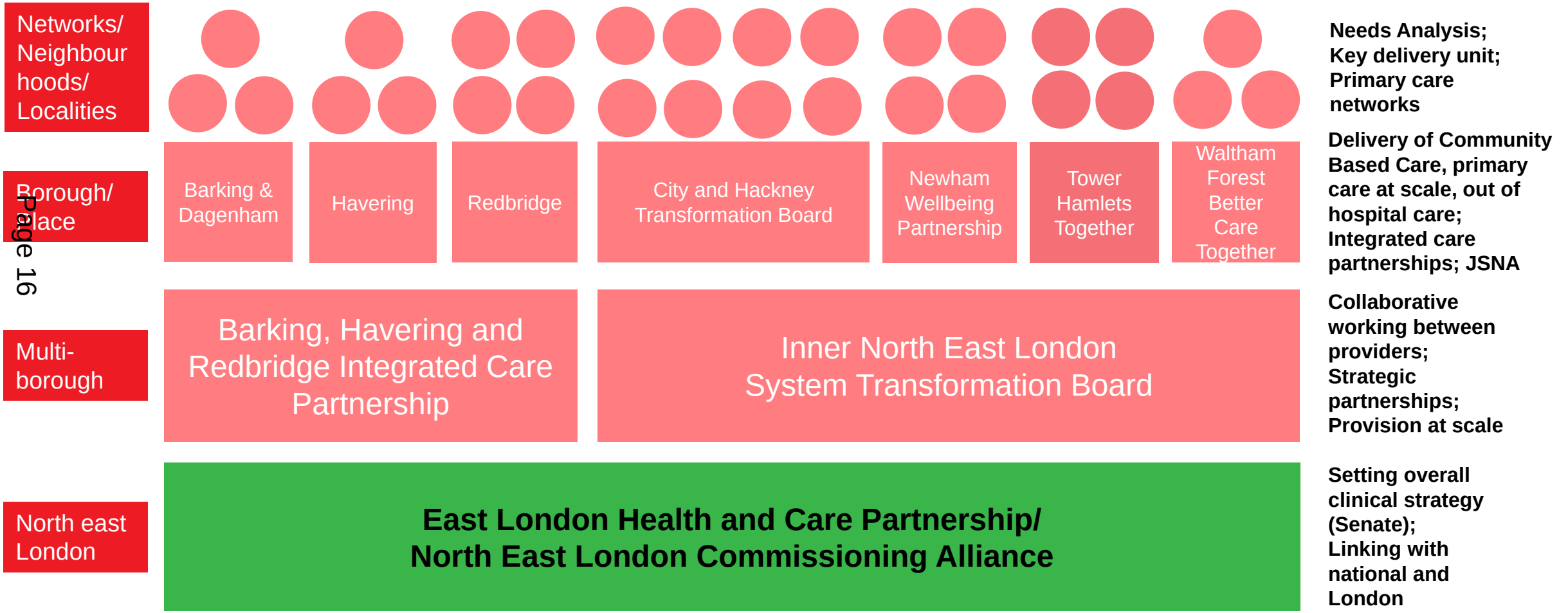
The NHS Long Term Plan has a number of commitments and issues where we need to focus further 2019-23

East London Health & Care Partnership

Personalisation	Workforce	Primary Care	Prevention	Resources
• Consistent social prescribing approach (new link workers in primary care) • Developing personal health budgets (e.g. extended offer to people with cancer) and clear linkage with personal budgets in social care • Personal care records and care plans • Use of telehealth and remote monitoring	• A partnership approach with local councils and other partners (e.g. skills advisory panels) • Better use of technology and smarter working across partners (e.g. maternity passport) • Extend support and use of volunteers / apprentices • Further commitments and targets to be released in April	• Development of primary care network infrastructure to support improved service delivery • Support to prevention and lifestyle management (social prescribing) • Care home support	• Support to self-care and building local resilience • Community wealth building / regeneration – work / leisure / crime (the wider determinants of health) • Emphasis on health inequalities (linked to London Mayor's Health Inequality Strategy)	• Pooling of resources to support transformation • Shifting resources into community and primary care from hospitals • Need to ensure that health and care systems become "sustainable"

Integrated Health and Care in North East London
(March 2019 DRAFT)

East London Health & Care Partnership



Common framework for integrated care delivery and planning in north east London

East London Health & Care Partnership

Neighbourhood Network/ Locality	• Understanding local need, including predictive analysis • Coordinating care for the defined population of local people • Improving service access and quality of care for local people • Addressing inequalities and unmet need • Co-producing and co-designing health services with patients and the public • Helping local people to stay healthy to include the wider determinants of health and positive mental wellbeing • Using personalised interventions to support care navigation, e.g. social prescribing/personal health and care budgets • Mobilising community assets to improve health and wellbeing • Primary care networks, delivering enhanced services (e.g. long-term condition management at GP practice/group level)
Borough/ Place	• Developing local health and care plans to integrate health, social care and voluntary and community services at neighbourhood/network and borough level to address key challenges and improve outcomes for local people • Ensuring borough-based service commissioning and delivery, linked to place based strategies • Supporting the development of neighbourhoods and networks and to hold them to account • Addressing inequalities within and between neighbourhoods/networks • Focus on effective use of resources across the system, improving outcomes and service quality for local people • Delivery of local community-based services (e.g. Children & Young People's services, IAPT)

Multi-borough	• Strengthen system support for local health and care integration partnerships and plans • Enable and support greater provider collaboration, increasing utilisation of existing capacity and resource and the development of provider alliances • Develop and enable a collaborative approach to tackling significant system challenges • Delivery of key clinical strategies best planned across multi-borough footprint (e.g. frail elderly pathway, homelessness, planned care/outpatients, prevention) • Achievement of key performance standards (e.g. cancer diagnostic standard, mental health investment standard) • Delivery of networked services (e.g. diagnostics)
ELHCP	• Oversight and support of system development and 'once for north east London' infrastructure development (e.g. Discovery) • Delivering on enablers to support system development including digital, workforce, estates and financial sustainability • Holding systems to account for delivery of outcomes-based care for local people • Leading transformation programmes best planned across the north east London footprint (cancer, maternity, mental health) • Providing strategic overview and direction for multi-borough and place-based transformation programmes (e.g. end of life care, primary care, prevention, personalisation) • Leadership of clinical strategy for north east London through the Clinical Senate (e.g. neuro-sciences)
NELCA	• Strategic commissioning development around key priorities and outcomes • Development and agreement of commissioning strategy to support the ELCHP transformation plan • Commissioning governance and decision making • Future responsibility for specialised commissioning

Refreshing the ELHCP Strategy: High Level Engagement Timetable

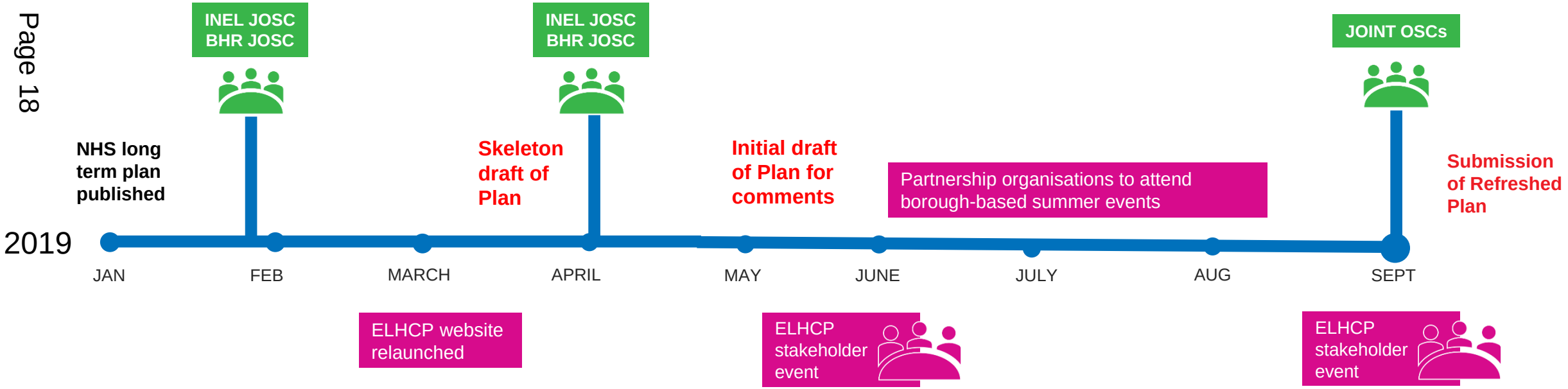
East London Health & Care Partnership

Engagement and discussion with Health & Wellbeing Boards in each local Council area; Engagement with local politicians;

Integrated commissioning meetings at Place level; CCG and NHS provider Boards;

Public engagement events – at neighbourhood and Borough level, with local provider and commissioner leadership

Healthwatch events – local and cross-ELHCP activity co-ordinated by Waltham Forest Healthwatch



ELHCP Citizens' Panel: ongoing panel questions on issues related to the NHS long term plan & ELHCP refresh

Ongoing opportunities on social media and website to contribute comments/ideas

Havering
LONDON BOROUGH

OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 9 APRIL 2019

Subject Heading:	NELFT Street Triage Service
Report Author and contact details:	**Anthony Clements, Principal Democratic Services Officer, London Borough of Havering**
Policy context:	**The information presented gives details of the Street Triage Service operated by the North East London NHS Foundation Trust (NELFT).**
Financial summary:	**No impact of presenting information itself.**

SUMMARY

NELFT officers will present to the Joint Committee details of the Street Triage Service provided by the Trust for people who may be experiencing mental health problems.

RECOMMENDATIONS

1. That the Joint Committee considers the information presented and takes any action it considers appropriate.

REPORT DETAIL

A Street Triage Service has been established by NELFT in recent years in order to allow Mental Health Professionals to provide immediate advice to police officers who are dealing with people with possible mental health problems.

The service covers all the boroughs represented on the Outer North East London Joint Health Overview and Scrutiny Committee and further details are given in the attached presentation.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

NELFT NHS
NHS Foundation Trust

NELFT STREET TRIAGE TEAM

Based at Sunflowers Court, Goodmayes Hospital, Barley Lane Ilford Essex IG3 8XJ

Jacqui Van Rossum – Executive Integrated Care Director – NELFT

Caroline O'Donnell – Integrated Care Director – Acute and Rehabilitation Directorate (ARD)

MH Crisis Care Concordant

- In 2014 NHS England welcomed the Mental Health Crisis Care Concordat as an important step forward in improving care and standards for people in a mental health crisis. The Concordat, launched by the Department of Health, is a joint agreement which describes how police, mental health services, social work services and ambulance professionals should work.

NELFT Street Triage was introduced and piloted to meet the requirement of the MH Crisis Concordant which focuses on Access to Support 24hrs, Urgent and Emergency Access to Crisis Care, Quality of Treatment and Care & Recovery.

- The introduction of Street Triage allowed Mental Health Professionals to provide immediate advice to police officers who are dealing with people with possible mental health problems.

Why Street Triage?

- 1 in 4 people experience a mental health problem at any one time in their lives
- Policing Mental Health relates to about 20% of police time, meaning they will often come across suspects, victims & witnesses who are suffering from MH issues
- Home office, Department of Health and Ministry of Justice have identified a need to work more collaboratively for better outcomes/ experiences.
- Supports the drive described within the new MH Crisis Care concordat.
- Police Federation raising concerns over the usage of S136 MHA powers.
- Reports that custody is not the ideal place of safety; we should not be criminalising persons suffering from mental ill health.
- Prevent presentations to Accident and Emergency Departments when a person has no physical health concerns.

NELFT MH Acute Care Pathways

- Over the past few years NELFT Acute and Rehabilitation Directorate (ARD) have introduced a real focus on offering Acute Crisis Care within the patients own home as an alternative to Acute admission. This has been achieved through Home Treatment Teams who offer an alternative to Acute admission. As an extension of that service NELFT have introduced Street Triage.

NELFT joined forces with the MET Police and London Ambulance Service to ensure people with mental health issues are prevented / diverted from detention under S136 of the Mental Health Act '83.

- The Street Triage Pilot was launched on **7 April 2015** and has now been fully integrated into the Mental Health Acute Response Team which includes the Acute Crisis Assessment Team (ACAT), Bleep Holder Team (Health Based Place of Safety, 136 team), Mental Health Direct Team, Emergency Duty Team and the recently developed Liaison & Diversion Team.

- In **April 2016** CCGs agreed to continued funding with the addition of LAS joining this collaboration.

Street Triage Operational Model

- 3 full time Band 6 Mental Health Nurses
- Staffed 5 days a week, Monday – Friday 5pm-1am for face to face to contact
- Weekends & Bank Holidays staff are available from 9am to 1am
- Outside of these hours there is a dedicated phone line 07872 050 047 manned 24hrs / day to provide a consistent service by the Acute Response Team
- Covers the 4 localities, namely Redbridge, Barking & Dagenham, Waltham Forest & Havering

Key Outcomes

- Reduced inappropriate or unnecessary use of Section 136 of the MHA.
- Reduced time spent by officers in dealing with patients who are experiencing mental health issues
- An improved experience for people who come into contact with the police through either detention under Section 136 or for other reasons related to their mental health.
- Reduced inappropriate use of A&E as a place of safety.
- Reviewed and Improved crisis, care and contingency plans for service users.
- Reduced number of attendances in Police Custody.
- Improved multi-agency team work.
- Reduced costs to health, criminal justice system, Ambulance service and Acute Trusts.

Key Elements of Street Triage

- Face to face assessments where appropriate (on the street / people's homes etc.)

- A dedicated phone line and telephone support available to the police for advice from the Acute Response Team

- Sharing of information to enable informed decisions to be made by officers on the street about the options available to them.

- Onward referrals to appropriate health, social care or support services of individuals who have come to the attention of the police.

Monitoring and Evaluation

- All referrals are documented on RIO (Patient recording system)
- Risk Assessment and Care plan formulated on Rio
- Bi monthly meetings with all stakeholders through the Police Liaison Group Meeting
- Data review on Street Triage activities
- Clinical and Management supervision of staff
- Case Study reviews to improve experience service users and professionals
- Feedback from service users, carers and our key stakeholders, uploaded onto our electronic Datix system

Feedback

Service User Quotes

"The police are not psychiatrists" "I felt safer with a nurse" "The police scare me"

Carers Quotes

"The way he was behaving, we thought he was going to be arrested" "I am thankful my wife was seen at home"

"This is less stressful for everyone being seen at home and not in hospital"

Police Feedback

"Since working on this borough I have dealt with several MH calls and some have been of quite a serious nature. Your team have on all occasions attended in a prompt and professional manner and given the advice required to deal with the person in question. On most occasions the person/s are known to the Triage team and have been able to provide all the necessary information almost immediately. I have recommended Triage to many colleagues on many occasions as I have found them to be a great help and support on the street in making vital decisions with information that is not available to police".

"This is a worthwhile resource which should be available 24 hours a day. This services bridges a gap between the police service and mental health workers".

Yearly DATA

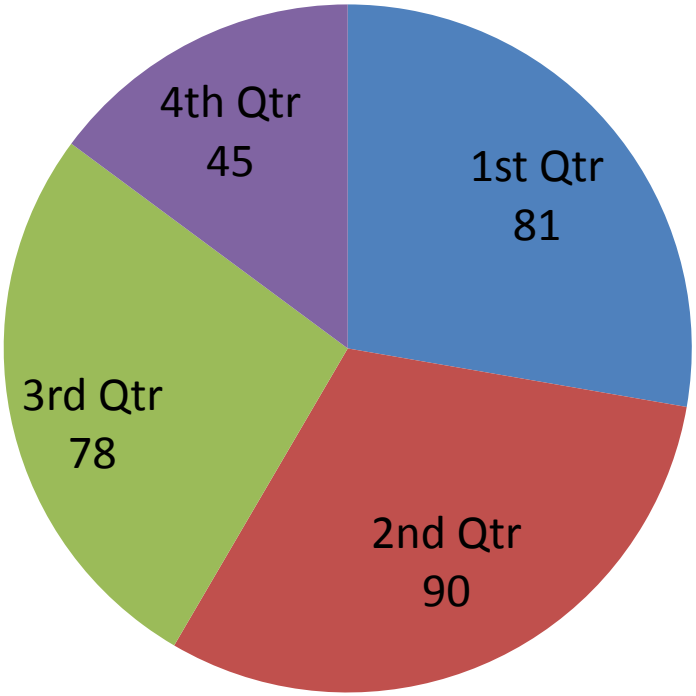
Referral Received for Year 2018/2019

Q1: 81 Referrals

Q2: 90 Referrals

Q3: 78 Referrals

Q4: 45 Referrals (Jan & Feb. March not included)



Q1 Data Analysis

Out of the 81 total referrals to Street Triage

Week Days referral = **43**

Weekend referrals = **38**

Outcome of those Referrals

Telephone Support To police/LAS = **39**

Placed under S136 = **2**

Alternative assessment offered (not placed on S136) = **6**

Assessed at home/ street = **34**

If Street Triage Service was not available

31 clients would have been placed on S136

50 clients would have been taken to ED

Q2 Data Analysis

Out of the 90 total referrals to Street Triage

Week Days referral = **51**

Weekend referrals = **39**

Outcome of those Referrals

Telephone Support To police/LAS = **58**

Placed under section 136 = **0**

Alternative assessment offered (not placed on S136) = **17**

Assessed at home/ street = **15**

If Street Triage Service was not available

35 clients would have been placed on S136

54 clients would have been taken to ED

1 Client would have been taken to the Police Custody

Q3 Data Analysis

Out of the 78 total referrals to Street Triage

Week Days referral = **45**

Weekend referrals = **33**

Outcome of those Referrals

Telephone Support To police/LAS = **50**

Placed under section 136 = **0**

Alternative assessment offered (not placed on S136) = **11**

Assessed at home/ street = **17**

IF Street Triage Service was not available

25 clients would have been placed on S136

52 clients would have been taken to ED

1 Client would have been taken to the Police Custody

Q4 Data Analysis

Full data to be obtained at the end of this quarter

Any Questions

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Havering
LONDON BOROUGH

OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 9 APRIL 2019

Subject Heading:	Access to Healthcare for Vulnerable Migrants
Report Author and contact details:	**Anthony Clements, Principal Democratic Services Officer, London Borough of Havering**
Policy context:	**The information presented gives details of work commissioned by Healthwatch Redbridge on access to healthcare for vulnerable migrants**
Financial summary:	**No impact of presenting information itself.**

SUMMARY

Officers from Healthwatch Redbridge and Refugee and Migrant Forum Essex & London (RAMFEL) will give details of their research into access to healthcare for vulnerable migrants.

RECOMMENDATIONS

1. That the Joint Committee considers the information presented by Healthwatch Redbridge and RAMFEL officers and takes any action it considers appropriate.

REPORT DETAIL

Under its legal powers, Healthwatch Redbridge has the right to bring to the Joint Committee details of its work. The organisation has asked to present a report it has commissioned by RAMFEL to look into the experiences of vulnerable migrants seeking to access healthcare and this is attached. Officer from both Healthwatch Redbridge and RAMFEL are due to be present at the meeting in order to discuss the report and give further details.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

Healthwatch Report – Access to healthcare for vulnerable migrants

Healthwatch commissioned Refugee and Migrant Forum Essex & London (RAMFEL) to look into issues around access to healthcare for vulnerable migrants. In particular we were asked to look at - Ensuring people have access to the right health and care services they need to stay well.

RAMFEL works with a range of vulnerable migrants that have different entitlements to healthcare along with varying needs. For example an undocumented migrant would not automatically have entitlement to secondary care, may in fact be an undocumented migrant who is an asylum seeker or victim of trafficking after which they would have entitlement to secondary care. The rules are complicated for us to understand at RAMFEL as professionals in this field, so for healthcare professionals, vulnerable migrants themselves and those administering access it can be very confusing.

Methodology

9 individuals gave in depth interviews regarding their experience of accessing healthcare and 11 people (separate to the in-depth interviews) completed questionnaires as part of this small research project. We have also added anonymous case studies based on individuals we have worked with. We also spoke to staff regarding their experience of supporting clients who had difficulty accessing healthcare.

Findings

1. Vulnerable migrants deterred from accessing medical services

   Vulnerable migrants especially those with insecure immigration status are being put off accessing medical services even when they need them as they worried about the consequences. Clients tend to hear information from friends or the media, leading to information often being inaccurate;

   "I have recently heard that if you are an "overstayer" or with "no recourse to public funds" and need medical operation you have to pay the medical bill from the hospital, even for childbirth…previously I accessed healthcare, hospital and GP's easily but now I am very worried".

   Trying to understand entitlement to healthcare is becoming increasingly complex and is creating anxiety and mis-information with vulnerable migrants in Redbridge (stats). For example in the quote above, someone who has leave to remain in the UK with a No Recourse to Public Fund (NRPF) restriction, will have paid or received a fee waiver for an Immigration Health Surcharge which entitles them to access healthcare during their period of leave the same as a UK citizen. However as you can see from the quote above it may put people off accessing healthcare.

   Florence told us that she,

   "avoids using healthcare services which may incur a cost. Its hard to go to get treatment when you have no status because you have no money. It's too scary to imagine what would happen if I needed to access healthcare for a serious condition, but not be able to afford to pay for it. The hospital was really really good and the mid-wives were excellent".

None of the people we interviewed understood the difference between primary and secondary health care, no one was able to explain exactly their entitlement to healthcare and at least 3 clients felt they weren't entitled to support that they in fact were, a common theme though was one of fear of being denied care, of being unable to pay for care or of receiving treatment leading to future immigration applications being denied.

2. Poverty, destitution and low income

   Those interviewed were a mix of asylum seekers, refugees and other vulnerable migrants with and without status, therefore the financial means of the clients varied. However in different ways financial issues did affect their ability to access healthcare.

   Transport

   "I have a budget of £5 for day to live on. It's difficult for me to pay for travel to and from hospital appointments"

   "If I dont have money I walk to the GP even though its far away".

   38% of those interviewed mentioned issues with transport affected their ability to access healthcare however 43% of clients said they experienced financial difficulties.

3. Lack of access to correct and understandable information

   Many of the clients we interviewed spoke enough English to complete the interview or questionnaire, out of the 4 clients who needed an interpreter to complete the interview however 3 of them said that lack of interpreting and translation was an issue, the one client who did not find it an issue was because the medical staff spoke his language;

   "Language is a major barrier for non-English speakers. I find it difficult to know where to go or find the location of the GP. Unable to access online services as I can't read English".

   "Accessing healthcare in Ilford is not good, a lot of problems, no interpreters"

   "Everything was good[but], they don't provide interpreters"

4. Psychological effect of the "hostile environment"

   One mother who had recently given birth by caesarean felt hounded by the home office in the days after giving birth, the home office used discharge information to find her current address and performed an immigration raid which left her "physically shaking" afterwards. Struggling at the time with homelessness and her new born baby as a first time mum, the immediate intervention of the Home Office and the collusion with medical services certainly engendered a feeling of hostility at an already difficult time. The child in question is a British citizen, and the mum now has leave to remain.

   Another mother we interviewed was diagnosed with cancer, shortly after which she was presented with a bill for treatment of the cancer and of the cost of giving birth 6 years ago, that she had up until that point been unaware she needed to pay for.

5. Lack of advice and support

   Mohammed was unable to apply to renew his HC2 certificate through the asylum support related services who he informed us should process this for him and was unable to pay for medicine at that time. Other interviewees had similar experiences and there was no clear

point at which the NHS would provide them with the necessary information, to ensure they understood their rights and entitlements. RAMFEL is also concerned that whilst asylum seekers have a right to access medical care as well as clients with leave to remain with NRPF attached, they may fall foul of unsophisticated attempts to screen people who may have to pay for medical treatment.

"Belinda is concerned about what will happen once the maternity card runs out this April because she has no status. She's concerned as she is destitute".

All clients interviewed had been able to register with a GP, although this result may be slightly misleading in that all individuals interviewed were clients of RAMFEL.

Case Study #1

Mrs. A from Tanzania has been suffering from mental health issues for several years, at various points she has been sectioned under the mental health act, attempted suicide and has a long history of self-harm and addiction. Mrs. A has no status in the UK, this places limits on the services she can access unless she passes thresholds for care within the care act. Mrs. A is street homeless and is not taking her medicine as it makes her drowsy and she is worried about being attacked on the streets, or freezing on the streets whilst asleep in winter. Mrs. A is regularly attended to by emergency services, for self-harm and mental health issues. As she is unable to care for herself properly she is referred to the Redbridge Home Treatment Team. She is refused access to care because she has "no recourse to public funds" and is only self-harming in an attempt to access housing. After a lengthy legal battle Mrs. A wins temporary support, whilst in support Mrs. A again attempts suicide, disengages with support services and her support by the home treatment team is stopped again.

Restriction to services she should have received endangered her life and her limited access to certain services means that considerable effort is spent by emergency services whilst other services wait until her health deteriorates to level that they may be compelled to intervene. RAMFEL found it very difficult to provide legal services to Mrs. A because her health and street homelessness were unattended to, even though a viable claim could potentially be made.

Case Study #2

Mrs. B from Ghana lives in Redbridge and was worried about having an operation doctors informed her was necessary as she did not want it to lead to the rejection of her immigration claim due to having more than £500 outstanding debt to the NHS. Only after receiving legal advice from RAMFEL did she decide to go ahead with the operation

Case study #3

Mrs. C has recently received her status to remain in the UK as the sole carer of her son who is a British citizen. When she gave birth to her son a few months ago by caesarean, she gave

details of where she was temporarily staying as she was homeless at that time, due to her giving birth by caesarean and other health complications she needed to be visited daily by a health visitor. She believes that the address on her discharge notice was shared with immigration, who visited her at that property to inform her that she should leave the country.

Case study #4

A member of staff at RAMFEL spoke of a client in a previous role they had supported. Mrs D had been in the country for several years, she suffered a stroke whilst out shopping and was rushed to hospital. When she was asked about her passport, she became worried and left the hospital for fear of being detained by immigration services. She was unable to receive treatment that would have lessened the effects of the stroke. Mrs. D was entitled to receive healthcare as she was a victim of trafficking, she didn't know yet what that meant and the hospital were unaware. An assessment of a client's eligibility for healthcare can be an extremely complex issue that requires in depth legal and medical knowledge to assess. The process is one that will leave those entitled without support at certain points and will come at considerable human and administrative cost.

The 'hostile environment' that the government wants to create for vulnerable migrants is one in which they are now increasing intimidated, bullied and scared by those they go to for help. In Redbridge as in case study A & B we can see the devastating and cruel effects this has on people's lives. We find that our clients tend to get most of their information about services through informal networks such as friends, community & religious institutions. Through such networks horrific stories such as those above will spread confusion and fear. There are limited services for vulnerable migrants to get accurate and practical information in the right language or format regarding healthcare, and even with information eligibility to healthcare is incredibly complex and may first require a full review of their legal status in the UK.

Conclusions

Vulnerable migrants are for a range of reasons finding it difficult to access the right health and care services they need to stay well. Most of them are finding their way to services eventually although this sample group are undoubtedly affected by the fact that they are linked in with a service that helps them to access healthcare. From the different difficulties that we have found

Recommendations

1. Redbridge should encourage all services that it manages to recognise vulnerable migrants with health care needs as human beings first and foremost, challenging where possible the governments 'hostile environment' and not take part in the bullying, intimidation or humiliation of certain vulnerable migrants
2. Redbridge should look at where denying treatment is creating additional costs as well as human suffering. For example the case of Mrs. A cost significantly more in emergency services and legal fees than necessary secondary care would have done. In the same way

that support to those with TB or other infectious diseases is exempt from restricted access to healthcare, housing etc the council or CCG should undertake research to look at where restricting access costs more overall to the state or the borough.

3. Redbridge needs to provide an advice service through which vulnerable migrants can understand their rights and entitlements to healthcare and be actively supported to access them. For example, clients entitled to free prescriptions should be informed about the HC1 form/HC2 certificate.

   “I had to pay for prescriptions myself and often cutting back on food” quote from an interviewee eligible to apply for free prescriptions.

4. Training needs to be provided to gate keepers in relevant services as to the rights and entitlements to medical or social care of different groups of vulnerable migrants, to ensure there is not a repeat of the case of Mrs. A. Regular updated information regarding changes in law

5. GP surgeries and other NHS services need to be made aware of the obligation to provide interpreting services to clients who need it. More easily accessible interpreted information on-line or in the facilities would be beneficial.

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