MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Barking & Dagenham
2 October 2018 (4.00 - 6.00 pm)

Present:

COUNCILLORS

London Borough of Barking & Dagenham	Eileen Keller (Chairman) and Paul Robinson
London Borough of Havering	Nic Dodin and Ciaran White
London Borough of Redbridge	Beverley Brewer and Muhammed Javed+ and Neil Zammett
London Borough of Waltham Forest	Richard Sweden and Saima Mahmud
Essex County Council	Chris Pond
Epping Forest District Councillor	Aniket Patel
Co-opted Members	Ian Buckmaster (Healthwatch Havering) and Richard Vann (Healthwatch Barking & Dagenham) cil)

+substituting for Councillor Stuart Bellwood

Also present:
Shelagh Smith, Chief Operating Officer, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
Liz Crees, Cancer Speciality Manager, BHRUT
Nicky Agar, Lead Chemotherapy Nurse, BHRUT

Dan Burningham, Programme Director – Mental Health, City & Hackney CCG
Mark Lawrence, Metropolitan Police
Briony Sloper, London Ambulance Service

Dr Usman Khan, Consultant in Public Health, Barking & Dagenham
Anthony Clements, Principal Democratic Services Officer, Havering
Leanna McPherson, Democratic Services Officer, Barking & Dagenham
Jilly Szymanski, Scrutiny Co-ordinator, Redbridge

One member of the public was also present.

All decisions were taken with no votes against.

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

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

Apologies were received from Councillors Stuart Bellwood, Redbridge (Muhammed Javed substituting) Nisha Patel, Havering and Catherine Saumarez, Waltham Forest. Apologies were also received from Mike New, Healthwatch Redbridge.

11 DISCLOSURE OF INTERESTS

6. HEALTH BASED PLACES OF SAFETY.

The following personal interest was disclosed;

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

12 MINUTES OF PREVIOUS MEETING

The minutes of the meeting of the Joint Committee held on 26 July 2018 were agreed as a correct record and signed by the Chairman.

13 BHRUT - IMPROVING CANCER CARE

BHRUT officers explained 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 pre-assessment 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.

Members from Redbridge accepted the clinical case for the changes but felt that they did warrant formal consultation, particularly in view of the extra travelling distances for patients from both Redbridge and Barking & Dagenham. It was felt that the PPC was not a substitute for formal processes and Local Healthwatch organisations could be contacted by the Trust to ask patients what they felt about the changes. Officers responded that they did not need to consult as the most complex cases already travelled to Queen's – patients did not have a choice in where they have their treatment; it was based on the treatment they needed. The Trust was happy to work with Healthwatch on the issue.

Other issues raised by Members included the extent of consultation about the issue with staff, with Clinical Commissioning Groups and with voluntary

organisations. There were also concerns about whether the plans had been approved by the Trust Board and whether the proposals contradicted intentions to keep the Cedar Centre at King George open. Officers confirmed that any financial efficiencies resulting from the changes would be reinvested in the Living with Cancer and Beyond service. Details of the number of Redbridge residents and BME members on the PPC could be provided, as well as the support of the groups for the proposals. The plans were ready and in place to be implemented following discussion with the Overview and Scrutiny Committees.

It was explained that staff currently rotated between the King George and Queen's sites and staff could have better career progression by being based at the one site through better support and skills enhancement. Chemotherapy nurses were very difficult to recruit and agency nurses at times had to be used at an additional cost. The Macmillan cancer charity supported the expansion of the health and wellbeing services and officers would give details of engagement with other voluntary services.

The figures for patient numbers covered the period June 2017 – May 2018. Councillor Pond felt it was unlikely that the Essex Health Overview and Scrutiny Committee would consider the proposals to be a major change of services.

A Member from Havering raised concerns that the oncology car park at Queen's would not be big enough and that the wider transfer of services from King George to Queen's would result in Queen's being unable to cope with the extra patients. It was clarified that there was a dedicated car park for Oncology. There was already a helpline available for chemotherapy patients that was staffed 24 hours a day and the centralisation of chemotherapy on the Queen's site would allow for emergency patients to be seen in the Sunflower Suite, thus avoiding a visit to A & E.

Officers could provide a breakdown of the figures for numbers of patients affected by the proposals, by age and ethnicity. It was emphasised that the proposals did not mean the closure of the Cedar Centre at King George. The existing cancer pathway did mean that people were already sent to other facilities depending the type of their cancer. Choices of treatment venue could not be given to patients and the venue often had to at Queen's for certain treatments etc.

The Joint Committee agreed to recommend that, as part of the ongoing engagement process, the Local Healthwatch organisations should be asked by the Trust to research patient views on the proposals

14 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.

The Joint Committee noted the position.

15 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.

The Joint Committee noted the report by Healthwatch Havering.

16 **JOINT COMMITTEE'S WORK PLAN**

It was agreed that a report from NELFT on the street triage service should be brought to a future meeting of the Joint Committee. It was also suggested that a report be taken on the issue of the discharge of patients into community-based settings looking in particular at the issue of for example a patient being discharged to a nursing home when they simply required some reablement.

Chairman

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