Public Document Pack

JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

4.00 pm	**Tuesday 9 July 2019**	**Barking Town Hall, 1, Town Square, Barking, IG11 7LU**

COUNCILLORS:

LONDON BOROUGH OF BARKING & DAGENHAM

Councillor Eileen Keller (Chairman)
Councillor Paul Robinson
Councillor Mohammed Khan

LONDON BOROUGH OF WALTHAM FOREST

Councillor Umar Alli

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

EPPING FOREST DISTRICT COUNCIL

Councillor Alan Lion (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 (Pages 1 - 2)

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. Directions to the meeting venue are also attached.

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

Apologies for absence have been received from Councillor Umar Alli (Waltham Forest) and from Ian Buckmaster (Healthwatch 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 3 - 12)

To agree as a correct record the minutes of the meeting held on 9 April 2019 (attached) and to authorise the Chairman to sign them.

The notes of an informal briefing given to the Joint Committee by Healthwatch representatives concerning work on changes to cancer services are also attached for information.

5 EAST LONDON HEALTH AND CARE PARTNERSHIP UPDATE (Pages 13 - 30)

Report attached.

6 CANCER SERVICES (Pages 31 - 84)

Report and supporting documentation attached.

7 WINTER PRESSURES (Pages 85 - 100)

Report attached.

8 ESTATES UPDATE (Pages 101 - 112)

Report attached.

9 AMENDMENTS TO COMMITTEE'S TERMS OF REFERENCE (Pages 113 - 122)

Report attached.

10 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

Barking Town Hall

Travel Directions

Town Hall

1 Town Square

Barking

IG11 7LU

Public Transport

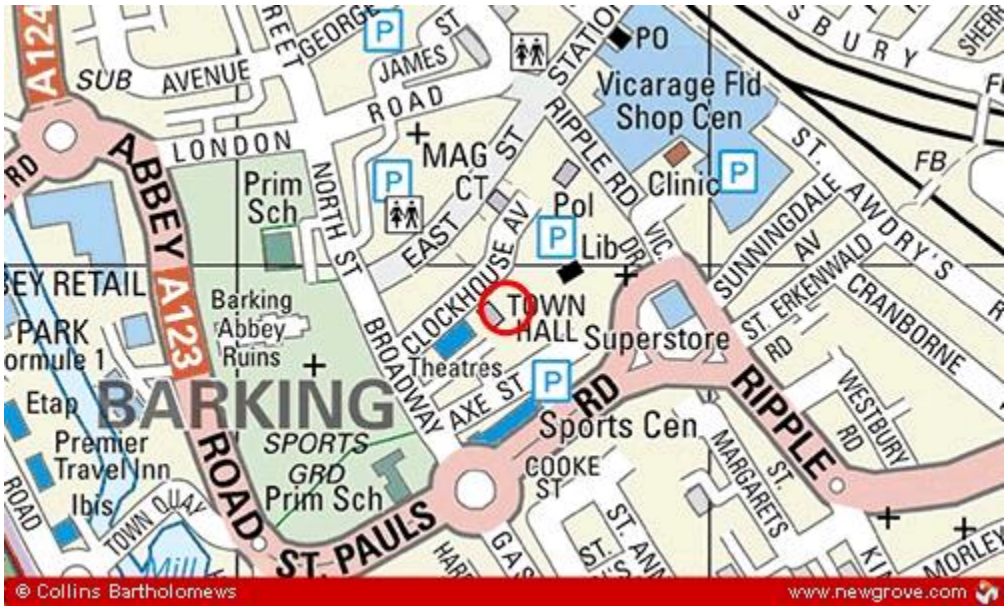
Bus: 5, 62, 169, 179, 238, 287, 368, 369, 387

Train: Barking

On arrival

Please see reception inside the main entrance, who will let the person/s you are meeting know you have arrived.

Location map



MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Redbridge
9 April 2019 (4.00 - 5.38 pm)

Present:

COUNCILLORS

London Borough of Barking & Dagenham	Paul Robinson and Eileen Keller
London Borough of Havering	Nic Dodin, Nisha Patel and Ciaran White
London Borough of Redbridge	Beverley Brewer and Nail Zammett
London Borough of Waltham Forest	Richard Sweden and Catherine Saumarez
Co-opted Members	Ian Buckmaster (Healthwatch Havering), Mike New (Healthwatch Redbridge) and Richard Vann (Healthwatch Barking & Dagenham)

Also present:
Simon Hall, Director of Transformation, East London Health and Care Partnership
Cri Jacob, Managing Director, Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs)
Caroline O'Donnell, Integrated Care Director, North East London NHS Foundation Trust (NELFT)
Shelagh Smith, Chief Operating Officer, BHRUT
Jeff Middleditch, Divisional Manager for Cancer and Clinical Services, BHRUT
James Tullett, Chief Executive, Refugee and Migrant Forum of Essex and East London (RAMFEL)
Cathy Turland, Chief Executive, Healthwatch Redbridge

Masuma Ahmed, Democratic Services Officer, London Borough of Barking and Dagenham
Anthony Clements, Principal Democratic Services Officer, London Borough of Havering
Jilly Szymanski, Scrutiny Co-ordinator, London Borough of Redbridge

Three members of the public were also present.

All decisions were taken with no votes against.

23 CHAIRMAN'S ANNOUNCEMENTS

The Chairman announced details in case of fire or other event that may require the evacuation of the meeting room or building.

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

Apologies were received from Councillors Saima Mahmud, Waltham Forest, Chris Pond, Essex and Aniket Patel, Epping Forest.

25 DISCLOSURE OF INTERESTS

There were no disclosures of interest.

26 MINUTES OF PREVIOUS MEETING

The minutes of the meeting of the Committee held on 15 January 2019 were agreed as a correct record and signed by the Chairman.

It was noted that the proposed move of location of Moorfields Eye Hospital was expected to be scrutinised at a joint meeting with the Inner North East London Joint Health Overview and Scrutiny Committee scheduled for 18 September 2019.

It was noted that NHS officers had confirmed that no decision had been taken at this stage to close Moore Ward, Goodmayes Hospital and the facility remained open for patients.

27 NHS LONG TERM PLAN

Health officers explained that the local health economy faced a number of challenges including population growth, challenging health outcomes and an overreliance on emergency health services. The attraction and retention of workforce was also a significant challenge and officers were keen to hear from the Committee what it felt the priorities should be. There was also a highly ambitious 10 year NHS plan at national level and the impact of the Social Care Green Paper would also need to be considered.

Some services in North East London had improved with for example the establishment of an Early Diagnosis Cancer Centre at Mile End. Workforce initiatives had included the introduction of physician associate roles and investment had also been increased in digital innovation.

It was wished that care would be community-based with borough-based integrated community care partnerships being established. Multi-borough systems had also been established across the BHR area and initiatives at

North East London level had included the Commissioning Alliance, Clinical Senate and work on air pollution.

It was planned to bring a refreshed version of the local NHS Plan to the joint meeting with the Inner North East London Joint Health Overview and Scrutiny Committee in September 2019. Work was in progress with Local Healthwatch organisations and localised public engagement events were also planned. Engagement work would also be undertaken with Health and Wellbeing Boards and a digital citizens panel and a stakeholder event was planned on 6 June.

With the agreement of the Chairman, the Committee was then addressed by three members of the public who felt that financial resources for local healthcare were very stretched and that it was crucial to consider equality issues. It was felt that resources locally had been moved from areas of high deprivation to areas of low deprivation and that Councils should be mindful of the Public Sector Equality Duty.

Another member of the public who was visually impaired and had hearing difficulties explained that they could easily access A & E services at King George but would find this much more difficult if services were moved to Queen's. Confirmation was therefore sought over whether the long term plan would secure A & E services at King George.

Members of the public also raised issues such as the mention of a £49m reconfiguration of A & E across BHR in the papers for the Inner North East London Committee and that detailed plans for the future of local A & E services should now be published. In response, the Chairman read out a statement from the Leader of Redbridge Council giving assurances that A & E services would continue to be provided at King George.

NHS officers agreed that it was important to have clear measures of how effective the long term plan was being and were happy to have discussions on what these measures should consist of. It was also noted that the three BHR CCGs already worked as a single team with for example the clinical lead covering all three boroughs. Local control would be retained via the integrated care system.

Long Term Plan work on mental health services would focus on what types of service would be needed, rather than necessarily altering the number of in-patient beds. Investment in mental health services was already being increased by the CCGs. The Mental Health Transformation Board for the area was focussing on community, non-inpatient mental health services. Officers felt though that it was unlikely that the number of existing mental health beds would need to be reduced any further. It was also confirmed that an Equalities Impact Assessment would be carried out on the proposals in the Long Term Plan.

It was accepted that primary care performance had been poor in Outer North East London though officers felt this was now improving. Efforts to

improve GP retention included offering more portfolio careers which allowed new GPs the opportunity to also work with partners such as NELFT and BHRUT. It was suggested that the Primary Care Strategy could be brought to a future meeting for scrutiny.

The changes to the GP contract would also see extra investment coming in and the physician associate roles would continue to be established in North East London. A GP careers event had also recently taken place.

It was AGREED:

1. **That the Primary Care Strategy should be brought to a future meeting of the Committee and that an update on implementation of the NHS Long Term Plan in Outer North East London should be given to the Committee in approximately 12 months time.**
2. **That it to be noted that more detailed scrutiny of the NHS Long Term Plan would take place in a joint meeting with the equivalent committee for Inner North East London, scheduled for 18 September 2019.**

28 **NELFT STREET TRIAGE SERVICE**

NELFT officers explained that the Street Triage service came out of the Mental Health Crisis Concordat that was introduced in 2015. Mental health issues were thought to take up 20% of Police time and NELFT had worked with Police Borough Commanders to reduce the number of people experiencing mental health crises being placed in custody.

The Street Triage Service was part of the single NELFT pathway for mental health crisis. The service was available 5 pm – 1 am Monday to Friday and 9 am – 1 am Saturday and Sunday. The service covered the four ONEL boroughs and gave a dedicated phone line for Police and London Ambulance Service officers dealing with people exhibiting mental health issues. This allowed direct contact with a clinician who could undertake an assessment.

The service was monitored using data collated via the Police Liaison Group as well as feedback from service users, carers and the Police. The service has resulted in a reduced number of referrals to both A & E and Police custody.

Officers agreed that data could be provided on the position in 2014/15 before the service was introduced. Other work undertaken by NELFT to improve the acute care pathway included working with community recovery teams and the Police to seek to prevent crises happening. The NHS Long Term Plan also sought to enhance crisis support and prevention for children and young people.

It was clarified that section 136 powers allowed Police detention of people from a public place and there were two suites at Goodmayes Hospital that could receive people detained in this way. Funding had also been received to establish a third suite at the same location by March 2020. It was agreed that there was a higher level of section 136 detention among people of BME backgrounds and revised training for Police on the use of section 136 powers was being considered.

Legislative changes had recently reduced the maximum period for this type of detention from 72 to 24 hours and all detentions were required to be agreed by two doctors and a mental health practitioner. It was confirmed that section 136 transfers from Whipps Cross Hospital to the suites at Goodmayes were quite straightforward to organise as NELFT ran the psychiatric liaison service at Whipps Cross.

It was AGREED:

That an update on the Street Triage Service should be given to the Committee in approximately 18 months.

29 **ACCESS TO HEALTHCARE BY VULUNERABLE MIGRANTS**

An officer from Refugee and Migrant Forum Essex & London (RAMFEL) explained that the organisation's report, which had been commissioned by Healthwatch Redbridge, had found a hostile environment with regards to healthcare and that it was often difficult to know who could access healthcare services. Twenty people had been interviewed for the report, some in depth. Refugees and asylum seekers were allowed full access to healthcare whereas those people classified as 'no recourse to public funds' were often denied healthcare. People who had been refused asylum received primary and emergency care plus secondary care if this was considered necessary.

The RAMFEL officer added that eligibility for care needed to be assessed by an immigration adviser and clinician and that monies were often not recovered by the NHS, even if people were charged for treatment. Vulnerable migrants were often deterred from accessing medical services even if they had paid the immigration health surcharge.

Problems faced by vulnerable migrants included low income affecting people's ability to get to medical appointments and language barriers meaning a lack of access to information. There were also psychological effects e.g. not accessing health services due to fears of information being shared with the Home Office. An additional problem had been faced by unaccompanied asylum seekers with mental health issues who had been wrongly denied healthcare based on their status.

The report had found that more work needed to be carried out to change he hostile environment in the NHS. It was felt that the denial of e.g. secondary

care led to people requiring more costly emergency care. Concern had also been expressed by GPs over eligibility to treatment rules.

The report had recommended that there should be improved training for NHS staff on immigration status and related issues. The managing director of BHR CCGs added that she was aware of the confusion over eligibility for access to primary care and she was happy to highlight this ongoing problem.

The Local Safeguarding Board offered training on dealing with issues such as Female Genital Mutilation and training had also been available for Redbridge Members on issues around people with 'no recourse to public funds'. Further information on training available could be found on the RAMFEL website.

The Committee noted the RAMFEL report and it was AGREED:

That an update on the position with access to Healthcare for Vulnerable Migrants should be taken in one year's time.

30 **JOINT COMMITTEE'S WORK PLAN**

It was noted, subject to confirmation by the Waltham Forest full Council, that Waltham Forest would transfer their representation to the equivalent Joint Committee for Inner North East London, whilst retaining one representative on the Outer North East London Committee. Councillor Sweden recorded his thanks to other Members and the Committee Clerk for their support.

Potential future work programme items included updates on community urgent care and the East London Health and Care Plan finance issues. Whilst due to be the subject of an informal briefing, it was suggested that changes to cancer services should also be placed on the agenda for a future meeting.

It was also suggested that a review of the recent unsuccessful bid for £49m for reconfiguration of local A & E services should be undertaken at the next meeting of the Committee. This could include scrutiny of why nearly all bids from Outer North East London had been unsuccessful.

Other suggestions included NHS performance targets for 2019/20, A & E, waiting lists, race equality issues and the NHS workforce disability equality scheme.

It was agreed that the next meeting should cover cancer services, the position with the unsuccessful bids for funding and an update on the development of the plans for the East London Health and Care Partnership.

Chairman

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NOTES OF AN INFORMAL BRIEFING TO OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY SCRUTINY COMMITTEE RE HEALTHWATCH REPORT – CHANGES TO CHEMOTHERAPY SERVICES AT BHRUT, REDBRIDGE TOWN HALL, 9 APRIL 2019, 5.40 – 6.10 PM

Present

As per minutes of ONEL JHOSC meeting, 9 April 2019

- Healthwatch representatives had recently met with patients who had undergone chemotherapy or other treatment for cancer. The main concern raised had been that the priority 'red card' for cancer patients to show at A & E had not been recognised by staff meaning that cancer patients were not triaged appropriately at A & E. BHRUT offices responded that whilst there was a well-defined pathway for ambulances arriving at A & E, it was accepted that there was insufficient recognition among staff of the 'red card' that is shown by a walk-in patient. Signs would be put up in A & E and other relevant areas giving details and instructions to staff about the meaning and use of the 'red card'.
- Feedback had also been given that the chemotherapy suite at Queen's Hospital was cramped and had a lack of privacy and natural light. There was also a lack of assessment for patient transport and parking, whilst free for cancer patients, was in short supply due to a mobile unit being located on approximately a quarter of the cancer services car park. Patients were also not made sufficiently aware of the parking options at Queen's Hospital.
- Other issues raised included that it was no longer possible to confirm a patient's next oncology appointment whilst they were at their current appointment. The Cedar Centre facility at King George Hospital had been found to be underused with a particular lack of BME users. The proportion of BME patients using the chemotherapy service as a whole (around 25%) had also been found to be lower than expected.
- Patients were very supportive of the cancer service and the staff involved. BHRUT confirmed that the Trust supported the Healthwatch work and had provided input etc and would also feed the findings of the Healthwatch report into the NHS long term plan.
- The Chief Operating Officer at BHRUT thanked the Barking and Dagenham, Havering and Redbridge Healthwatch organisations for their work and confirmed that the Trust wished to work in partnership with Healthwatch.
- Opening hours of the chemotherapy department had been extended but it was not possible to increase the space in the unit. The unit size met the required standards and it was accepted that the general lack of daylight at Queen's remained a problem. The decontamination unit had been placed in the car park due to an earlier fire in the building but this was due to be removed shortly, freeing up additional parking spaces. The Trust was happy to undertake further

work on the use of the Cedar Centre and the diversity of service users. Whilst Trust officers were proud of the Living Beyond Cancer hub at the Cedar Centre, it was accepted that this was not yet being used as much as they would like. Leaflets about the service were being translated into different languages.

- It was also clarified that there were no additional beds or chairs in the unit, and the same number of patients were still being seen at any one time. The unit was however now open longer hours and for six days per week. Some patients needed to have a blood test prior to their chemotherapy session and it was also important that chemotherapy was not made up too early. Some waits for patients on the day of their treatment were therefore unavoidable.
- A Member felt that the Healthwatch report showed that the Committee had been correct to raise concerns that Queen's Hospital would have insufficient parking spaces if cancer services were transferred there from King George. BHRUT officers confirmed that they accepted all the recommendations in the Healthwatch report and reiterated that more parking spaces would be available shortly when the temporary unit was removed from the car park area.
- It was clarified that the carer of a chemotherapy patient had stated that they had not been given any instructions for injections that needed to be administered at home. BHRUT officers agreed that this should not have happened and would share the Healthwatch report with the chemotherapy team. The BHRUT officers also asked for Healthwatch to provide further details of this incident, outside of the meeting.
- The Committee agreed that BHRUT would provide a written response to the Committee covering the following:
    1. A response to all recommendations made in the Healthwatch report.
    2. The Trust's position now on the decision to close Cedar ward at King George Hospital.
    3. How the increase in demand for cancer services in the coming years will be handled by BHRUT.

- It was further agreed that the formal BHRUT response on the above issues should be put on the agenda for the next JHOSC meeting.

Havering
LONDON BOROUGH

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

Subject Heading:	East London Health and Care Partnership – Update July 2019
Report Author and contact details:	**Anthony Clements, Principal Democratic Services Officer, London Borough of Havering**
Policy context:	**The information presented gives details of the current work of the East London Health and Care Partnership (ELHCP).**
Financial summary:	**No impact of presenting information itself.**

SUMMARY

NHS officers will present to the Joint Committee details of how current work undertaken by the East London Health and Care Partnership.

RECOMMENDATIONS

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

REPORT DETAIL

The ELHCP brings local health and care leaders to plan around the long-term needs of local communities. The work of the partnership, which consists of all

Council and NHS organisations in the North East London area will be explained to the Joint Committee in more detail by NHS officers.

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

East London Health and Care Partnership update – July 2019

What is the East London Health and Care Partnership?

- The East London Health and Care Partnership (ELHCP) is the name for the north east London Sustainability and Transformation Partnership (STP).
- STPs were created by the NHS to bring local health and care leaders together to plan around the long-term needs of local communities.
- Initially, different parts of the local health and care system in north east London, following discussion with staff, patients and others in the communities they serve, drew up a plan in 2016 to be delivered in partnership.
- The partnership is made up of the area's eight councils and 12 NHS organisations, combining expertise and resources to make sure health and care services meet the needs of local people, now and in the future.
- ELHCP is overseen by an executive group made up of local authority and provider chief executives as well as ELHCP managers, Clinical Commissioning Group (CCG) managing directors and GP Federation representatives.
- Jane Milligan is the executive lead for the STP and Rob Whiteman is the independent chair. Simon Hall is the Director of Transformation.

Who are the partners?

We are:

- **Seven CCGs**
- **Eight London Councils**
- **Five NHS Trusts – three acute and two community**
- **286 GP Practices**

Waltham Forest

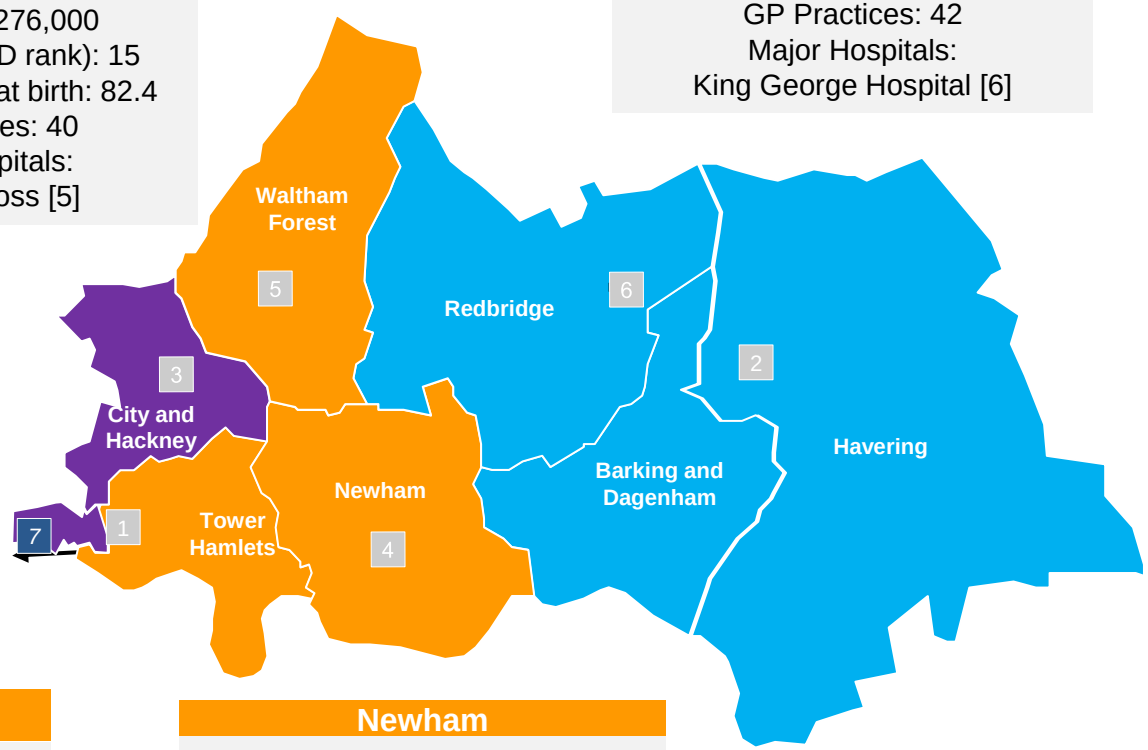
Population: 276,000
Deprivation (IMD rank): 15
Life Expectancy at birth: 82.4
GP Practices: 40
Major Hospitals:
Whipps Cross [5]

Redbridge

Population: 300,600
Deprivation (IMD rank): 119
Life Expectancy at birth: 82.7
GP Practices: 42
Major Hospitals:
King George Hospital [6]

Community Trusts

North East London Foundation Trust (NELFT) and East London Foundation Trust (ELFT) provide community and mental health services in the area.



City and Hackney

Population: 277,000
Deprivation (IMD rank): 2 (Hackney) & 226 (City of London)
Life Expectancy at birth: 80.9 (Hackney)
GP Practices: 42
Major Hospitals:
Homerton[3]
St Bartholomew's [7]

Havering

Population: 250,500
Deprivation (IMD rank): 166
Life Expectancy at birth: 81.9
GP Practices: 43
Major Hospitals:
Queen's Hospital [2]

Tower Hamlets

Population: 296,300
Deprivation (IMD rank): 6
Life Expectancy at birth: 81.0
GP Practices: 35
Major Hospitals:
Royal London [1]

Newham

Population: 338,600
Deprivation (IMD rank): 8
Life Expectancy at birth: 81.3
GP Practices: 49
Major Hospitals:
Newham University Hospital [4]

Barking and Dagenham

Population: 206,700
Deprivation (IMD rank): 3
Life Expectancy at birth: 80.0
GP Practices: 35

Our challenges

We have:

- the highest population growth in London – equivalent to a new borough in by 2034
- poor health outcomes for local people including obesity, cancer, mental health, dementia
- a changing population with increasing diversity, people living longer with one 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 environment
- service quality issues including a high reliance on emergency services, late diagnoses and treatment and access to services particularly primary care
- a health and care workforce with a high turnover, recruitment difficulties and high reliance on temporary agency workers – although there are huge differences across the patch and between providers/sectors and
- a gap between the demand and cost of services with the resources available. This is estimated at £1.2bn over the next 5 years if nothing is done.

Local variation

ELHCP recognises that there is significant variation within north east London – health and care outcomes, population, services and quality, relationships between organisations and resources.

The following pages provide analysis to look at this variation divided into three geographical areas.

- Barking and Dagenham, Havering and Redbridge
- Newham, Tower Hamlets and Waltham Forest
- City of London and Hackney

Barking and Dagenham, Havering and Redbridge (BHR)

- High quality, safe and compassionate care for all commissioned services – delivering better outcomes for local people
- Establish our integrated care system, with primary care as the foundation of a system delivering improved health and wellbeing, through our strong health and care partnerships
- Transforming the way that care is delivered and securing financial recovery through the work of our multi-agency transformation boards and delivery of our joint NHS system financial recovery plan

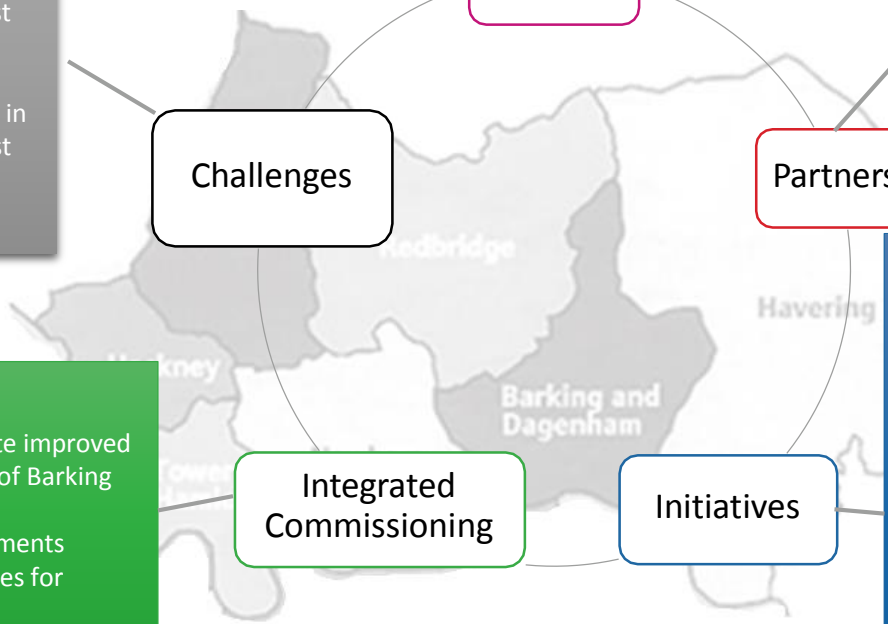
Priorities

- Barking and Dagenham faces major health challenges and health outcomes are poor for many local people because of a combination of poverty, deprivation and lifestyle. The borough has the highest rate of unemployment and lowest male and female life expectancy in London
- Havering has a predominantly older population
- In Redbridge, there is a wide variation across the borough in terms of deprivation. The borough sees the second highest rates of people with diabetes in London
- BHR is under significant and growing financial pressure

Challenges

- Barking and Dagenham Clinical Commissioning Group
- Redbridge Clinical Commissioning Group
- Havering Clinical Commissioning Group
- NELFT
- Barking Havering and Redbridge University Hospitals Trust
- NHS Improvement
- London Borough of Barking and Dagenham
- London Borough of Havering
- London Borough of Redbridge
- Healthwatch
- 3 GP Federations:
  - Havering Health (Havering)
  - Healthbridge Direct (Redbridge)
  - Together First (Barking and Dagenham)

Partners



Integrated Commissioning

The BHR Integrated Care Partnership Board have:

- Signed up to a clear vision for BHR to 'accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge'
- Strengthened partnership governance arrangements
- Identified key transformation areas and priorities for integrated care

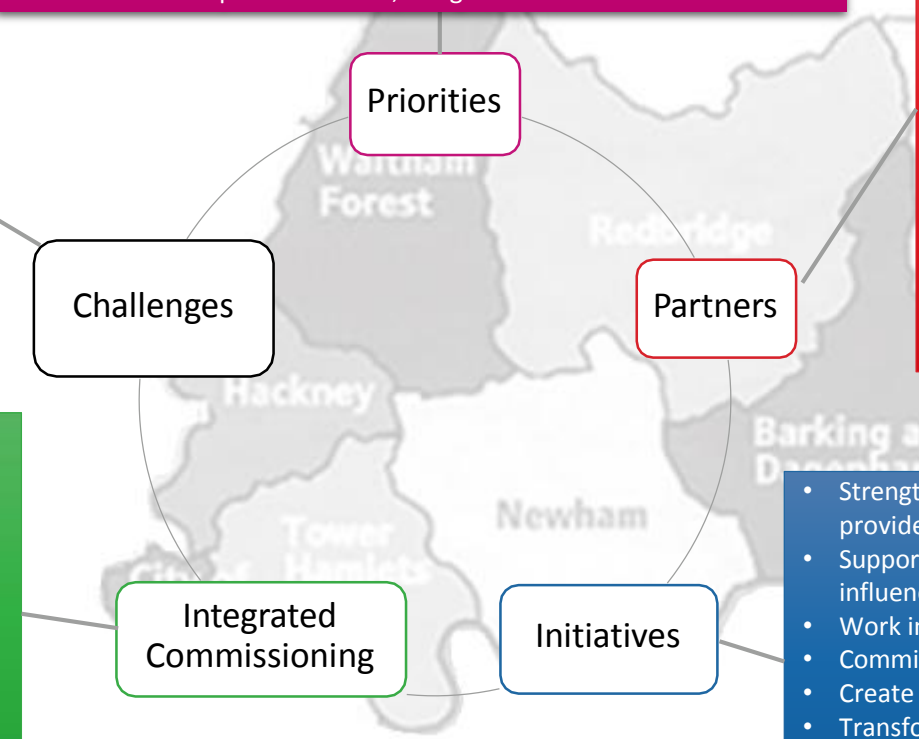
Initiatives

- Establishment of seven key Transformation Boards
- Work with Local Authority colleagues to support the prevention agenda
- Transform the planned care pathways to ensure care is delivered in the most appropriate setting
- Improving service models to improve the unplanned care pathway
- Development of an NHS Financial Recovery Board that provides a forum for NHS Partners to discuss how we plan collectively to address the financial position
  - Agreement of an integrated system Financial Recovery Plan that spans the CCGs, BHRUT and NELFT
  - Financial recovery driven through three of the main transformation boards
  - Strengthening clinical leadership across organisational boundaries to drive the cultural change required for our Transformation Programme and Financial Recovery

Newham, Tower Hamlets and Waltham Forest (WEL)

- Finalisation and implementation of a new community services model, to deliver the agreed ICS outcomes
- Developing a case for change
- Deliver some initial significant strategic programmes
- Unscheduled care pathway redesign
- Improve the health outcomes of the local population through the effective commissioning of high quality services
- Commission person-centred, integrated health and care services

- Newham is ranked fourth worst in the country for housing deprivation. About half of all the households living in private housing live in overcrowded conditions and 20% in social housing
- Many people in Tower Hamlets are living with a long-term condition and hospital admission rates for heart disease and stroke are above the national average
- For Waltham Forest, the younger population are reported to have significant issues related to childhood obesity and incidents of tuberculosis compared to the rest of London



- Barts Health NHS Trust
- East London Foundation Trust
- London Borough of Tower Hamlets
- Tower Hamlets GP Care Group
- NHS Tower Hamlets Clinical Commissioning Group
- London Borough of Newham
- Newham Health Collaborative
- NHS Newham Clinical Commissioning Group
- North East London Foundation Trust
- Waltham Forest GP Fednet
- London Borough of Waltham Forest
- Waltham Forest Clinical Commissioning Group
- Healthwatch
- Community and Voluntary sector services

- Newham has agreed to a vision for developing an integrated community (health and social care model) through the Newham Wellbeing Partnership
- Tower Hamlets established Tower Hamlets Together to take forward arrangements for integrated health and Social Care services including an integrated commissioning function
- Waltham Forest have established their Integrated Strategic Commissioning Function which integrates commissioning portfolios across London Borough of Waltham Forest and Waltham Forest CCG

- Strengthen collaboration with neighbouring CCGs and local providers
- Support local people and stakeholders to have a greater influence on services at a place level
- Work in partnership to commission high quality hospital services
- Commission person-centred, integrated health and care services
- Create a high performing and sustainable workforce
- Transform care and long term conditions including Diabetes, TB and Respiratory
- Commission and develop GP services that are modern, accessible and fit for the future

City and Hackney

- Improve the long-term health and wellbeing of local people and address health inequalities
- Maintain financial balance as a system
- Deliver a shift in focus & resource to prevention and early intervention
- Deliver proactive community-based care closer to home and outside of institutionalised settings where possible
- Deliver integrated care which meets the physical, mental health and social needs of our diverse communities
- Empower patients and residents
- Joined up support that meets the physical, mental and other needs of patients and their families
- Developing and retaining a skilled workforce
- Transforming services and achieving efficiencies through our improved digital offer
- Reducing exposure to the main preventable risk factors for poor health and inequalities (including smoking, inactivity, obesity, alcohol and substance misuse)

Priorities

- General population increase in recent years. Hackney has seen the largest population increase
- The CCG faces significant health and wellbeing challenges
- Specific pockets of very high deprivation, high levels of child poverty, high mortality rates from causes considered preventable, along with higher than national rates of mortality from cardiovascular disease are reported for the CCG
- Over 40% of children in Year 6 are overweight or obese
- Hackney has one of the highest rates of smoking in London
- Residents are more likely to be living with a long-term condition, such as diabetes, lung conditions, heart problems
- A high number of local people are reported to have mental health conditions, including severe mental health conditions

Challenges

- NHS City and Hackney Clinical Commissioning Group (CCG)
- City of London Corporation
- London Borough of Hackney
- The commissioners are partnering with the organisations that provide services and support in our area:
  - City and Hackney GP Confederation
  - City and Hackney Health and Social Care Forum (HSCF)
  - City and Hackney Local Pharmaceutical Committee (LPC)
  - East London NHS Foundation Trust (ELFT)
  - Healthwatch City of London
  - Healthwatch Hackney
  - Homerton University Hospital NHS Foundation Trust (HUHFT)
  - Voluntary sector providers

Partners

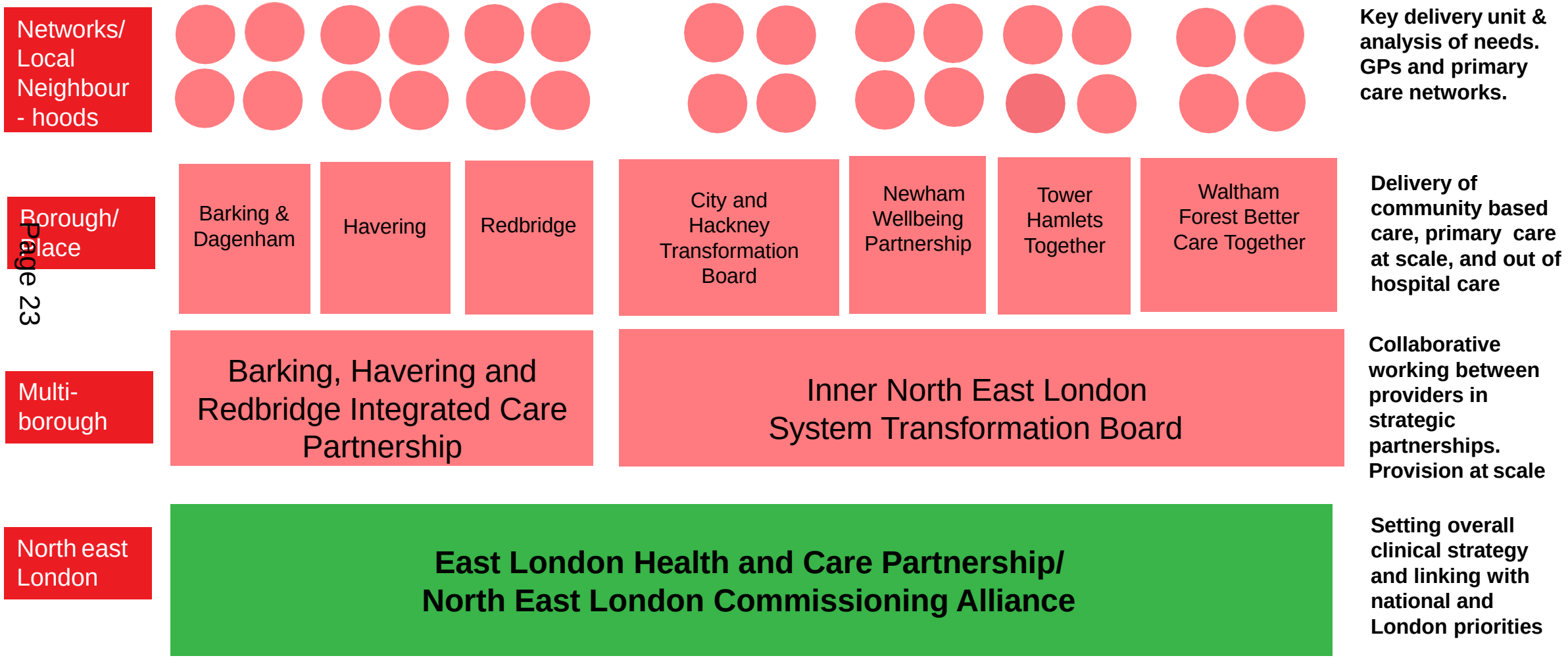
- The move to a neighbourhood model for the delivery of prevention, health and social care community-based services will continue at pace for City and Hackney and will enable innovation in the redesign of community services, and enable partners to work even more closely together to deliver new models of care
- Innovation in the approach to prevention making use of all our existing staff 'Making Every Contact Count'
- Redesign of outpatients services with care being provided closer to home
- Design a **clear prevention offer for children and young people** in relation to their well-being
- Maintain a financially robust health and care system
- Develop our integrated commissioning system

Integrated Commissioning

- More health and care budgets from across Local Authorities and the CCG will be pulled together to ensure efficiencies
- Improve health and wellbeing outcomes for City of London and Hackney residents through closer joint working and integration between local health and care organisations Improve health and wellbeing outcomes in our boroughs, by planning and delivering health, social care and public health services together
- Involve service users are at the centre of everything, and better tailor services to the needs of our diverse communities
- Establishment of four work streams, and five enabler groups t to improve services and care for local people
- Developing a systems medium term financial plan and financial control total

Initiatives

Health and care in north east London: a visual representation



Responding to the NHS Long Term Plan

- The national Long Term Plan sets out how the NHS will improve the quality of patient care and health outcomes. For more information visit the NHS website. The East London Healthcare Partnership is responsible for working with partners to develop a local version of the Long Term Plan to show how the new aims and commitments will be delivered locally
- A system operating plan has been submitted to NHS England and can be viewed on our website http://www.eastlondonhcp.nhs.uk/ourplans/
- This sets out how the partnership will work together and deliver specific commitments to improve performance in key priorities like cancer, maternity and mental health during 2019/20.
- It forms the first stage in our response to the NHS Long Term Plan.
- The next stage is to develop a five year plan and we are involving our partners and local people to produce this.

ELHCP priorities – overview

2016 STP Priority	NHS Long Term Plan Priority	NEL Long Term Plan Response
Digital Transformation Estates Workforce	Digital Transformation Workforce	Digital Transformation Estates Workforce System Reform
Maternity 0-25	Starting Well	**Start Well** Maternity 0-25
Cancer Mental Health Urgent and Emergency Care Medicines Optimisation	Cancer CVD Mental Health Respiratory Stroke	**Living Well** Cancer CVD Mental Health Respiratory Stroke Urgent and Emergency Care
Frailty End of Life Care	Ageing Well	**Ageing Well** Frailty End of Life Care
Primary Care Prevention	Personalisation Primary Care Prevention	**Cross Cutting** Personalisation Primary Care Prevention

Timelines

- NHS England released the implementation framework and system support offer for developing our response to the Long Term Plan: www.longtermplan.nhs.uk/implementation-framework/
- The implementation framework sets out the approach Sustainability and Transformation Partnerships are asked to take to create five-year strategic plans for 2019/20 to 2023/24.
- Our initial plan needs to be submitted by **27 September 2019** and we intend to take it to each health and wellbeing board in advance of that deadline.
- Plan will then go to JHOSCs (ONEL/INEL) in **September/October**
- Final plans submitted and published by **mid-November 2019**. We will publish a plain English summary of the plan alongside the main document.

Engagement

- The seven Healthwatch organisations have been leading a piece of engagement focused on primary care, prevention and personalisation. Their evidence suggests that our communities want:
  - Better access to GP appointments (preferably within one week)
  - Good quality information and advice
  - Responsive person centred services that include carers, family and social network.
- Stakeholder event on 6 June with over 200 attendees
- Engagement at local, system and NEL level continues

National next steps

- NHS England will aggregate system plans along with additional national activity
- This will be published as part of a national implementation plan by the end of the year, so that NHS England can properly take account of the Government Spending Review decisions on workforce education and training budgets, social care, councils' public health service and NHS capital investment.
- Locally, we see our response as an opportunity to signal to NHS England's national team what we think we need from the spending review.

Next steps

- Planning for submission of initial plan in September
- Workstream level engagement and events e.g.mental health summit
- Meeting with cabinet members for health to discuss process for sign off and submission
- Next ELHCP event, focusing on delivery of the plan is planned for **16 October 2019** with a session on social care (save the date).
- Work does not end with the submission of the plan – focus on delivery.

Any questions

Thank you

www.eastlondonhcp.nhs.uk

Havering
LONDON BOROUGH

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

Subject Heading:	BHRUT responses to Healthwatch chemotherapy recommendations and statement on current position, plus joint statement with CCG on future provision
Report Author and contact details:	**Natasha Dafesh, Senior Communications Officer – Stakeholder Relations, BHRUT**
Policy context:	**The information presented provides responses to each of the Healthwatch chemotherapy recommendations following changes to the service, and two requested statements.**
Financial summary:	**No impact of presenting information itself.**

SUMMARY

BHRUT officers will present to the Joint Committee responses to each of the Healthwatch chemotherapy recommendations. It will also present a statement about the current situation of the Cedar Centre, and a joint statement with the CCG about the future provision of cancer services.

RECOMMENDATIONS

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

REPORT DETAIL

Following a service change in October 2018 which saw all chemotherapy services delivered from Queen's Hospital and the Living With and Beyond Cancer Hub established at King George Hospital. Healthwatch subsequently carried out an engagement exercise and published a number of recommendations.

As requested by the Outer North East London Joint Health Overview and Scrutiny Committee this report covers our response to each of the recommendations along with a statement regarding any final decision to close Cedar ward at King George Hospital. It also includes a joint statement with the CCG focused on the management of increased demand over the coming years.

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.

Appendices:

- Healthwatch report: What would you do? It's your NHS. Have your say. Changes to chemotherapy services at BHRUT: a review of patient experience by Barking, Havering and Redbridge Healthwatch
- BHRUT Improving Cancer Services presentation to JHOSC on 2 October 2018
- BHRUT Improving care for our cancer patients presentation to JHOSC on 15 January 2019

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RESPONSES REGARDING CHEMOTHERAPY SERVICES

INTRODUCTION

Following a service change in October 2018 which saw all chemotherapy services delivered from Queen's Hospital and the Living With and Beyond Cancer Hub established at King George Hospital, Healthwatch carried out an engagement exercise to gather the views of patients to understand if the changes had impacted on their care and experiences.

Prior to the move we presented at the Joint Health Overview Scrutiny Committee (JHOSC), where we highlighted the benefits of the changes. These included:

- improved patient care and immediate access to specialists if needed
- increased ability to deal with growing future demand
- better work patterns for staff, and
- reduced delays

JHOSC agreed no formal consultation was required. The changes in general were supported by stakeholders, including the Public Health team at Redbridge.

We had plans for engaging widely with patients, however due to unforeseen circumstances the moves were brought forward and this was not possible. We did ensure however, that every patient affected was contacted and given a named contact for any questions or concerns.

It was therefore agreed we would work with Healthwatch to run a focus group retrospectively to see how patients felt about the move – this was conducted in March 2019.

Following the publication of the Healthwatch report in April 2019 we were very pleased to hear that our patients were happy with the quality of their care, and that no significant problems or concerns were raised as a direct result of the chemotherapy services move.

However, concerns were raised at the focus group that were outside the original scope of work about wider service issues, which Healthwatch then made recommendations against. This kind of valuable insight is helpful as it allows us to continually adapt and improve our services.

This report includes:

HEALTHWATCH RECOMMENDATION RESPONSES

Accident and Emergency

The main concern to emerge from the event was the apparent lack of familiarity of staff in both Urgent Treatment Centre and the mainstream Emergency Departments, with the specific healthcare needs of patients undergoing treatment for cancer.

We recommend as a matter of urgency, clinical leads from urgent and emergency care meet their counterparts in oncology to agree protocols for dealing with cancer patients who hold red cards and require urgent or emergency treatment to ensure that their cancer treatment is not compromised in any way.

Since the Healthwatch report was published we have taken the following actions:

1. Trust colleagues have met with the Partnership of East London Cooperatives (PELC) who provide the Urgent Treatment Centre service. They are now displaying clear notices in waiting areas to ensure our cancer patients know to identify themselves.

2. Staff who carry out the streaming of walk-in patients to our Emergency Departments (EDs), have been briefed to flag to the appropriate department that the patient has a red card when directed there.

3. Signs have been placed in clinical areas to remind staff to prioritise these patients.

4. We have refreshed our system and have clear protocols in place and flags on our patient record system.

It is worth noting that whilst our ED staff are highly skilled and trained, there may be a need to refer to a specialist on call for cancer patients, in order that the best possible care and treatment is provided.

Red cards
When they first present in our EDs, patients with a red card are fast-tracked to find out what is wrong, and to assess their risk for infection (alerting staff to the increased risk of neutropenic sepsis).

However, it does not necessarily mean they will be fast-tracked to immediate treatment. Once the assessment has been made they will then be prioritised based on their medical need.

We will review how the red cards are explained to patients as the report has highlighted the potential for miscommunication or misunderstanding.

Sunflower Suite (Queen's Hospital)

The lack of privacy, cramped space and lack of natural light needs to be addressed by the Trust. Patients are undergoing treatments which can be quite traumatic. Having conducive surroundings has a huge impact on the wellbeing of patients undergoing lengthy treatments.

There has been no increase in beds or chairs on the Sunflower Suite to accommodate extra patients. The move from Cedar Ward at King George Hospital has resulted in treating an additional 10 patients per week on Sunflower Suite and there has been no impact or increase of the number of patients being treated at any one time.

With 24 to 27 days available each month to spread the activity, the growth on any given day is minimal, and this current increase in demand has been comfortably accommodated by extended hours and Saturday opening.

Should further capacity be needed, the option to extend the service to seven-day working is possible, opening on a Sunday should demand require it.

It is worth noting that due to the increase in the number of patients presenting with more complex cases, the number of patients being treated at Cedar Ward was naturally reducing over time and correspondingly the number was increasing at Sunflower Suite; see following table.

Number of chemotherapy treatments													
2018	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total**
KGH	225	195	202	155	147	72	49	52	28	35	7	0	1167
QH	524	498	504	548	591	659	717	708	696	754	777	705	7681

Sunflower Suite does have three skylights, however, we appreciate there are no windows letting in natural light. At the current time there are no other available options.

Patient Transport & Parking Facilities

Patients and carers should have access to parking when they need it. If the car park is required for other purposes, we would recommend the Trust identify how they could ensure patients can access other parking facilities free of charge.

All patients should be assessed for patient transport.

Parking

We do provide free parking for cancer patients whilst receiving treatment at Queen's. However, we acknowledge the dedicated oncology parking was reduced at the time as a result of two temporary units (a mobile decontamination unit (EMS) following a fire in our endoscopy suite and an MRI scanner) being placed in the car park.

However, the decontamination unit was removed on 16 April and has improved the availability of parking spaces considerably.

As part of our ongoing review of services, should parking for chemotherapy patients become a significant problem at any point in the future due to an increase in demand we will reassess the current arrangements, and consider other options.

Patient transport

Consultants assess all our patients prior to their first treatment, and authorise transport if the criteria are met.

If, over the course of a patient's treatment, nurses notice changes in their condition and their ability to attend our hospitals, they are reassessed and transport is booked where appropriate.

Oncology Appointments

We recommend the system for booking patient appointments is reviewed. Patients should be able to confirm their next appointment before leaving the department.

The direct booking at reception for oncology appointments was stopped due to the large number of appointments requiring overbooking into clinics which cannot be done by the reception team.

There were also issues with long queues for patients waiting to book their appointments.

We are currently considering what options are available to help improve the current process.

Chemotherapy Appointments

We recommend the system for booking chemotherapy appointments is reviewed to ensure patients are booked in appropriately and not made to wait unnecessarily. Patients should not have to wait for long periods of time when they could be booked in later in the day.

If appointments are being offered before 9.30am, medication should be ready to be administered.

This is a very complex issue that we constantly strive to improve, and is a topic frequently discussed at our Chemotherapy Working Group.

Changes to the scheduling of the system have been made over the last few months, and templates have been provided to assist both the nursing and booking teams.

However, chemotherapy being dispensed on time is dependent on a number of factors, including the prescription being completed, the health of the patient, and bloods being within set parameters. Anything that requires further review or escalation to consultants will naturally slow the process down to ensure the continued safe treatment of our patients.

We try to accommodate requests for specific times as much as possible. Appointments at 9.30am are offered to patients who require at least 30 minutes pre-medication to try and prevent delays if the pharmacy has been unable to dispense the medication the night before.

Questionnaire

Information and issues identified through surveys and questionnaires should be addressed. Patients should feel listened to and valued for their opinion.

Feedback from our patients is invaluable as it helps us to make improvements to our services. For example following patient comments regarding staffing levels in oncology, we held a recruitment drive and have increased our staffing numbers. We also extended our hours to include Saturdays.

There are a number of ways patients can give feedback, share their suggestions, and raise issues or concerns. This includes our Friends and Family Test, which every patient is encouraged to complete, and is where we ask them 'how likely are you to recommend our ward/service to friends and family if they needed similar care or treatment?'

As well as patients raising things locally with staff on the wards, our corporate teams such as our Patient Experience team, support, listen and respond to patient feedback aiming to improve the overall experience.

Our Patient Advice and Liaison Service (PALS) is also available to help patients and their relatives or carers with any advice or concerns.

Reviewing our services and continuously improving is a priority for us, and looking at new ways to incorporate the views and feedback from patients and visitors is vital to this.

Phlebotomy

We would recommend that phlebotomy services are reviewed to understand where a better service could be initiated.

We recognise the opportunity for improvements in our Phlebotomy service (blood tests), and this has been a focus for the Trust over the past 12 months.

Based on feedback and data we are currently rolling out new initiatives such as an electronic appointment booking system, and a pilot of Saturday working at Queen's Hospital with a view to migrate to a seven day Phlebotomy service in the future.

Our patient partners are working closely with the division.

In addition, we are working closely with our system partners (NELFT and the CCGs) to improve services.

We are also looking into the possibility of a dedicated service for cancer patients.

Clinic services

Patients should be able to ask for additional clinical support when they are attending clinics and not be sent to Accident and Emergency or Urgent Treatment Centre.

As previously stated, patients have raised concerns that Emergency Department clinicians do not always have the right level of experience to respond to the specific healthcare needs of patients undergoing treatment for cancer.

The most important thing is that our patients get the right advice and the right treatment from the right clinician. Whilst this may feel like an inconvenience by patients who are directed to another department, ultimately our key concern is their health and ensuring their needs are being met by the most appropriate person and service.

If required, patients from the clinic can be considered for direct admission to the ward but the safety and comfort of the individual patient dictates the option chosen.

Cedar Centre

Patients who have used the new 'Living with Cancer and Beyond Hub' have rightly praised it, however we recommend that more patients need to be made aware of the opportunities. More publicity and information should be made available to patients attending Queens Hospital.

We were however, concerned that the diversity figures presented by the Trust are not representative of the local populations particularly in Redbridge and Barking & Dagenham. Although we are aware a patient has the choice to use these services, we would recommend the Trust review the types of services being offered to identify why they are not being used by particular community groups.

Health and wellbeing services are part of a major programme of work, formerly known as the 'recovery package' for cancer patients, and now referred to as 'personalised care.'

We have been working on the delivery of health and wellbeing groups for the past five years. There is national guidance on the core content of health and wellbeing information that should be available for cancer patients; we ensure we always follow this guidance when planning any groups.

The first stage of delivering personalised care is about ensuring our patients have had a Holistic Needs Assessment (HNA) which enables them to identify their main concerns at various points throughout the pathway of diagnosis and treatment.

Our clinical nurse specialists have been conducting HNAs with our patients for approximately two years. From these we have been able to run reports to evidence the top four concerns of our patients which in turn helps us to plan services to meet their needs. Finance and worry, and fear and anxiety, are consistently rated in the top four concerns; we have therefore increased our complementary therapy service to help address anxiety and are in the process of increasing our welfare benefits service.

Our group sessions are designed to meet people's information and support needs both pre and post treatment.

The first session was initiated over five years ago, which is a one day post treatment health and wellbeing event. This is evaluated from written feedback from patients and carers who attend, and a patient partner also contributes.

Patient feedback from this event highlighted they would have found the information more useful before they started treatment, so in direct response we devised the EMPOWER session (a highly-commended service) which is a two-hour weekly workshop open to all patients recently diagnosed with any cancer.

Patients and carers complete feedback forms at every session. Weekly huddles are also held to review the attendance and comments of groups from the previous week, the information from which is used to build on and improve services.

In terms of signposting patients to the Cedar Centre service, our main form of communication about the range of activities on offer is via our newsletter, which is shared in the following ways:

- Oncology outpatient reception
- Receptions and waiting rooms in both Radiotherapy and Chemotherapy
- Macmillan information room
- Copies inserted in every new patient pack
- Promoted by all clinical nurse specialists (the keyworker for each patient) who signpost direct to services

We plan to expand this, by offering patients the option to sign up to this electronically to receive the newsletter by email – something already offered to those attending EMPOWER.

All the services available at the Cedar Centre (including complementary therapies and psychological support) are listed on our website, including contact details and how to book, plus a video to help people feel at ease for their first visit,

and we hope to produce more videos about the services available in the coming months – more information can be found at www.bhrhospitals.nhs.uk/cancer-services

We have also begun issuing letters to all newly diagnosed patients inviting them to attend EMPOWER. It is expected that once people access this session they will take up more of the other services we offer.

For those who prefer social media, we have a cancer Twitter account (@BHR_cancerinfo) that regularly publicises activities taking place, so we have a range of ways for patients to hear about our services and engage with us.

All services are available to all patients having chemotherapy or radiotherapy treatment – however it's worth noting that accessing these additional services is optional.

Demographics
The important point to note in regards to demographics is that the diversity of patients accessing our health and wellbeing services is largely reflective of our patients receiving treatment. We believe this to be a more appropriate measure than local populations.

We will continue to monitor and analyse the uptake of services.

See Appendix 1 for tables and charts showing a breakdown of ethnicity data between 1 December 2018 and 31 March 2019 for both the number of patients receiving treatment and those attending health and wellbeing services.

Pharmacy

Patients should be given better information and support to access pharmacy services. No patient should be asked to wait for a prescription if it will take over four hours to prepare. Better systems should be in place to allow patients to return to collect their prescription at a suitable time.

If patients are required to contact the pharmacy, the Trust must ensure contact details are continually reviewed and updated.

Some cancer patients are required to pick up prescriptions following appointments in Oncology outpatient clinics and due to the complexities of their conditions, these can take longer to prepare than standard medication, and need a number of checks completed.

However patients are provided with an approximate timeframe so they can leave and return to the Pharmacy later to pick up the drugs.

It is rare for a patient to have to wait four hours to have chemotherapy prepared, however chemotherapy for many patients cannot be pre-prepared as it has to be confirmed on the day after consideration of their physical condition; time then needs to be allowed for the preparation and administration to occur. Unfortunately this can cause a delay however it is necessary to safeguard our patients.

For outpatient prescriptions it would be very rare that preparation would take four hours, unless there was an issue that had to be checked with the prescriber. In this case Pharmacy would advise the patient and ask them to come back later.

Pharmacy details have not changed and we accept on this occasion we may have given out the wrong number.

The provision of the chemotherapy medication for patients at the Cedar Centre was not ideal in that medication often could not be prepared until patients arrived at Cedar on the day of treatment and the distance between the hospitals inevitably caused some delays for the patients while they waited for the drugs to be delivered from Queen's Hospital.

This delay has been removed and although we cannot eliminate delay from the system completely, the movement to Sunflower Suite has made the system more efficient for patients.

Patient Engagement

We recommend the Trust review the way patients and carers are involved in the development of the service. The Trust told us they had engaged with some patients who were previously using cancer services but we were not able to confirm whether they were recent users of current services.

Most patients and carers we spoke with told us they were not actively engaged with during the service change and would welcome the opportunity to have an input into the proposals.

We acknowledge that on this specific occasion we were unable to engage with patients as we had planned due to unforeseen circumstances which meant the service had to be moved much quicker than had been expected.

Whilst we regret patients and their families or carers were not able to input into the changes on this occasion, we strongly believe the move was in the best interests of patients and are pleased the Healthwatch findings did not highlight anything to the contrary.

As is standard practise, we will continue to review the service, and engage with all relevant stakeholders as appropriate.

We have very good engagement with our Patient Partner for the service, whose views and opinions are routinely taken on board, whether on general opportunities to improve or develop, or on specific proposals.

We also listen to views and suggestions, and ensure ideas are followed through, from the Cancer Patient Public Advisory Group (CPPAG).

APPENDIX 1

Table 1 and Chart 1 – Ethnicity of patients receiving treatment, 1 December 2018 to 31 March 2019

Table 2 and Chart 2 – Ethnicity of patients attending health and wellbeing services, 1 December 2018 to 31 March 2019

Table 1

Ethnicity of patients receiving treatment 1 December 2018 to 31 March 2019	
Ethnicity	**Count**
White British	541
Any other White background	53
Indian or British Indian	45
Black African or Black British African	37
Asian – other	23
Black Caribbean or Black British Caribbean	17
Any other ethnic group	16
Pakistani or British Pakistani	16
Bangladeshi or British Bangladeshi	10
Not stated / refused	10
Any other Black background	9
White Irish	6
Chinese	5
Any other mixed background	3
Mixed White and Black African	3
Mixed White and Black Caribbean	3
Unknown	3
Mixed White and Asian	1
TOTAL	**801**

Table 2

Ethnicity of patients attending health and wellbeing services 1 December 2018 to 31 March 2019	
Ethnicity	**Count**
White British	181
Black African or Black British African	11
Indian or British Indian	10
Any other White background	8
Asian – other	4
Black Caribbean or Black British Caribbean	4
Not stated / refused	4
Any other Black background	3
Bangladeshi or British Bangladeshi	2
White Irish	2
Any other ethnic group	1
Chinese	1
Mixed White and Black African	1
Mixed White and Black Caribbean	1
Pakistani or British Pakistani	1
Unknown	1
TOTAL	**235**

Chart 1

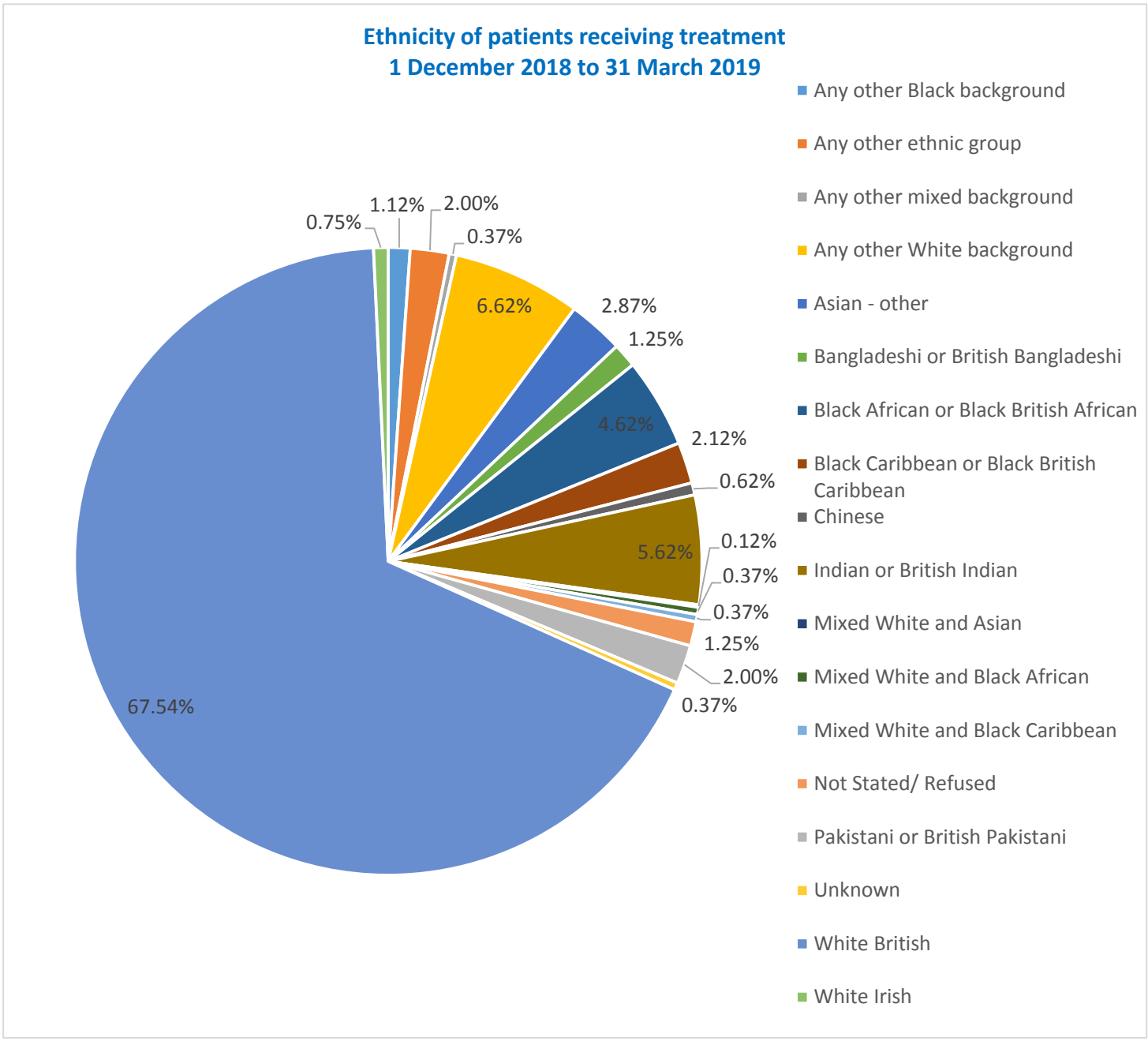
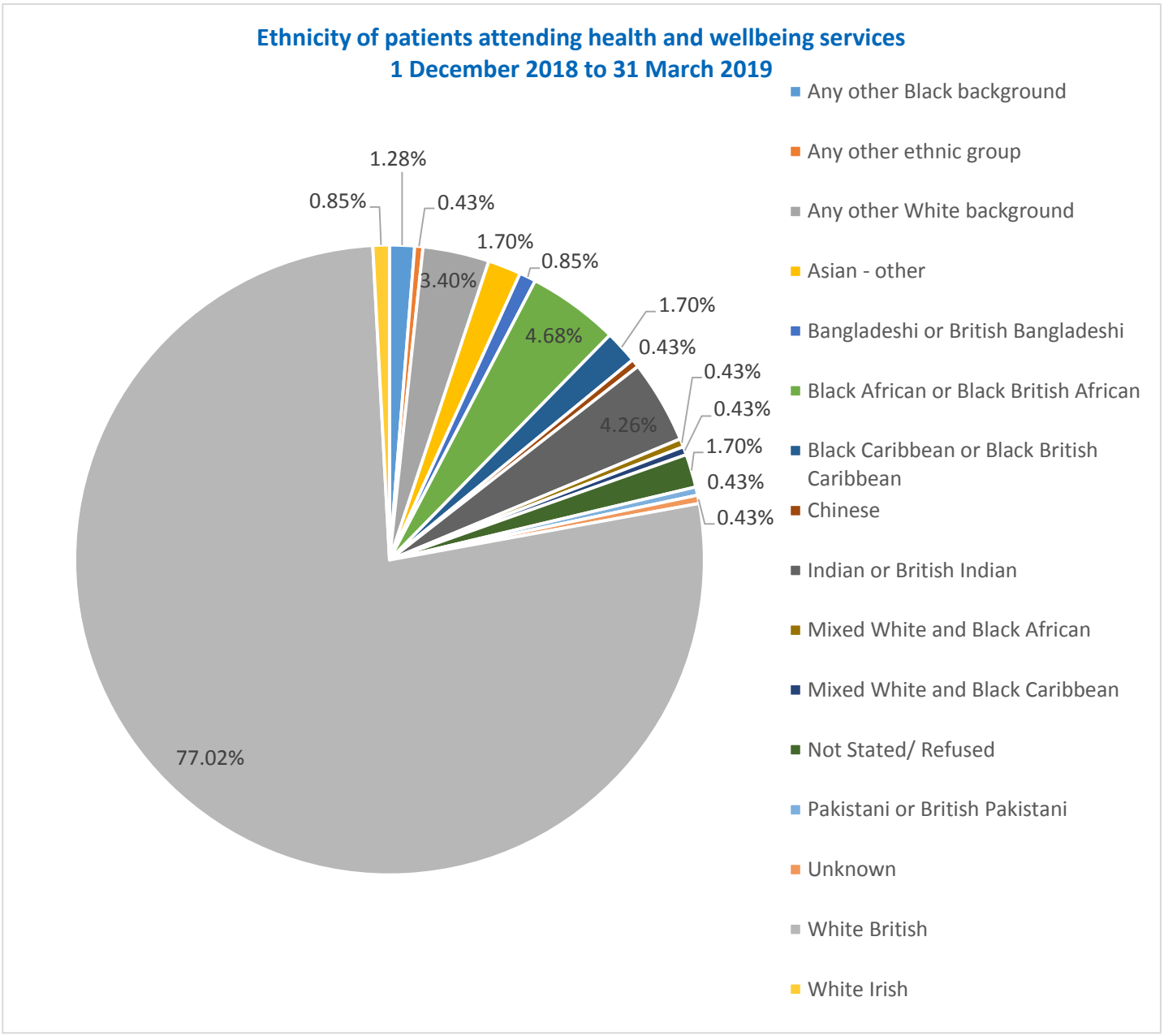

Ethnicity of patients receiving treatment
1 December 2018 to 31 March 2019
0.75%
1.12%
2.00%
0.37%
6.62%
2.87%
1.25%
4.62%
2.12%
0.62%
5.62%
0.12%
0.37%
0.37%
1.25%
2.00%
0.37%
67.54%
Any other Black background
Any other ethnic group
Any other mixed background
Any other White background
Asian - other
Bangladeshi or British Bangladeshi
Black African or Black British African
Black Caribbean or Black British Caribbean
Chinese
Indian or British Indian
Mixed White and Asian
Mixed White and Black African
Mixed White and Black Caribbean
Not Stated/ Refused
Pakistani or British Pakistani
Unknown
White British
White Irish

Chart 2


Ethnicity of patients attending health and wellbeing services
1 December 2018 to 31 March 2019
1.28%
0.85%
0.43%
1.70%
0.85%
3.40%
4.68%
1.70%
0.43%
0.43%
0.43%
4.26%
1.70%
0.43%
0.43%
77.02%
Any other Black background
Any other ethnic group
Any other White background
Asian - other
Bangladeshi or British Bangladeshi
Black African or Black British African
Black Caribbean or Black British Caribbean
Chinese
Indian or British Indian
Mixed White and Black African
Mixed White and Black Caribbean
Not Stated/ Refused
Pakistani or British Pakistani
Unknown
White British
White Irish

BHRUT STATEMENT REGARDING ANY FINAL DECISION TO CLOSE CEDAR WARD AT KING GEORGE

We would like to keep the Cedar Centre open so it can continue to be used as a dedicated space for our Living With and Beyond Cancer hub.

We opened the hub because of the increasing need to expand and enhance health and wellbeing support for our cancer patients, a crucial element for them both during and after their treatment. There are also psychological benefits of receiving this support at a different location to where they receive their treatment. In addition we are able to continue to improve the quality of care and patient experience, and manage future demand, because we have consolidated chemotherapy services at Queen's. Feedback from our patients supports this position.

JOINT STATEMENT FROM BHRUT AND CCG ON THE MANAGEMENT OF INCREASED DEMAND OVER THE COMING YEARS

As reported to the JHOSC in January 2019 and based on trend analysis, the BHR system anticipates a likely increase of up to 6 per cent year-on-year in terms of patients requiring chemotherapy due to a range of factors, including population increase, improvements in screening, subsequent earlier diagnoses and people living longer.

The current service at Queen's Hospital has comfortably accommodated the additional patients from the Cedar Centre at King George Hospital (approximately ten per week) through extended hours and the move to a six day service.

A further increase in demand can still be accommodated within the current available capacity which could be further extended to a seven day service as and when appropriate.

The way BHRUT treats its cancer patients is constantly developing. For example, and where clinically appropriate, the Trust can now provide chemotherapy to patients at home.

The Trust will also continue to look at further collaborative working across the health care system and not treat patients in isolation. BHR already has a Cancer Collaborative working across the system and this is also helping drive forward how we commission, provide and manage cancer care services in the future.

Within London, early diagnostic centres are being developed, with one planned to support care for patients from BHR. These will start to impact on the number of patients being screened and thus presenting earlier to hospital and starting their care and treatment sooner. This may also alter the types of treatment for patients both within acute trusts and community settings.

BHRUT has been fortunate in having the opportunity to be involved in the Grail trial in partnership with University College Hospital, with an additional CT scanner placed in King George Hospital to facilitate an increase in screening for Lung Cancer patients from our local community. This project will contribute hugely to the early diagnosis of lung cancer.

Medical technology is constantly developing and local Radiotherapy services will continue to play an increasingly important role in caring for cancer patients and managing future demand. The Trust has benefited from significant investment in its Radiotherapy department including three state-of-the-art machines offering top-class treatments for patients at Queen's Hospital.

Queen's is the only hospital in the world to have two Halcyon machines, offering high quality, high speed, fully image-guided radiotherapy in a more patient-centred way. Treatment times are reduced, while still delivering the same level of radiotherapy treatment, making it a much more comfortable experience for the patient. Queen's also boasts The Edge, a specialist machine with enhanced precision and accuracy used in the treatment of complex cancer cases.

The BHR system is also focused on recruitment and retention of staff. The Queen's chemotherapy unit has a training model for the development of specialist chemotherapy nurses which both patients and the Trust has benefited from over a number of years.

The Trust plans to continue to 'grow its own' staff while attempting to recruit into vacant posts. Staffing levels and new models of working are constantly assessed and considered, so that rotas are resilient and provide the best possible patient care.

As patients benefit further from advances in technology and care, the development of local chemotherapy services will remain clinically-led and will be part of the wider BHRUT clinical strategy which will be developed in the context of an integrated care system. The development of this strategy has already begun and includes an independent review of the future demand and population need for the BHR system as a whole.

It's your NHS. Have your say.

Changes to chemotherapy services at BHRUT: a review of patient experience by Barking, Havering and Redbridge Healthwatch

local healthwatch
working together

Introduction

The Healthwatch organisations from Redbridge, Havering and Barking and Dagenham were asked by the Outer North East London Joint Health Scrutiny Committee to gather the views of patients using chemotherapy services at Barking and Dagenham, Havering and Redbridge University Trust (BHRUT).

We recently held a focus group on Wednesday 27 March at Havering Town Hall, with patients and carers who had recent experience of using chemotherapy services at Queens and King George's Hospitals.

The service was changed in October without consultation and now provides chemotherapy from the Queens Hospital site in Romford.

Attendees

A total of **18** people attended the focus group. Healthwatch Barking and Dagenham also met with **two** people after the event as they were unable attend on the day. Their numbers have been added to the figures below:

- **12** patients had received their chemotherapy at Queens Hospital
- **1** patient had received their chemotherapy at KGH
- **2** patients had received chemotherapy at both sites
- **5** carers or family members attended

Sunflower Suite and Mandarin B Ward (Queens)

Ward staff were ***'really welcoming, nurses were great, amazing, caring, wonderful volunteers, professional and brilliant'***.

Most said there was a calm atmosphere, some told us they felt safe and supported. Most who had used the day unit said it was outstanding but felt it was very cramped. One patient who was on a clinical trial felt there was no privacy in the very limited space.

Some told us they were concerned that there was little privacy and had noted that since the changes last year, the beds seemed closer together to accommodate more patients using the space ***'We're packed in like sardines'***.

All were still concerned that there was no natural light and many said this meant the lights were on all night.

Some patients told us they thought the section for younger patients was underused and empty at busy times. Some patients had taken it upon themselves to move into this section as they couldn't understand why it would be allowed to stand empty and place everyone into a small space.

Some felt privacy had become an issue with patients and family members saying private conversations could be overheard.

The use of student nurses was mentioned. All patients and family members said they understood and supported the use of student nurses but this had on many occasions led to a longer treatment session going from an average of 2-3 hours into 3-4 hours or more for some patients.

Most patients and carers said they had not seen new staff on the wards apart from student nurses. They felt staff were doing an excellent job under difficult circumstance, explaining that they felt staff were coping with additional patients and duties and had little time to chat to patients in between tasks. Some told us they knew of staff not taking their breaks in order to see to patient's needs.

A number of patients and carers said they felt the pressure on staff had increased when the shift pattern changed (longer day shifts) and they noticed a number of staff left at this time (they were uncertain whether this was as a direct result of the changes).

Most patients remained concerned that staffing levels were putting staff under increasing pressure. Some described the increased stress on staff had a 'knock-on' effect on them as it left them feeling uneasy about the service and standards.

One patient recounted an experience when they were given, without any warning or guidance or training whatsoever; a box of injections for five days by one of the nurses. They were told they were to inject themselves but offered no instruction or explanation. This was a cause of great stress and when they next met with their consultant, they explained what had happened. The consultant was very surprised.

Some patients and carers said they would have like more basic information about the ward, such as where you could get drinks etc (***'no one tells you'***).

Some wanted more comprehensive information at the start or prior to their treatment to understand what will happen. Most were in favour of more 1:1 personal services being offered as an option, ***'Personalised care and support at all times would be good'***.

Two patients had received treatment at KGH whilst the move was taking place.

Both told us they were not formally informed about the changes. Both finished their treatment before the move.

Living with and beyond cancer hub - Cedar Centre

Four patients had used the Cedar Centre since it had opened in December last year. Ten patients and none of the four carers had heard of the services being offered but were interested to try them.

Of those that had used the services:

- None had used the weekly EMPOWER sessions.
- One had completed the HOPE course.
- None had used the carer's space.
- One had attended the Look Good Feel Better sessions.
- One had used complementary therapies.
- Three had attended for welfare advice but not at the Cedar centre (this was at Queens).
- No patients had received 1:1 psychology sessions at the Cedar centre although two patients had used a similar service at Queen's hospital.
- None had tried the art therapy/creative writing/relaxation or visualisation workshops
- One patient was about to begin attending the Myeloma support group.

All patients who had used the Cedar centre were pleased with the results.

The majority of patients and carers were unaware of the services on offer, with most saying they would want to take advantage of them.

Some patients said travelling to the Cedar centre could be an issue as they would be restricted due to school times or public transport.

Patient Transport

Most patients told us they were not offered patient transport.

One patient had been offered patient transport but said they had refused as they had not required it.

Parking Facilities

Most patients and family members who drove raised concerns about the parking facilities at Queen's hospital.

Most felt car parking costs should be free for all patients receiving long-term treatments, not just for chemotherapy patients. Some long-term

patients were aware that their carers could get a permit but this did not appear to be widely known. This kind of information should be provided as routine.

Many patients and carers expressed concern that part of the Sunflower Suite car park (about a quarter to a third) was currently housing a mobile Endoscopy suite due to a fire at the hospital a year ago. This presented major problems as the amount of spaces were always at a premium.

Clinic services

Although some patients felt the service had improved ***('Chemotherapy at Queens is done a lot more quickly; I see the same staff which is good.')***, a number of patients felt the service had become, at times, overloaded; ***('the clinic is more crowded; I used to go straight in at my appointment time, now I have to wait; the system is too overloaded to be efficient.')***

Four patients told us they felt the service had changed in regards to raising medical issues when attending their chemotherapy sessions.

One patient explained that when they asked to speak to a doctor on the ward (Mandarin B) about a medical problem, not being sure whether it was related to their condition. They were told there was no doctor available and if they were concerned about the issue then they should go to A&E.

One patient told us they had small veins and this meant it was difficult when having blood test. Although the ward had given them a heat pad, they said there were not enough on the ward and other patients had resorted to bringing in their own heat pads.

Oncology Appointments

Some patients told us the system for making consultant appointments had changed. Where they had previously been able to make an appointment before they left the department; they now have to wait for a letter with their next appointment to be generated afterwards. This is leading to a delay in confirming the next appointment which is required before they next attend for the chemotherapy session.

Some patients and carers told us this was causing complications as not all the letters were arriving before their next booked chemotherapy session was due.

Some had resorted to telephoning the consultant's secretary to get their appointment details as, to attend the chemotherapy session, they needed

to have an appointment with their consultant a few days before their next session.

For some, this has meant they are worrying unnecessarily, or having additional tasks to remember. One said: ***'I shouldn't have to do this, I already have enough to think about!'***

Some told us when they contacted the secretary, they were told their appointments had not been booked. Although the secretary would tell them they ***'would fit them in'***; they were still concerned that this would mean they were being squeezed into sessions that were already very full and this meant further delays and long waits with some consultants having up to 30 patients to see at a session. One patient told us they had to insist on an appointment in order not to delay their next chemotherapy session, ***'If you're not assertive, you would be overlooked.'***

One patient told us they had been using the chemotherapy services for 6 years. However, in the last 6 months they have seen a big increase in the number of people attending at any given day they are there. They felt this had caused problems with their appointment times (being much longer). They were increasingly concerned that the number of people will have an impact on the quality of care

Another patient explained they were told they needed a blood transfusion and that it would be ready at 9.30am. When they arrived they were told it wouldn't be ready to at least 11am and that each of the two units would take 2 hours apiece.

One carer comment ***'Cancer patients don't know how long they have to live; our time is precious.'*** They added that the waste of time waiting around hospitals was unnecessary. They asked why they could not be contacted to let them know there was a delay so they could have come later.

Phlebotomy

Blood tests have become a concern for many commenting that they are having very long waits in the oncology department and have been attending other departments to get the test completed. Some said they can wait for up to three hours. One patient commented ***'The blood test department is sometimes too slow depending on the phlebotomist you have on. One in particular can take 20 minutes out of your time!'***

Some patients would like to see the service hours extended (currently 8.30am to 1.30pm) and additional staffing used.

One patient suggested the phlebotomy clinic could supply pagers to allow patients the opportunity to make use of the café at Queens and come back when it was their turn. ***Note: Pagers are currently used within outpatients departments and could possibly be made available with little effort or additional outlay***.

Chemotherapy Appointments

Some patients told us they were still concerned that their appointments were being booked too early and they were left to wait for 2 or more hours before their chemotherapy medication is ready.

Most said they couldn't understand why they were asked to attend the appointment at 9.30am but would not begin to receive their treatment until after 11am. ***Note: The use of pagers (see above) was similarly suggested for chemotherapy appointment delays***.

Some patients also stated they had been told the staff responsible for making up the chemotherapy medication do not start work until 9am therefore they couldn't understand why they would need to be in the department for 9.30am as it takes time to create and dispense the product.

One patient told they were booked to attend a CT scan at KGH as the scanner at Queens was not being used. They had difficulty getting a cannula inserted as the department was unable to do this, even though they had called ahead to notify them of their need. They asked if they could go to Cedar Ward to get this done, only to discover it had recently closed.

Pharmacy

Some patients felt the time taken to receive their chemotherapy prescriptions should be addressed. One patient told us they have been asked if they wished to wait but, when they asked how long it would take, they were told it would be over four hours. This patient had school aged children which meant it would have been impossible to stay there as they had to collect their children from school. Although they asked to be contacted, they were not.

They later tried to telephone the pharmacy only to find out the number they had originally been given was wrong.

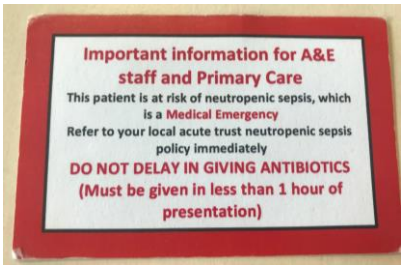
Questionnaire

Some patients said they were being contacted after their appointments to complete surveys over the phone.

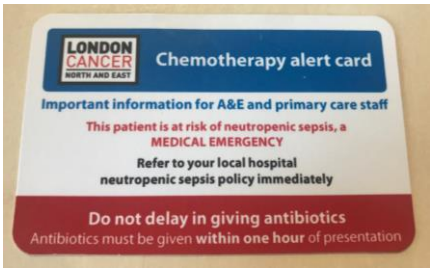
Although they didn't mind doing this, they felt the information they were being asked was repetitive and any issues or concerns did not seem to be passed on when they attended their next appointments which meant they had to repeat themselves.

Accident and Emergency

A major concern was highlighted in regards to the use of chemotherapy priority cards (see images below) when accessing Accident and Emergency Department at both Queen's and KGH.



A number of patients provided examples of problems when they have had to attend A&E and identify themselves as a chemotherapy patient receiving treatment.



Although they were all issued with a 'red card' by their oncology consultant; they were not prioritised as they had expected within the first hour due to their increased risk of sepsis.

Some patients had been expected to wait for over two hours. In one case, a patient and their family member had waited over four hours to be seen and triaged within Queens A&E department.

Patients were very concerned that they were being asked to sit in A&E and Urgent Care Departments without being prioritised due to the high risks of infection associated with their treatment.

Two patients reported being told to 'take a seat' next to patients who were vomiting and clearly very unwell. At least three patients told us they resorted to waiting outside the department (in the winter months) for many hours before being seen. One said, ***'The 'Red Card' is useless and doesn't give (chemo) patients priority.'***

The majority of patient and carers spoken with who had experience of using A&E raised similar concerns about accessing emergency services when being treated with chemotherapy.

Many raised concerns that the A&E departments at both hospitals seemed reluctant to contact the oncology department to ask for further

information. One patient told us they took it upon themselves to contact the oncology department when the A&E clinician refused to do so.

Patients have been told to go to A&E if they have a problem with their condition but many told us they would like to contact the ward directly for support as they were unconvinced that A&E was the best place to receive appropriate support. One patient told us they had such poor experiences attending A&E on two separate occasions, they had begged their partner not to take them.

One patient told us, ***'I'm scared of A&E at Queens as they're not specialised in cancer care.'***

They continued; ***'I went to A&E after my third (chemotherapy) treatment as my temperature had soared. I had to explain the issue to four doctors! They had no knowledge of the risk to oncology patients.'***

These issues were raised with BHR CCG at their governing body meeting on Thursday 28 March 2019 and escalated to Healthwatch England to identify whether other Healthwatch organisations had heard of similar concerns.

Some patients also told us they were concerned that when then had attended A&E, they were treated by clinicians with very little experience of using a PICC line[1].

One patient said ***'The staff at A&E didn't know how to take blood from the PICC line. They were about to take it from my toe but my wife had to stop them and pointed out that a chemotherapy patient can't have blood taken from their toe.'*** *Note: blood was not taken from the toe.*

[1] PICC: (peripherally inserted central catheter line) - *Note*: *PICC lines are used to give someone chemotherapy treatment or other medicines. A PICC line is a long, thin, hollow, flexible tube called a catheter and normally put into one of the large veins of the arm, above the bend of the elbow.*

Recommendations

- ### Accident and Emergency

  The main concern to emerge from the event was the apparent lack of familiarity of staff in both Urgent Treatment Centre and the mainstream Emergency Departments, with the specific healthcare needs of patients undergoing treatment for cancer.

  We **recommend as a matter of urgency**, clinical leads from urgent and emergency care meet their counterparts in oncology to agree protocols for dealing with cancer patients who hold red cards and require urgent or emergency treatment to ensure that their cancer treatment is not compromised in any way.

- ### Sunflower Suite and Mandarin B Ward (Queens)

  The lack of privacy, cramped space and lack of natural light needs to be addressed by the Trust. Patients are undergoing treatments which can be quite traumatic. Having conducive surroundings has a huge impact on the wellbeing of patients undergoing lengthy treatments.

- ### Patient Transport & Parking Facilities

  Patients and carers should have access to parking when they need it. If the car park is required for other purposes, we would **recommend** the Trust identify how they could ensure patients can access other parking facilities free of charge.

  All patients should be assessed for patient transport.

- ### Oncology Appointments

  We **recommend** the system for booking patient appointments is reviewed. Patients should be able to confirm their next appointment before leaving the department.

- ### Chemotherapy Appointments

  We **recommend** the system for booking chemotherapy appointments is reviewed to ensure patients are booked in appropriately and not made to wait unnecessarily. Patients should not have to wait for long periods of time when they could be booked in later in the day.

  If appointments are being offered before 9.30am, medication should be ready to be administered.

- ### Questionnaire

  Information and issues identified through surveys and questionnaires should be addressed. Patients should feel listened to and valued for their opinion.

- **Phlebotomy**

  We would **recommend** that phlebotomy services are reviewed to understand where a better service could be initiated.

- **Clinic services**

  Patients should be able to ask for additional clinical support when they are attending clinics and not be sent to Accident and Emergency or Urgent Treatment Centre.

  As previously stated, patients have raised concerns that Emergency Department clinicians do not always have the right level of experience to respond to the specific healthcare needs of patients undergoing treatment for cancer.

- **Cedar Centre**

  Patients who have used the new 'Living with Cancer and Beyond Hub' have rightly praised it, however we **recommend** that more patients need to be made aware of the opportunities. More publicity and information should be made available to patients attending Queens Hospital.

  We were however, concerned that the diversity figures presented by the Trust are not representative of the local populations particularly in Redbridge and Barking & Dagenham. Although we are aware a patient has the choice to use these services, we would **recommend** the Trust review the types of services being offered to identify why they are not being used by particular community groups.

- **Pharmacy**

  Patients should be given better information and support to access pharmacy services. No patient should be asked to wait for a prescription if it will take over four hours to prepare. Better systems should be in place to allow patients to return to collect their prescription at a suitable time.

  If patients are required to contact the pharmacy, the Trust must ensure contact details are continually reviewed and updated.

- **Patient Engagement**

  We **recommend** the Trust review the way patients and carers are involved in the development of the service. The Trust told us they had engaged with some patients who were previously using cancer services but we were not able to confirm whether they were recent users of current services.

Most patients and carers we spoke with told us they were not actively engaged with during the service change and would welcome the opportunity to have an input into the proposals.

Acknowledgements:

The Healthwatch from Redbridge, Havering and Barking & Dagenham would like to thank the patients and carers who provided responses and contributed to this report.

We would also like to thank BHRUT for their support on the day and for contacting current patients and providing information.

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IMPROVING CARE FOR OUR CANCER PATIENTS

Liz Crees

Cancer Specialty Manager

TAKING PRIDE IN OUR CARE

Barking, Havering and Redbridge University Hospitals NHS Trust

INTRODUCTION

- One of the busiest oncology departments in the country

- We are constantly focused on:
  – looking for new ways to improve our patients' care and experiences
  – improving efficiencies across the service
  – a holistic approach to caring for patients both during and after their treatment

- We must ensure we can meet the increasing demand now and into the future

- We believe we can best achieve this by:
  – creating a centre of excellence for cancer treatment at Queen's Hospital
  – creating a 'Living with and beyond cancer' hub

WE'VE GOT A LOT TO BE PROUD OF…

- Met the national 62 day cancer standard for 13 months in a row
  - Only trust in London to have achieved this
- Member of the UCLH Cancer Collaborative
- Part of the BHR Cancer Collaborative Committee
- Enhanced Supportive Care team shortlisted for national Nursing Times award
- EMPOWER programme shortlisted for Nursing Times and Health Service Journal awards

FOR HEALTHCARE LEADERS HSJ AWARDS FINALIST

Nursing Times Awards

STATE OF THE ART RADIOTHERAPY…

- State of the art radiotherapy centre at Queen's Hospital
- Three brand new machines – Halcyon (x2) and the Edge (x1)
- First in world to have two Halcyon machines on one site
  - halves treatment times; more accurate; more comfortable
- The Edge – can treat much more complex cases

CONTEXT

- Need to change how we deliver healthcare nationally
  – best use of resources (people, estate and finance)
  – deliver services in a way that meets changing demands of our population

- We serve more than 1million people from our three boroughs and across the whole of Essex (referred through our regional Neurosciences Centre)

- We expect a 6% increase year on year in patients requiring chemotherapy due to:
  – Population increase
  – Improvements in early diagnosis
  – State of the art treatments means people live longer
- Increases the need for services to be able to meet demand
- Increase in complexity in cases

Year	Chemotherapy patients treated
2015/16	1,695
2016/17	1,809
2017/18	1,905

OVERVIEW OF OUR SERVICES

- Provide treatment and health and wellbeing services across both King George and Queen's hospitals

- Essex Neurosciences Centre

- Cancer centre
  - Radiotherapy (Queen's)
  - Chemotherapy
  - 30 bed inpatient ward (Queen's)
  - Outpatient facilities

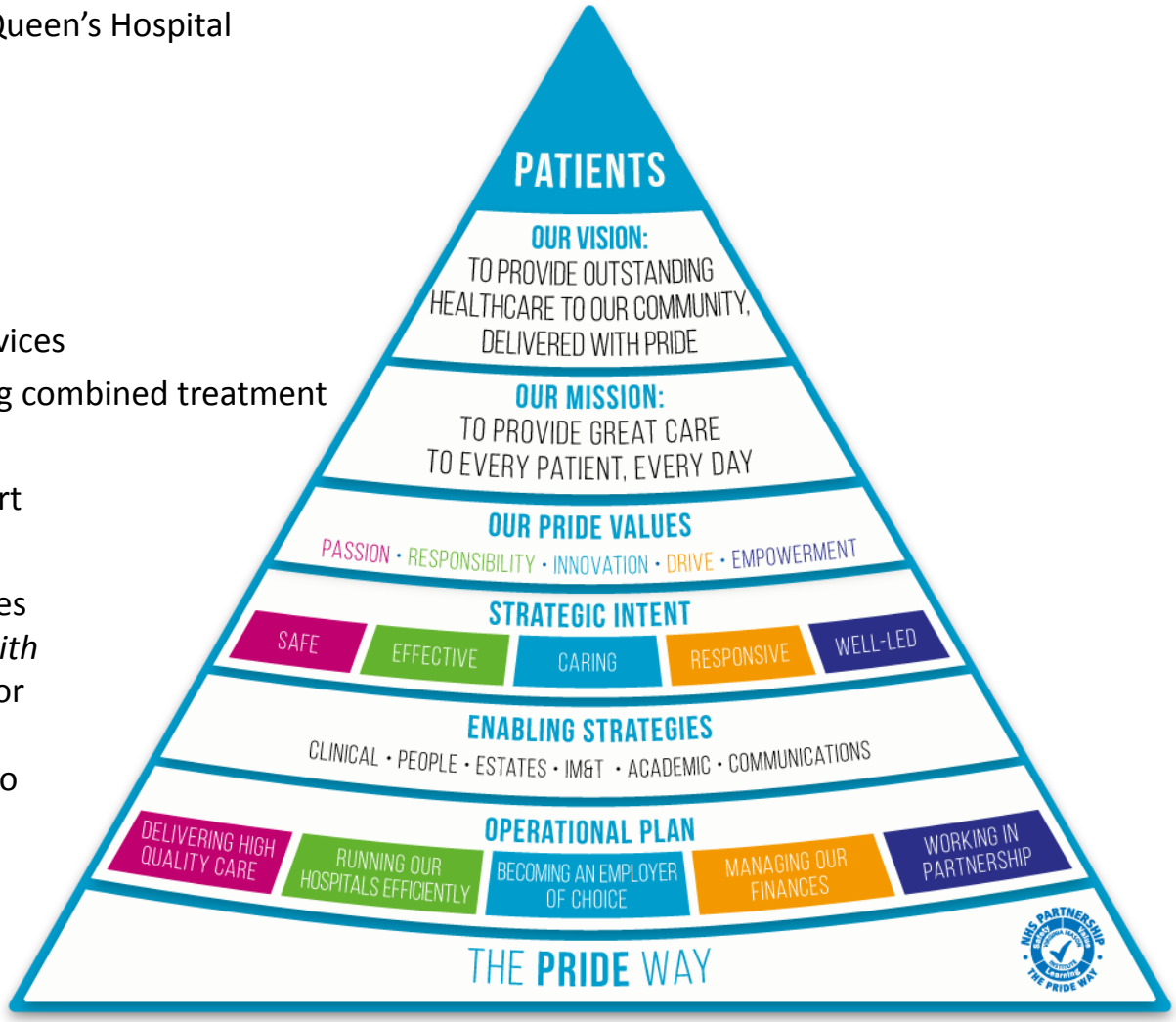
- Clinical trials unit (Queen's)

OUR PROPOSAL TO IMPROVE CHEMOTHERAPY SERVICES

- Centralise chemotherapy services at Queen's Hospital

- Brings this on-site with:
  - specialised medical cover
  - inpatient services
  - outpatients services
  - state of the art radiotherapy services
    - easier for patients requiring combined treatment
  - cancer clinical trials
    - improved ability to take part

- Review of health and wellbeing services – exploring Cedar Centre as a *Living with and beyond cancer* hub as beneficial for patients to receive their health and wellbeing care at a different location to their treatment



CURRENT TREATMENT PATHWAY

- All patients' pre-assessment at Queen's Hospital
- Treatment location decided by type of chemotherapy needed to give safest care
- Complex cases treated at Queen's – access to inpatient facilities and medical cancer specialists eg for drugs with high risk of anaphylactic shock; chemotherapy given together with radiotherapy
- Nursing staff rotate across both hospitals
- We treat on average 600 patients a month in Sunflower Suite at Queen's and average 150 per month in Cedar Centre at King George
  - Two years ago we saw on average 450 and 200 patients per month respectively
- Sunflower Suite – six day a week service
- Cedar Centre – consolidated treatments from four to two days a week due to lack of demand and increase in complex cases

CLINICAL CASE FOR CHANGE

Quality and safety

- King George Hospital – no medical cover in Cedar Centre
- Queen's Hospital– hub of medical expertise with facilities on one site
- Centralising nursing staff provides better training and mentoring; opportunity to 'grow our own' – staff prefer this approach

Efficiency and productivity

- Our pharmacy teams make all cancer treatments at Queen's – then transport
  - This can cause delays at Queen's – reflected in patient feedback
  - Unable to fulfil additional prescriptions at King George
- New proposals mean Pharmacy can dispense drugs earlier – can start giving treatments earlier

Future vision

- Centralising chemotherapy fits into our longer term ambitions to improve patient care
- Currently oncology patients who come in as emergencies go through our Emergency Department
- Longer term vision – telephone triage service as first port of call; ability to bring patients straight to acute oncology service to be cared for by our cancer team

PATIENT EXPERIENCE CASE FOR CHANGE

Patient feedback

- Negative feedback around waiting times and delays
- Reflected in Barking & Dagenham Healthwatch's Enter and View visit in September 2017 and in our Friends and Family Test

Living with and beyond cancer

- Currently offer a range of health and wellbeing services across both sites
- Want to improve portfolio of services for patients living with and beyond cancer
- Fulfil National Cancer Strategy - provide required holistic care to our patients
- Moving chemotherapy to Queen's frees up Cedar Centre
- Exploring the possibility of using this space as a Living with and beyond cancer hub

PATIENT NUMBERS

- 22% patients currently affected by the proposed change
- Expected to decrease over time due to increase in complex cases

CCG	QH	KGH	Total
Barking & Dagenham	433	149	582
Basildon & Brentwood	138	23	161
Havering	972	163	1135
Redbridge	314	167	481
W. Essex	45	22	67
Others	83	25	108
Total	1,985	549	2,534

Postcode	QH	KGH
IG1	128	72
IG4	26	4
IG5	44	30
Total	198	106

IMPACT

Travel

- Some impact on patients as reflected in numbers
- However reduced clinical risk, safer service, and improved care and experience
- Follows national practice for better outcomes eg stroke
- Consultants will continue to assess the need for patient transport
- Transport will continue to be provided wherever necessary, as is current practice

Parking

- Dedicated oncology car park next to Sunflower
- Free parking during treatment; £2 at other times
- Capacity not anticipated to be an issue

TIMELINES

- Implement improvements to delivery of chemotherapy services by end of October

- Allows us to be ready ahead of the increased demand of winter pressures

- Ongoing improvement of health and wellbeing services

COMMUNICATIONS AND ENGAGEMENT

- Involve and engage our patients, public, partners and stakeholders throughout implementation and delivery
  - Messaging through range of channels eg website, plasma screens, stakeholder and GP newsletters
  - Comprehensive leaflet outlining plans available digitally (printable) and in hard copy across both our hospitals

- Work closely with partners eg local authorities and Healthwatch organisations to help inform and engage

- Dedicated patient partner to ensure information is relevant and easy to understand

- Feedback developed into FAQs and housed on our website
  - Dedicated email address for comments and queries

- Continue to listen to patient feedback and liaise with Cancer Patient and Public Advisory Group (CPPAG) post-implementation

healthwatch

WHAT DO OUR PATIENTS THINK?

- Shared our proposals with our Patient Partnership Council (PPC) and CPPAG
  - All PPC members thought this would be a good idea to have the chemotherapy services on one site
  - It was queried if there would be sufficient capacity at Queen's – it was noted capacity will be available as treatments would be better spaced throughout the day and with potential treatments being delivered as part of a Saturday/Sunday for chemotherapy only
  - It was noted that PPC members were all in agreement with the proposed changes to our chemotherapy services

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IMPROVING CARE FOR OUR CANCER PATIENTS

Dr Sherif Raouf

Cancer & Clinical Support

TAKING PRIDE IN OUR CARE

Barking, Havering and Redbridge University Hospitals NHS Trust

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- State of the art radiotherapy centre at Queen's Hospital
- Three brand new machines – Halcyon (x2) and the Edge
- First in world to have two Halcyon machines on one site
  - halves treatment times; more accurate; more comfortable
- The Edge – can treat much more complex cases

WHY THE CHANGE?

- Need to change how we deliver healthcare nationally
  – best use of resources (people, estate and finance)
  – deliver services in a way that meets changing demands of our population
- We serve more than 1 million people from our three boroughs and across the whole of Essex (referred through our regional Neurosciences Centre)
- 6% increase year on year in patients requiring chemotherapy due to:
  - Population increase
  - Improvements in early diagnosis
  - State of the art treatments means people live longer
- Increases the need for services to be able to meet demand
- Increase in complexity of cases

SHORT TERM CHALLENGES

- Safety (patients' and staff)
- Staffing shortfall

LIVING WITH AND BEYOND CANCER HUB

- Good progress made
- Centre being well used
- New group room opened
- HOPE courses now rehoused, along with EMPOWER
- Positive patient feedback

A Make Up Masterclass in action

MANAGING THE TRANSITION

- Patients successfully transferred to Sunflower Suite for their treatment
- Supporting patients with transport
- Currently, offering chemotherapy 6 days per week, planned to extend to 7 days per week soon
- Generally positive feedback, some isolated issues/complaints
- Staffing situation much improved

COMMUNICATIONS AND ENGAGEMENT

- Close engagement with cancer patients through nursing team and 1-1 to reassure and support and via dedicated email address
- Continued broader involvement and engagement with patients, public, partners and stakeholders particularly including Healthwatch
- Messaging through range of channels eg website, stakeholder and GP newsletters, leaflets etc.
- Dedicated patient partner
- Continue to listen to patient feedback

healthwatch

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Havering
LONDON BOROUGH

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

Subject Heading:	BHR system update on winter planning
Report Author and contact details:	**Kirsty Boettcher, Deputy Director of Delivery – Unplanned Care Barking and Dagenham, Havering and Redbridge CCGs**
Policy context:	**The information presented provides an update on how health and social care services were managed during winter 2018/19.**
Financial summary:	**No impact of presenting information itself.**

SUMMARY

NHS officers will present to the Joint Committee details of how local partners worked together to manage pressures on health and social care services during winter 2018/19.

RECOMMENDATIONS

1. That the Joint Committee considers the information presented by BHR CCGs and BHRUT on behalf of the BHR A&E Delivery Board

REPORT DETAIL

This briefing provides an overview of urgent care winter pressures work in Barking and Dagenham, Havering and Redbridge (BHR) for 2018/19. It contains information on system-wide planning approach taken across North East London, specific actions in BHR, and the resulting impact on attendance and the four hour performance target in A&E at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT).

It also shares learning from winter 2018/19 which will inform preparations for next winter and our ongoing work to improve urgent and emergency care in BHR.

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

Managing winter pressures in BHR

Kirsty Boettcher, Deputy Director of Delivery – Unplanned Care, BHR CCGs

Aleksandra Hammerton, Deputy Chief Operating Officer (Emergency Care), BHRUT

East London Health & Care Partnership

Barking, Havering and Redbridge University Hospitals NHS Trust

CONTEXT

East London Health & Care Partnership

- Winter is the busiest time for both NHS and social care services
- We had a single action plan across the whole system in BHR, that fed into the East London Health and Care Partnership plan
- Based on learning from 17/18, our largest challenges across north east London were:
  - Workforce sustainability - particularly middle grade A&E doctors, A&E nurses, paediatric nurses, therapists, acute physicians, geriatricians and GPs who work within urgent care services.
  - Discharging patients to ongoing care, particularly where patients are from outside London.
  - Securing capacity within mental health services so patients coming to A&E get emergency mental health support and have access to MH beds.
  - Using shared data, such as knowing care home spaces across the area - exploring data management solutions.

PRIDE

SYSTEM PLAN

East London Health & Care Partnership

- Improving flu vaccine uptake rates
- CCG GP Chairs met with GP practices with highest urgent care demand to understand reasons for variation and opportunity to address these
- Communication and engagement with local GPs around support and services which can help prevent people needing to be admitted to hospital
- Public communications to raise awareness of where to go for urgent treatment and advice
- Review of paediatric demand and development of plan to address
- System level plans to improve demand management and ensure full benefit of new NHS 111 service
- Additional local structures in place to support performance challenges and winter:
  - Daily system calls with extra calls on Monday and Friday
  - Fortnightly A&E Delivery Board meetings attended by NHS England/NHS Improvement
  - Fortnightly escalation meetings with NHSE/NHSI
  - Monthly chief officer level system assurance meeting with NHSE/NHSI

PRIDE

A&E DELIVERY BOARD

East London Health & Care Partnership

Multi-agency partnership board oversees urgent and emergency care performance and delivery – Board meets monthly and Delivery group also meets monthly

Six sub-groups meet weekly / fortnightly, with detailed action plans and monthly escalations to the fortnightly A&E Delivery Board

These workstreams are:

- Ambulance demand
- Community capacity
- Hospital flow
- Out flow
- Older People
- Mental Health

PRIDE

COMMUNICATIONS

East London Health & Care Partnership

- National ‘Help Us Help You’ campaign – promotion across health hubs, online etc
- Media promotion – where to get urgent treatment, flu vaccine, how to stay well
- Websites and social media (including Council channels)
- Videos (111, pharmacy, urgent GP appointments)
- Articles in council magazines and newsletters
- National TV and print adverts

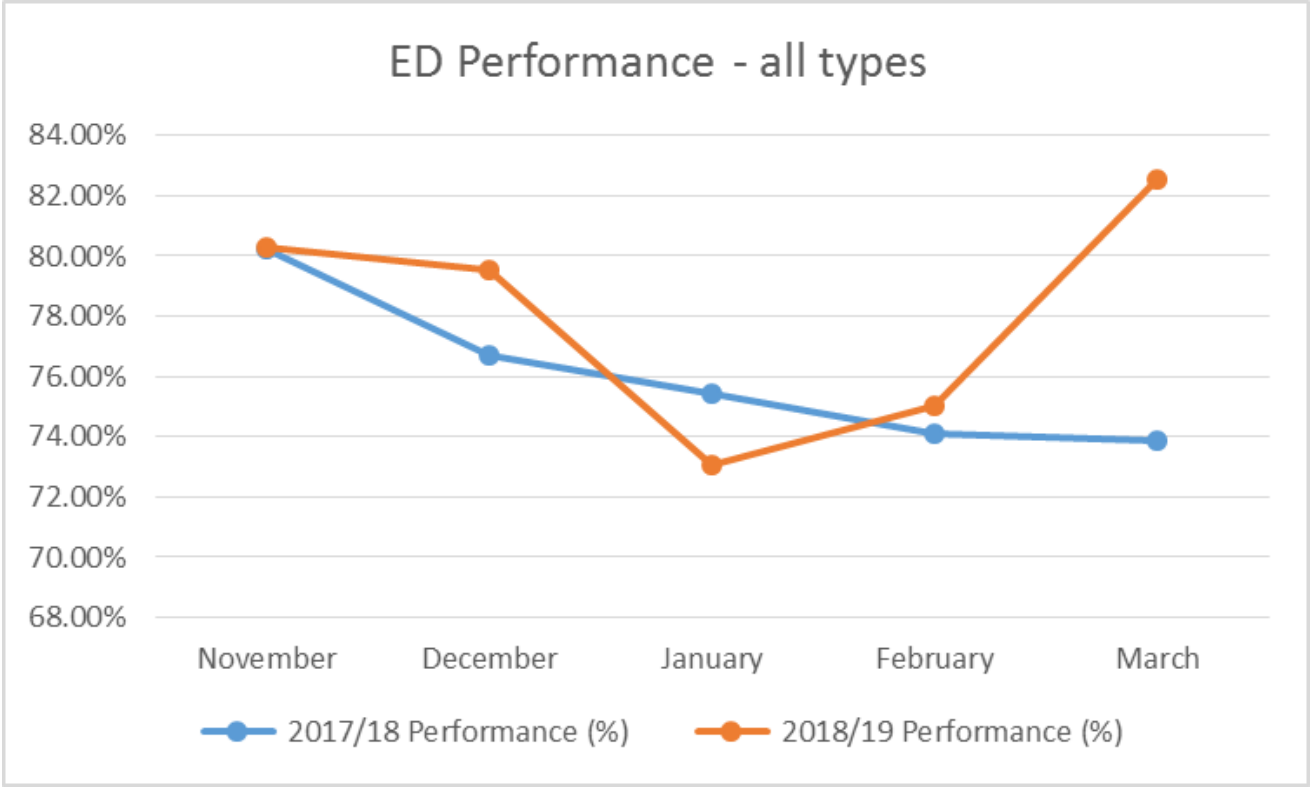
PRIDE

FOUR HOUR PERFORMANCE - BHRUT

East London Health & Care Partnership

- More people being seen within four hours, and number of patients increasing

- Key factors – numbers of people attending A&E, staffing in A&E and hospital bed availability



PRIDE

ATTENDANCE

East London Health & Care Partnership

- Additional 9,198 patients seen Queen's and King George Hospitals (compared to November to March 2017/18)
- However, in July 2018 we introduced Urgent Treatment Centre model at Queen's Hospital and worked to improve pathways in Urgent Care Centre at King George Hospital. This enabled 33,305 patients to be seen and treated in these two units during the winter months. Many of these patients would otherwise have been seen in the Emergency Departments (ED)
- A number of patients were seen in both the UTC or UCC and ED
- Together with improved performance, this means more patients were being seen and treated within four hours and were able to return home
- Whipps Cross (which sees some Redbridge patients) saw a 4.32% fall in four-hour performance during the same period (from 85.01% in 17/18 to 80.69%)
- Data review to clarify 'duplication' of patients – where patients are seen by the UCC but are transferred to ED for specialist opinion

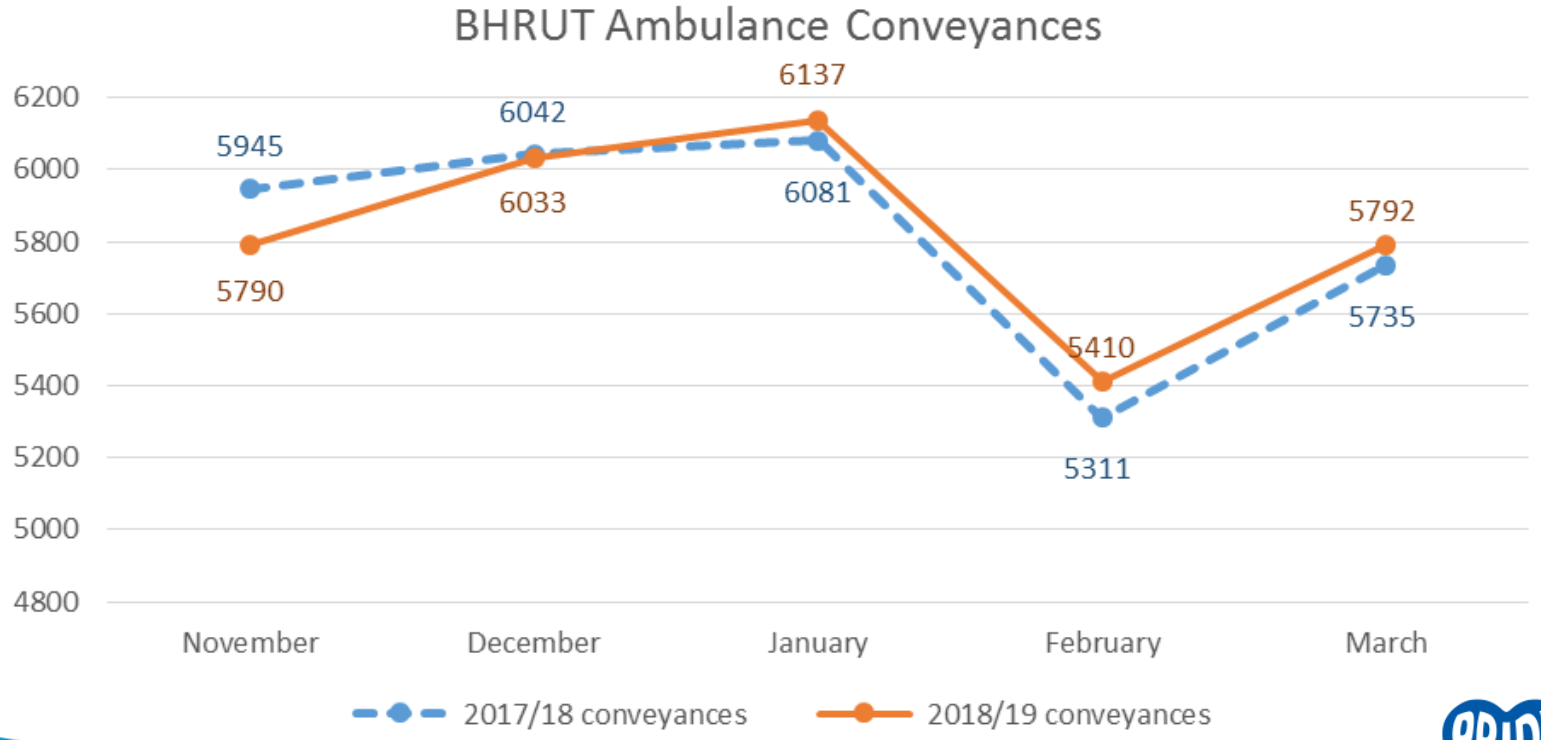
PRIDE

AMBULANCE CONVEYANCES

East London Health & Care Partnership

- Ambulance attendances increased slightly - greatest increase at KGH

- Queen's is once again almost the busiest (2nd) hospital for ambulance conveyances



URGENT TREATMENT CENTRE

East London Health & Care Partnership

- National guidance says that urgent treatment centres (UTCs) will be GP-led, open at least 12 hours a day, every day, offer appointments that can be booked through 111 or through a GP referral, and are equipped to diagnose and deal with many of the most common ailments people attend A&E for
- 24-hour UTC introduced at Queen's in July 2018 - service expanded to deal with minor injuries (suspected fractures, minor burns or wounds) from August 2018
- Average of 6,275 patients per month seen at Queen's UTC (November to March) 45% of all attendances are now seen in the UTC
- The Urgent Care Centre (UCC) at KGH saw a 13% increase (1,931 patients) compared to winter 2017/18. No minor injuries or access to diagnostics – plans in development. It is also open 24 hours a day
- NHS 111 can book patients into appointment slots at KGH UCC – available for Queen's UTC for winter 2019
- Queen's UTC and KGH UCC are managed by The Partnership of East London Cooperatives (PELC) not BHRUT

PRIDE

LEARNING

East London Health & Care Partnership

- Partnership held ‘winter wash-up’ session in June to explore issues and learning, and plan ahead

- National 2018/19 winter pressures funding provided to local authorities to help with social care provision – no health funding allocation expected in 2019

- Health and social care partners continue to work together through six A&E Delivery Board sub groups

- Exploring feedback from clinicians that there are duplicate attendances across the GP hubs and UTC/UCC sites – which has contributed to the data on attendance growth

PRIDE

IMPROVEMENTS

East London Health & Care Partnership

- Implementation of red2green on the wards has helped flow and reduced patients' length of stay
- Weekly system-wide reviews on each ward to progress safe and appropriate discharge. Focus on getting patients directly home wherever possible.

PRIDE

IMPROVEMENTS

East London Health & Care Partnership

- New RAFTing area now open at Queen's
  - Aims to improve ambulance turnaround times
  - State-of-the-art-equipment
  - Its own phlebotomy room
  - Cubicles equipped with machines to monitor patients' vital signs, which can also be monitored from the central desk
  - Feedback from London Ambulance Service is that they have seen a reduction of 12 minutes per patient in the time spent at Queen's as a result

PRIDE

LOOKING FORWARD

East London Health & Care Partnership

- Decisions on any investment need to be made early to support critical recruitment. Reviews underway, with decisions in July for winter 2019/20

- Investment bid for national funding being made by the East London Health and Care Partnership to fund a 24 hour Enhanced Mental Health Liaison team in A&E

- 'Task and finish' group addressing the increase in 12-hour breaches for mental health patients. Also working with Waltham Forest to look in detail at capacity and demand

PRIDE

LOOKING FORWARD

East London Health & Care Partnership

- Approximately 30% of A%E attendances are children. Queen's UTC has improved staffing to enable them to see more children. Plans will also be developed through the BHR Children and Young People's Transformation Board

- Development on "Home is Best" service by the Older Peoples' Transformation Board. Will integrate community services and provide a single point of access for primary and secondary care

- Development of an integrated model of assessment for frail older people aged 75+ to co-ordinate care in order to avoid admission

PRIDE

Havering
LONDON BOROUGH

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

Subject Heading:	NHS Estates update
Report Author and contact details:	**Anthony Clements, Principal Democratic Services Officer, London Borough of Havering**
Policy context:	**The information presented gives details of the current position with NHS estates projects in North East London.**
Financial summary:	**No impact of presenting information itself.**

SUMMARY

NHS officers will present to the Joint Committee an update on NHS estates issues covering the Outer North East London area.

RECOMMENDATIONS

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

REPORT DETAIL

Following the unsuccessful bids for capital funding for a number of NHS estates projects in early 2019, the Joint Committee has asked for details of how the NHS now plans to fund these major projects and for details of the position moving forward.

The attached presentation gives some initial details from the NHS and officers will be present to provide further details at the meeting.

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

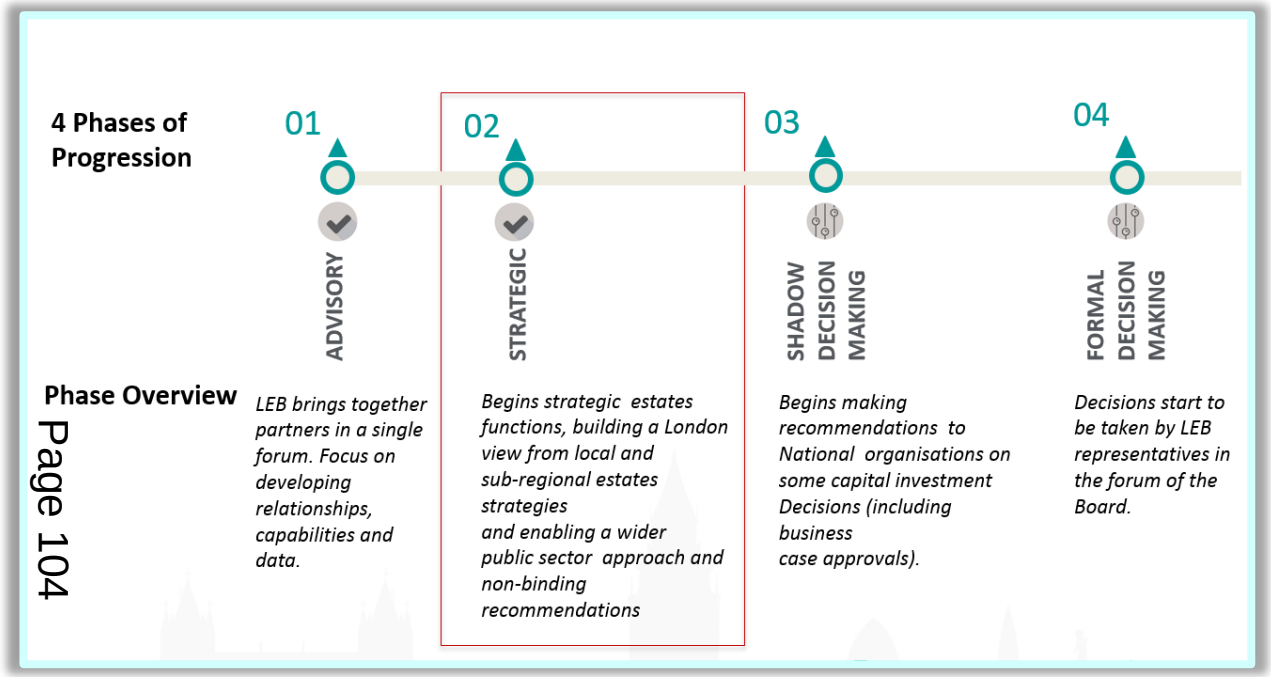
North East London Estates Workstream

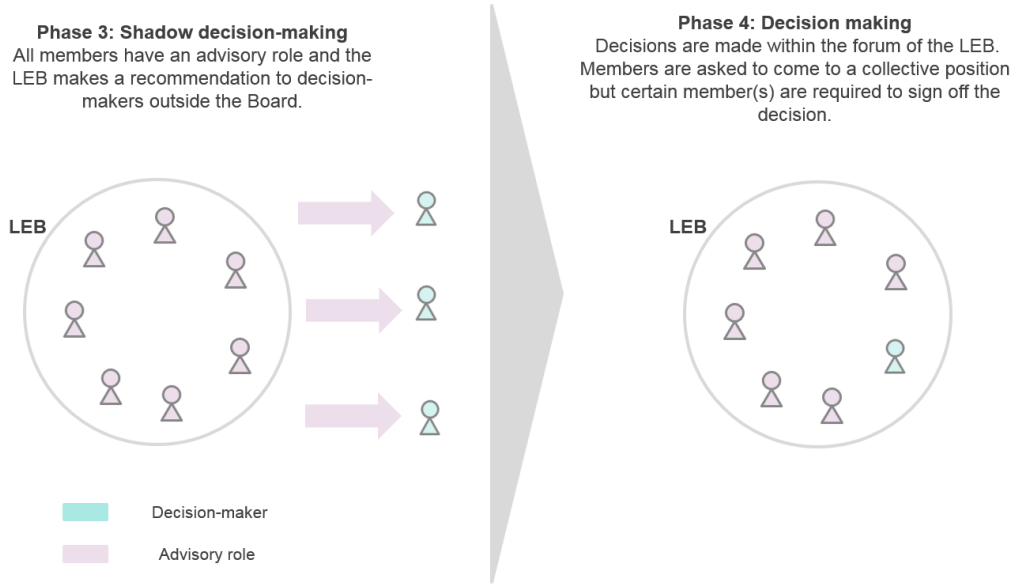
ONEL JHOSC update – July 2019

London Devolution Context

Next Steps for Devolution and ELHCP Estates Impact

East London Health & Care Partnership





Within the gateway criteria for phase 3, the London Estates Board Operating Framework ("the Operating Framework") references an "***MoU(s) signed by all partners which set out the specifics of the internal delegations and agreed prioritisation framework***". Our proposal is as follows:

- **Update the Operating Framework -** this will provide additional clarity around new processes and ambitions for the next phases. A short MoU between London and national partners, which draws out the commitments from each partner required to implement the updated Operating Framework. We are currently considering whether a second 'intra-London' MoU may be appropriate, similar to the Greater Manchester model.
- **Phase 3 is an opportunity for the LEB to develop and test new ways of working** and partners will consider whether anything further is required prior to phase 4.
- **The capital prioritisation framework is being agreed as part of the London Estates Strategy**. We do not propose to replicate this in any additional agreements, given that the strategy will have partnership sign-off.

London Devolution Next Steps

East London Health & Care Partnership

- Publication of the London Health and Care Estate Strategy and Phased, prioritised capital pipeline in Quarter 4 2018/19
- Surplus site pipeline is currently under development and to be available in Quarter 4 2018/19.
- A proposal which outlines the achievements of the London Estates Board (LEB) and London Estates Delivery Unit (LEDU), proposals for phase 3 and the implications for different partners will be developed and agreed by the end of March 2019.
- The LEB Chairs will engage on proposals with national and London partners, including NHS England (NHSE), NHS Improvement (NHSI), DHSC and HMT. Advice will be sought from national colleagues on engagement with NHS England and NHS Improvement during the transition to a more integrated model of working.
- London partners will also work up the governance model, including the proposed Investment Committee, ensuring that this is integrated into the new NHSE/NHSI regional governance. To align with new regional NHSE/I governance process by end March 2019.
- Following engagement, the agreed proposals will be incorporated into an MoU, which will be signed by partners Q1 2019/2020.
- Subject to agreement from partners and the timeline for NHSE/NHSI integration, London partners aim to begin **shadow-running in Q1 2019/2020**.

East London Health & Care Partnership

Wave 4 – Next Steps

Wave 4 bids potential alternative funding sources

East London Health & Care Partnership

Scheme Name	BIDDER	Alternative Funding Sources currently being considered
St Georges Health Centre	BHR CCGs /NELFT	• NHS PS – further engagement had with NHS PS to identify the funding and delivery routes • 3rd party Developer – discussion had with Octopus who are very interested in developing the scheme • NELFT options: Discussion had with NELFT to explore if this can be one of the options to be considered • Havering Local Authority – exploring this funding source and delivery route, keen to be considered as a vehicle for the development • LIFT – option being discussed but not one of the preferred routes
Acute Reconfiguration Queens and KGH Hospitals	BHRUT	BHRUT are in the process of refreshing the Trust clinical services strategy which will inform the estates strategy for BHRUT going forward and alternative sources of funding will be sought as part of this process.
Maternity Expansion at Queens Hospital	BHRUT	
Children's and Young Person's Assessment Unit CYPAU at Queen's Hospital	BHRUT	

Where can capital funding come from?

East London Health & Care Partnership

There are different sources of capital funding available to the NHS:

Disposal of NHS Property/Land	Other Internally Generated (Depreciation)	NHS Property Services (NHSPS) Customer Capital
National Capital Budgets (for example, STP)	Community Health Partnership (CHP) Capital	Third Party Developer Capital
Section 106 / CIL Grants	Other, including Local Authority Funding*	Charitable Funding / Donations

The source of the funding should NOT be confused with the delivery route – what are the delivery vehicles?

*In the context of this guidance, LA funding is being treated as third party capital, even though it is from the public purse. This is because it is external to the DHSC family

East London Health & Care Partnership

NEL estates strategy next steps

Engagement

East London Health & Care Partnership

Key stakeholder engagement

- The strategic estates plan (SEP) draws together existing plans/information submitted and prepared by each organisation
- Key stakeholders commented and reviewed SEP prior to publication in October 2018
- Key stakeholder feedback was extensive and robust, and changes were made to the SEP as a result of their comments
- ELHCP followed process set out by NHSE to develop the SEP

Approach to patient & public involvement

A draft communication and engagement strategy was reviewed by the estates strategy working group and by the ELHCP Estates Board. It is currently being shared with comms leads in partnership organisations before going back to the estates board for agreement and implementation.

As we have stated, public consultation end engagement on estates programmes and projects will take place at local level, and will be planned and implemented by commissioners/and or providers, as appropriate.

For example, local plans such as the redevelopment of the Whipps Cross hospital site and the Rainham and Beam Park Housing Zone project have been the subject of reports to councillors in Waltham Forest and Barking and Dagenham respectively.

We have been, and will continue to report on the work of the estates workstream directly to elected members.

Involvement

East London Health & Care Partnership

"We need to ensure that health and care estate-based changes are based upon robust, clear evidence and that a commitment to effective consultation and engagement is evident in the planning and implementation of the individual estates strategies."

Draft ELHCP communication and engagement strategy

The Partnership is committed to involving the public, patients, staff, families, carers and everyone involved in health and care services.

We welcome the attention of the public and all those who want to see high quality, sustainable care and health services for local people.

Ongoing work to engage patients, service users and the public on the NHS long-term plan which sets-out the drivers and aspirations for the next ten years and beyond is being led by Waltham Forest Healthwatch.

Engagement and updating of the SEP is ongoing as work continues to include assets and infrastructure managed and owned by the east London local authorities.

Proposed next steps

East London Health & Care Partnership

- ELHCP Estates Plan has been published on our website and agreed with all stakeholders – working together with communications team on the engagement plan for developing a transparent clear plan for all stakeholders including engagement with patients and public
- The ELCHP partners will develop this plan into a robust strategy that reflects the full transformation implications of the sustainability and transformation plan (STP). The key driver for the strategy is the Partnership's clinical vision and the developing models for integrated health and care services.
- Greater integration of the strategic estates plan with local authority plans to ensure best use of public assets and support for new ways of commissioning integrated care services. There is still more to do to include the social care and community infrastructure that will support new ways of providing services for local people and integrating the IT innovation to determine less capacity requirements.
- We are currently progressing with the detailed investment plan, working through possible sources of funding for schemes in the pipeline, and linking our work with the LEB/LEDU programmes.
- Through our Governance with monthly Estates Operational meetings we have started reviewing and doing the assurance on various business cases (Wellington way, Suttons wharf, Froud Development and Pontoon Docks in Newham)
- One Public Estate: C&H have submitted OPE around St Leonard's to develop the business case for the site. TH for the Whitechapel redevelopment and Redbridge (Goodmayes and KGH) sites looking to maybe join the next phase in the Autumn

Havering
LONDON BOROUGH

OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE, 9 JULY 2019

Subject Heading:	London Borough of Waltham Forest – Amendment to Representation on Committee
Report Author and contact details:	**Anthony Clements, Principal Democratic Services Officer, London Borough of Havering**
Policy context:	**It is suggested that the Committee amends its terms of reference to reflect a change in the level of representation by Waltham Forest.**
Financial summary:	There are no financial implications arising from noting the amended committee representation and/or approval of the revised terms of reference. The overall costs of clerking the meetings will remain unchanged but the split between Councils will vary in line with the revised membership.

SUMMARY

In light of a recent decision by London Borough of Waltham Forest to reduce its level of representation on the committee, this report proposes some adjustments to the Committee's terms of reference in order to reflect this.

RECOMMENDATIONS

1. That the Joint Committee notes the decision by London Borough of Waltham Forest to reduce its level of representation on the Committee from three Members to one.

2. That the Joint Committee agree the proposed changes to its terms of reference, as shown in the appendix to this report, in order to reflect the change in level of representation by the London Borough of Waltham Forest.

REPORT DETAIL

1. At its meeting of full Council on 25 April 2019, the London Borough of Waltham Forest agreed to reduce its level of representation on the Outer North East London Joint Health Overview and Scrutiny Committee from three Members to one. The basis for this decision was that local health services have, in recent years, been organised more around the health economy for Barking & Dagenham, Havering and Redbridge. Examples of this trend have included the work of the BHRUT Acute Trust which has only minimal involvement with patients from Waltham Forest and the increasing move of the Clinical Commissioning Groups for the BHR area to work on a combined basis with for example a joint clinical lead being appointed for the three areas.

2. Some services such as those mental health and community services provided by the North East London NHS Foundation Trust continue to be provided on a four-borough basis that fully matches the area covered by this Committee. As such, Waltham Forest has chosen to keep one representative on this Committee in order to continue to have an opportunity to scrutinise these issues.

3. Some changes to the Committee's terms of reference are required in order to reflect the reduced involvement of Waltham Forest on the Committee. For clarity, these proposed changes are shown in track changes in the appendix to this report. Some other minor amendments to the Terms of Reference, reflecting the requirements of current legislation etc, are also suggested and shown in track changes.

IMPLICATIONS AND RISKS

Financial implications and risks:

There are no financial implications arising from noting the amended committee representation and/or approval of the revised terms of reference.

It should be noted that there are minor financial implications to the member Councils as a result of the reduction in membership from Waltham Forest. The overall costs of clerking the meetings will remain unchanged but the split between Councils will vary in line with the revised membership, as costs of clerking the committee is shared between them. Clerking and administrative support is provided to the Joint Committee by oneSource on behalf of the London Borough of Havering and the other member Councils are invoiced accordingly on a quarterly basis. Some slight changes in the proportion of these costs paid per borough will be required in light of the decision by Waltham Forest to reduce its representation..

Legal implications and risks: None – the recommendations proposed do not in any way alter the status of the Joint Committee under section 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. The Authorities have a discretion over the terms and conditions of the Committee and this proposal appears uncontroversial.

Human Resources implications and risks:
There are no direct HR implications or risks to the Council or its workforce that can be identified from the recommendations made in this report.

Equalities implications and risks: None – the change of membership level by Waltham Forest more closely reflects the remit of the Joint Committee and the services that it scrutinises on behalf of local residents..

BACKGROUND PAPERS

None.

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TERMS OF REFERENCE FOR
OUTER NORTH EAST LONDON
JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Establishment of the JHOSC

1. The Outer North East London Joint Health Overview and Scrutiny Committee (the JHOSC) is established by the Overview and Scrutiny Committees having health responsibilities of the London Borough Councils of Barking & Dagenham, Havering, Redbridge and Waltham Forest ("the borough OSCs") in accordance with s.190-191 of the Health and Social Care Act 2012 and consequential amendments and the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013.

Membership

2. The JHOSC will consist of three Members appointed of each of the Borough OSCs with the exception of Waltham Forest which will have one Member.

3. In accordance with section 21(9) of the Local Government Act 2000, Executive Members may not be members of an Overview and Scrutiny Committee.

4. The Essex County Council may nominate one full Member for the Joint Health Overview and Scrutiny Committee. Thurrock Borough Council Health Overview and Scrutiny Committee may nominate an observing Member of the Joint Health Overview and Scrutiny Committee. The Councils of the Borough of Brentwood and District of Epping Forest may also each nominate an observing Member.

5. Appointments made to the JHOSC by each participating London borough OSC or Council will reflect the political balance of the borough Council, unless a participating borough OSC agrees to waive the requirement and this is approved by the JHOSC.

Attendance of Substitute Members

6. If a Member is unable to attend a particular meeting, he or she may arrange for any appropriate Member of the borough Council to attend as substitute, provided that a Member having executive responsibilities may not act as a substitute. Notice of substitution shall be given to the clerk before the commencement of the meeting.

Role and Function of the JHOSC

7. The JHOSC shall have the remit to review and scrutinise any matter, including substantial variations, relating to the planning, provision and operation of health services that affect two or more boroughs in Outer North East London. The JHOSC will have the right to respond in its own right to all consultations on such matters, both formal and informal.

8. In fulfilling its defined role, as well as reviewing documentation, the JHOSC will have the right to do any or all of the following:

    a. Request information or to hold direct discussions with appropriate officers from each of the following organisations or their successor bodies:

    Barking and Dagenham Clinical Commissioning Group (CCG)
    Havering CCG
    Redbridge CCG
    Barking, Havering and Redbridge University Hospitals NHS Trust
    Barts Health NHS Trust Care Quality Commission
    East London Health and Care Partnership
    London Ambulance Service NHS Trust
    NHS England
    NHS Improvement
    North East London Commissioning Support Unit
    North East London NHS Foundation Trust
    Moorfields Eye Hospital NHS Foundation Trust

    as well as any other NHS Trust or other body whose actions impact on the residents of two or more Outer North East London Boroughs;

    b. Co-operate with any other Joint Health Overview and Scrutiny Committee or Committees established by two or more other local authorities, whether within or without the Greater London area;

    c. Make reports or recommendations to any of the NHS bodies listed above and expect full, written responses to these;

    d. Require an NHS or relevant officer to attend before it, under regulation 6 of the Regulations, to answer such questions as appear to it to be necessary for the discharge of its functions in connection with a consultation;

    e. Such other functions, ancillary to those listed in a to d above, as the JHOSC considers necessary and appropriate in order to fully perform its role.

    Although efforts will be made to avoid duplication, any work undertaken by the JHOSC does not preclude any individual constituent borough Overview and Scrutiny Committee from undertaking work on the same or similar subjects

Co-optees

9. The JHOSC shall be entitled to co-opt any non-voting person as it thinks fit or appropriate to assist in its debate on any relevant topic. Each borough Healthwatch organisation for Barking & Dagenham, Havering, and Redbridge shall be entitled to nominate one co-opted (non-voting) member of the JHOSC.The power to co-opt shall also be available to any Working Groups formed by the JHOSC.

Formation of Working Groups

10. The JHOSC may form such Working Groups of its membership as it may think fit to consider any aspect or aspects of its work. The role of such Groups will be to consider the matters referred to it in detail with a view to formulating recommendations on them for consideration by the JHOSC. The precise terms of reference and procedural rules of operation of any such Groups (including number of members, chairmanship, frequency of meetings, quorum etc) will be considered by the JHOSC at the time of the establishment of each such Group; these may differ in each case if the JHOSC considers it appropriate. The meetings of such Groups should be held in public except to the extent that the Group is considering any item of business from which the press and public could legitimately be excluded under the Access to Information legislation. The extent of available resources and the existence of relevant ongoing work at a borough level will also be considered by the JHOSC when considering whether to establish a working group.

Meetings of the JHOSC

11. The JHOSC shall meet formally at such times, at such places and on such dates as may be mutually agreed, provided that five clear days' notice is given of the meeting. The Committee may also meet informally as and when necessary for purposes including, but not limited to, visiting appropriate sites within the boroughs or elsewhere.

12. The JHOSC will meet on a minimum of four occasions per year with any variation to be agreed by the Committee. Meeting venues will normally rotate between the four Outer North East London boroughs.

    Meetings shall be open to the public and press in accordance with the Access to Information requirements. The public and press are permitted to report on JHOSC meetings using electronic media tools however oral commentary will not be permitted in the room during proceedings.

Attendance at Meetings

14. Where any NHS officer is required to attend the JHOSC, the officer shall be given reasonable notice in advance of the meeting at which he/she is required to attend. The notice will state the nature of the item on which he/she is required to attend to give account and whether any papers are required to be produced for the JHOSC. Where the account to be given to the JHOSC will require the production of a report, then the officer concerned will be given reasonable notice to allow for preparation of that documentation.

15. Where, in exceptional circumstances, the officer is unable to attend on the required date, and is unable to provide a substitute acceptable to the JHOSC, the JHOSC shall in consultation with the officer arrange an alternative date for attendance.

16. The JHOSC and any Working Group formed by the JHOSC may invite other people (including expert witnesses) to address it, to discuss issues of local concern and/or to answer questions. It may for example wish to hear from

residents, stakeholders and members and officers in other parts of the public sector and shall invite such people to attend.

17. The JHOSC shall permit a representative of any other authority or organisation to attend meetings as an observer.

Quorum

18. The quorum for the JHOSC shall be four, provided there is present at least one Member from at least three of the London borough OSCs. For meetings involving the writing or agreeing of a final report of the Committee, the quorum shall comprise at least one representative from each of the four London borough OSCs.

Chair and Vice Chair

19. Each meeting will be chaired by a Member from the host borough on that occasion.

Agenda items

20. Any member of the JHOSC shall be entitled to give notice to the Clerk of the Joint Committee that he/she wishes an item relevant to the functions of the JHOSC to be included on the agenda for the next available meeting. On receipt of such a request (which shall be made not less than five clear working days before the date for despatch of the agenda) the relevant officer will ensure that it is included on the next available agenda.

Notice and Summons to Meetings

21. The Clerk of the Joint Committee will give notice of meetings to all members. At least five clear working days before a meeting the relevant officer will send an agenda to every member specifying the date, time and place of each meeting and the business to be transacted, and this will be accompanied by such reports as are available.

22. Any such notice may be given validity by e-mail.

23. The proper officer of each Council shall ensure that public notice of the meeting is displayed in accordance with the customary arrangements of that Council for giving notice of Committee etc. meetings.

Reports from the JHOSC

24. Where required, for any reviews that require recommendations, the JHOSC will prepare a formal report and submit it to the relevant bodies. In accordance with current Department of Health Guidance on the Overview and Scrutiny of Health, the JHOSC should aim to produce a report representing a consensus of the views of its members. If consensus is not reached within the JHOSC, minority views will be included in the report.

25. In undertaking its role the JHOSC should do this from the perspective of all those affected or potentially affected by any particular proposal, plan, decision or other action under consideration.

Formal Consultations and Referrals to Secretary of State

26. Under guidance on Local Authority Health Scrutiny issued by the Department of Health in June 2014, only the JHOSC may respond to a formal consultation on substantial variation proposals covering health services in more than one constituent Council area. This power also extends to the provision of information or the requirement of relevant NHS officers to attend before the JHOSC in connection with the consultation.

27. The JHOSC may only refer matters directly to the Secretary of State on behalf of Councils who have formally agreed to delegate this power to it.

Procedure at JHOSC meetings

28. The JHOSC shall consider the following items of business:

(a) minutes of the last meeting;
(b) matters arising;
(c) declarations of interest;
(d) any urgent item of business which is not included on an agenda but the Chair, after consultation with the relevant officer, agrees should be raised;
(e) the business otherwise set out on the agenda for the meeting.

Conduct of Meetings

29. The conduct of JHOSC meetings shall be regulated by the Chair (or other person chairing the meeting) in accordance with the general principles and conventions which apply to the conduct of local authority committee meetings.

30. In particular, however, where any person other than a full or co-opted member of the JHOSC has been allowed or invited to address the meeting the Chair (or other person chairing the meeting) may specify a time limit for their contribution, in advance of its commencement which shall not be less than two minutes. If someone making such a contribution exceeds the time limit given the Chair (or other person chairing the meeting) may stop him or her.

31. The Chair (or other person chairing the meeting) may also structure a discussion and limit the time allowed for questioning by members of the JHOSC.

Officer Administration of the JHOSC

32. The London Borough of Havering will be the Lead Authority for clerking and administering the JHOSC. The Clerk of the Committee will be the Principal

Democratic Services Officer, London Borough of Havering. Costs of supporting the JHOSC will be shared, in proportion to their representation on the Committee, by the London Boroughs of Barking and Dagenham, Havering, Redbridge, Waltham Forest and by Essex County Council, in cash or in kind.

Voting

33. Members may request a formal vote on any agenda item by informing the Clerk of the Joint Committee at least five working days before a meeting. If it is not possible to give this notice, Members have the right to request a vote at a meeting itself, provided they explain to the meeting why it has not been possible to give the standard notice of this request. The decision on whether to allow a vote, if the standard notice has not been given, will rest with the Chairman of that meeting.

34. Any matter will be decided by a simple majority of those members voting and present in the room at the time the motion was put. This will be by a show of hands or if no dissent, by the affirmation of the meeting. If there are equal votes for and against, the Chair or other person chairing the meeting will have a second or casting vote. There will be no restriction on how the Chair chooses to exercise a casting vote. Co-opted members will not have a vote.

Public and Press

35. All meetings of the JHOSC shall be open to the public and press unless an appropriate resolution is passed in accordance with the provisions of Schedule 17 of the National Health Service Act 2006.

36. All agendas and papers considered by the JHOSC shall be made available for inspection at all the constituent authority offices, libraries and web sites.

Code of Conduct

37. Members of the JHOSC must comply with the Code of Conduct or equivalent applicable to Councillors of each constituent Local Authority.

General

38. These terms of reference incorporate and supersede all previous terms of reference pertaining to the JHOSC.