

## Notice of Meeting

### HEALTH & WELLBEING BOARD

**Tuesday, 20 October 2015 - 6:00 pm**  
**Conference Room, Barking Learning Centre, 2 Town Square, Barking, IG11 7NB**

Date of publication: 12 October 2015

Chris Naylor  
Chief Executive

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#### Membership

CLlr Maureen Worby (Chair)	(LBBD) Cabinet Member for Adult Social Care and Health
Dr W Mohi (Deputy Chair)	(Barking & Dagenham Clinical Commissioning Group)
CLlr Laila Butt	(LBBD) Cabinet Member for Crime and Enforcement
CLlr Evelyn Carpenter	(LBBD) Cabinet Member for Education and Schools
CLlr Bill Turner	(LBBD) Cabinet Member for Children's Services and Social Care
Anne Bristow	(LBBD) Deputy Chief Executive and Corporate Director for Adult and Community Services
Helen Jenner	(LBBD) Corporate Director of Children's Services
Matthew Cole	(LBBD) Divisional Director of Public Health
Frances Carroll	(Healthwatch Barking & Dagenham)
Dr J John	(Barking & Dagenham Clinical Commissioning Group)
Conor Burke	(Barking & Dagenham Clinical Commissioning Group)
Jacqui Van Rossum	(North East London NHS Foundation Trust)
Dr Nadeem Moghal	(Barking Havering & Redbridge University NHS Hospitals Trust)
Sultan Taylor	(Metropolitan Police, Borough Commander)
John Atherton (Non-voting member)	(NHS England)

# AGENDA

**1. Apologies for Absence**

**2. Declaration of Members' Interests**

In accordance with the Council's Constitution, Members of the Board are asked to declare any interest they may have in any matter which is to be considered at this meeting.

**3. Minutes - To confirm as correct the minutes of the meeting on 8 September 2015 (Pages 3 - 9)**

## **BUSINESS ITEMS**

**4. Healthwatch Annual Report 2014/15 (Pages 11 - 74)**

**5. Health and Adult Services Select Committee's Scrutiny Review on Local Eye Care Services (Pages 75 - 150)**

**6. Accountable Care Organisation Update (Pages 151 - 155)**

**7. Health and Wellbeing Outcomes Framework: Performance Report - Quarter 1 2015/16 (Pages 157 - 184)**

**8. Contract - Procurement Strategy and Waiver for Public Health Primary Care Services Contracts 2016/17 (Pages 185 - 203)**

**9. Contract - Advocacy Services Re-tender (Pages 205 - 218)**

**10. Contract - Extension for the Provision of Extra Care Accommodation Services (Pages 219 - 225)**

## **STANDING ITEMS**

**11. Systems Resilience Group - Update (Pages 227 - 229)**

**12. Sub-Group Reports (Pages 231 - 239)**

**13. Chair's Report (Pages 241 - 246)**

**14. Forward Plan (Pages 247 - 256)**

**15. Any other public items which the Chair decides are urgent**

**16. To consider whether it would be appropriate to pass a resolution to exclude the public and press from the remainder of the meeting due to the nature of the business to be transacted.**

## **Private Business**

The public and press have a legal right to attend Council meetings such as the Health and Wellbeing Board, except where business is confidential or certain other sensitive information is to be discussed. The list below shows why items are in the private part of the agenda, with reference to the relevant legislation (the relevant paragraph of Part 1 of Schedule 12A of the Local Government Act 1972 as amended). ***There are no such items at the time of preparing this agenda.***

- 17. Any other confidential or exempt items which the Chair decides are urgent**

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## **Our Vision for Barking and Dagenham**

### **One borough; one community; London's growth opportunity**

#### **Encouraging civic pride**

- Build pride, respect and cohesion across our borough
- Promote a welcoming, safe, and resilient community
- Build civic responsibility and help residents shape their quality of life
- Promote and protect our green and public open spaces
- Narrow the gap in attainment and realise high aspirations for every child

#### **Enabling social responsibility**

- Support residents to take responsibility for themselves, their homes and their community
- Protect the most vulnerable, keeping adults and children healthy and safe
- Ensure everyone can access good quality healthcare when they need it
- Ensure children and young people are well-educated and realise their potential
- Fully integrate services for vulnerable children, young people and families

#### **Growing the borough**

- Build high quality homes and a sustainable community
- Develop a local, skilled workforce and improve employment opportunities
- Support investment in housing, leisure, the creative industries and public spaces to enhance our environment
- Work with London partners to deliver homes and jobs across our growth hubs
- Enhance the borough's image to attract investment and business growth

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## MINUTES OF HEALTH AND WELLBEING BOARD

Tuesday, 8 September 2015  
(6:00 - 8:30 pm)

**Present:** Cllr Maureen Worby (Chair), Dr Waseem Mohi (Deputy Chair), John Atherton, Conor Burke, Cllr Laila Butt, Cllr Evelyn Carpenter, Frances Carroll, Matthew Cole, Dr Ravi Goriparthi, Helen Jenner, Dr Nadeem Moghal, Bruce Morris, Cllr Bill Turner, Jacqui Van Rossum and Sean Wilson

**Also Present:** Sarah Baker, Cllr Eileen Keller, Cllr Adegboyega Oluwole and Ian Winter CBE

**Apologies:** Anne Bristow, Dr John and Chief Superintendant Sultan Taylor

### 16. Declaration of Members' Interests

Jacqui Van Rossum, Executive Director Integrated Care (London) and Transformation, NELFT, declared a non-pecuniary interest in agenda item 5, Improving Post-Acute Stroke Care (Stroke Rehabilitation) – the Case for Change.

### 17. Minutes - 7 July 2015

The minutes of the meeting held on 7 July 2015 were confirmed as correct.

### 18. Joint Strategic Needs Assessment 2015 - Key Recommendations

During this item Councillor Laila Butt, Cabinet Member for Crime and Enforcement, left and took no further part in the meeting and Helen Jenner, Corporate Director of Children's Services, arrived.

Ian Winter CBE, Care Act Programme Lead, introduced the report and gave a presentation that highlighted the key recommendations from the refresh of the Joint Strategic Assessment (JSNA) for 2015 and also provided demographic information on the health issues within the Borough, which included:

- The poor healthy life and life expectancy for both men and women.
- The effects of unemployment and deprivation, which were both high in the Borough.
- The impact that hypertension, late diagnosis and / or unmanaged diabetes and smoking related illness had on unplanned hospitalisation.
- Two thirds of the Borough's residents were overweight
- The significant health differences between the wards.
- The health risks in the longer term and the decisions that would be needed on potential investment.

The Board raised a number of issues, which included:

- In terms of planning, there was no agreed approach on how the partners would use their combined budgets to tackle health outcomes.
- An acknowledgement that, with reducing resources, it was no longer possible

for partners to continue to operate as they had in the past and there was a need for more intelligent investment in order to achieve the best outcomes. The style of approach suggested by the report was a way to focus on issues when resources were under increased pressure and the same level of universal service to all wards was no longer sustainable.

- The need to focus less on geographical sitting of services and to increase focus on what outcomes were to be achieved and how partners would then invest resources to achieve those health improvements.
- Ward information could create artificial community boundaries and was not always the best way to provide data on the effects on health of demographics / community turnover or to indicate specific health issue hot spots within the different areas within a ward. Once the principles were agreed with all partners, work could then commence to identify the super hot spots where a real difference in outcomes could then be achieved.
- The importance of issues such as, clinical need, paediatric emergencies, safeguarding, unplanned hospital admissions, people with multiple conditions / risks, accessibility of services for people with mental health and learning needs, health education and early intervention with families with young children and the effects of smoking and alcohol.
- Resources should be targeted to where there greatest impact could be achieved. This may reduce provision for those individuals that were better off health wise.
- Population health tools were available for use, once the decision was made on what issues to target.
- How GP practices could be working differently in the future.

The Board:

- (i) Supported the commissioning of services by partner organisations that aligned with the Joint Strategic Needs Assessment findings and the Health and Wellbeing Board key themes of prevention, protection and safeguarding, improvement and integration of services and care and support; and
- (ii) Requested that in-line with statutory requirements, the Public Health Department lead an update of the Joint Strategic Needs Assessment in 2016 to inform commissioning in 2016/17.

## **19. The Care Act 2014: Cap on Care Costs Deferred Until 2020**

Ian Winter, Care Act Programme Lead, presented the report, and explained that the Local Government Association (LGA) had written to the Government calling for a delay in the implementation of the cap on care costs system, which had been due to come into effect in April 2016. The Government had responded on 17 July to say that it had decided to delay the implementation until 2020. As a result the status quo would be maintained, which would include the means testing of an individual's ability to pay. The detail of the announcement, the reasons for delaying phase two of the Care Act and the effect that this would have on the local implementation programme were set out in the report.

The Board raised a number of issues, including:



- Independent Appeals Process.
- The Chair wished to investigate with officers the feasibility of an internal LBBD appeals process, which would be outside of the complaints process, and would report back to the Board on this in due course.
- The financial implications on the care costs under the Act were still highly significant.
- Effects of the financial changes and that further information on funding for winter 2015/16 was anticipated.
- Existing care packages were being reviewed.
- 80/90% of costs are outside care provision. As staff in the care industry were traditionally low paid, this cost would be affected by the minimum wage changes.

Bruce Morris, Divisional Director Adult Social Care, was asked to provide Councillor Bill Turner, Cabinet Member of Children's Services and Social Care, with the data, set out by ward, on the number of individuals that were worse off under the assessments so far.

The Board noted the delay in the implementation of phase two of the Care Act and the implications for the local Care Act implementation programme.

## **20. Improving Post - Acute Stroke Care (Stroke Rehabilitation) - the Case for Change**

Jacqui Van Rossum, NELFT, declared a non-pecuniary interest in this item.

Dr Ravi Goriparthi presented the report on behalf of the Clinical Commissioning Group, and explained that stroke is the largest cause of complex disability and that 30% of sufferers would require community stroke rehabilitation services. The level of care provided would have a significant effect on recovery and therefore the future quality of life of the individuals. An ageing population also increased the risk of stroke occurrence. Whilst the outcomes in hospital were good, the level of care and provision upon discharge were inconsistent.

Improving the pathway for post-acute stroke care was one of the Clinical Commissioning Group (CCG) priorities for 2015/16 and a BHR Stroke Pathway Transformation project had been established to ensure that people who have had a stroke achieve the best possible outcomes. Following an analysis of data from both acute and community providers, a service mapping exercise and stakeholder engagement, an case for change had been developed.

The Board raised a number of issues, including:

- Noting that the Health and Adult Services Select Committee (HASSC) were also looking at this issue at its next meeting.
- Rehabilitation is usually best within a patients home, rather than in a hospital environment.
- The suspected problems within the service provision had now been confirmed by data. This had indicated a complexity of pathways and that in some areas there was limited access to monthly reviews and inconsistencies of record keeping.
- Partners could now jointly look at how changes could be made to improve

outcomes and the development of a joint pathway and how this pathway would be organised across the bigger geographical area.

- The resource implications for the NHS and the potential costs on Adult Social care.
- The Health Service commissioning was now less fragmented; as a result Partners would need to jointly decide what was required to improve outcomes. A draft outline business case would be drafted to enable consultations to commence with HASSC and the wider community.

Having considered the issues, the Board:

- (i) Agreed that there was a clear case for change for stroke rehabilitation care;
- (ii) Agreed that stroke rehabilitation care and outcomes needed to improve;
- (iii) Agreed to continue to engage with Barking and Dagenham Clinical Commissioning Group on improving stroke rehabilitation care; and
- (iv) Noted that a further report would be presented to the Board in December 2015 / January 2016 on the business case for service improvement.

## **21. Urgent and Emergency Care and Vanguard Application**

Dr Nadeem Moghal, Medical Director, BHRUT, left during this item and took no further part in the meeting.

Mr Conor Burke, Chief Accountable Officer, Barking and Dagenham, Clinical Commissioning Group (CCG) was pleased to advise that the Systems Resilience Group, (a partnership of the CCGs, providers, local authorities, GP Federations, out-of-hours provider (PELC), London Ambulance Service, Healthwatch and the Local Pharmaceutical Committee (LPC)), had been successful in its application to become a national urgent care Vanguard.

Mr Burke explained that urgent and emergency care (UEC) was a key challenge for the health economy and its performance targets and the BHR urgent care conference, held on 1 July 2015, had gathered views on the transformation of the service during the next five years. The key themes that had emerged from that conference were:

- A desire to simplify pathways through co-design.
- Maximise the digital and technology opportunities.
- Self-care support.
- Aligned contracts to support integrated delivery.
- Development of the workforce to meet future needs.

Mr Burke highlighted the key comments made by delegates at the conference on how they saw the UEC currently and where they would wish it to be in 2020 and these were provided in more detail in the report. He added that it was accepted that the current situation was confusing and fragmented and this had resulted in people using hospital accident and emergency departments, rather than alternative provision. Following the conference the opportunity had arose to bid to become an UEC Vanguard.

Mr Burke advised that Vanguard had four core principles: clinical engagement, patient involvement, local ownership and national support. Vanguard sites were given access to a national support package and would be encouraged to deliver innovation quickly and this would include opportunities for radical care redesign and the removal of artificial barriers to change. Ultimately this would provide freedom and flexibility to drive change, including procurement and information sharing. In addition to the practical support offered by the national teams, there would be an opportunity to bid for support from a £200m Transformation Fund.

John Atherton, NHS England, congratulated the Systems Resilience Group and commented that the bid had been won against stiff competition.

It was noted that there would be a visit in October to see what needed to be done to deliver the aims and to develop the business case further.

The Chair commented that this was a really exciting opportunity that would enable further joint working opportunities and pilots with Partners.

The Board received the report and noted:

- (i) That the System Resilience Group had been successful in its application to become the first national urgent and emergency care (UEC) Vanguard in London; and
- (ii) That Vanguard status would provide a platform from which to implement the findings of the recent BHR Urgent Care Conference and would also provide an opportunity to look at the streamlining and simplification of the urgent care system and access for patients.

## **22. Review of the Joint Assessment and Discharge (JAD) Service**

Bruce Morris, Divisional Director Adult Social Care, presented the report and advised that the service had been operational since June 2014 and LBBD had hosted the service for the initial 12 months. A review had been undertaken during the summer and it had been concluded that the majority of activity and residents were based in Havering, and as a result the service should be hosted by Havering.

The Board:

- (i) Agreed to the transfer of hosting arrangements to the London Borough of Havering and delegate authority to the Corporate Director of Adult and Community Services to finalise the transfer, including the staffing arrangements detailed in the report; and
- (ii) Delegated authority to the Corporate Director of Adult and Community Services to sign a deed of variation to the Section 75 arrangement to formalise the transfer.

## **23. Contract - Waiver for Integrated Sexual Health and Chlamydia Screening Coordination Services**

Matthew Cole, Director of Public Health, presented the report on the commissioning of comprehensive open-access, accessible and confidential

contraceptive and sexually transmitted infections testing and treatment services for all age groups. A tri-borough procurement for the services for the London Boroughs of Barking and Dagenham, Redbridge and Havering, had been commenced in January 2014 but this was abandoned as the two bids received were substantially beyond the respective budget of the three councils. The subsequent tri borough negotiated procedure also had to be discontinued as all parties could not reach agreement on financial grounds. The three boroughs then agreed to negotiate individually a new contract with the current providers and to issue separate borough-based contracts for the provision of the services, the details of which were set out in the report.

The Board discussed the difficulties of tendering when there was a limited market of providers, the learning that had been obtained from the process and the difference between the Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT) and Terrence Higgins Trust Services. The Board also noted that initially it had been intended to include the Chlamydia Screening Coordination Services, however, BHRUT had indicated that it did not wish to provide the services and Chlamydia Screening Coordination Services would now be part of the Primary Care public health services procurement.

The Board:

- (i) Waived the requirement to tender, in accordance with the Council's Contract Rules; and
- (ii) Delegated authority to the Corporate Director for Adult and Community Services, in consultation with the Director of Public Health, Chief Finance Officer and the Head of Legal and Democratic Services, to approve:
  - (a) The direct award of a one year contract, for the period 1 October 2015 to 30 September 2016, with the option to extend for a further two year period on an annual basis, to Barking Havering and Redbridge University Hospitals NHS Trust for the provision of an Integrated Sexual Health Service; and
  - (b) A six month contract extension to Terrence Higgins Trust, for the period 1 October 2015 to 31 March 2016, to cover the notice period for the provision of the Chlamydia Screening Coordination Service, in accordance with the strategy set out in the report.

## **24. Systems Resilience Group - Update**

The Board received the report on the work of the System Resilience Group (SRG), which included the issues discussed at the SRG meetings held on 22 July and 20 August 2015.

## **25. Sub-Group Reports**

The Board received and noted the reports on the work of the:

- Mental Health Sub-group
- Integrated Care Sub-group
- Public Health Programme Board

- Children and Maternity Sub-Group

## **26. Chair's Report**

The Board noted the Chair's report, which included information on:

- The 'Make A Change' events and promotions.
- Barking and Dagenham's response to the Department of Health's in-year Public Health Grant Reductions.
- The increase in the number of safeguarding allegations being reported to CGQ nationally.
- News from NHS England on:
  - Female Genital Mutilation
  - New Programme to Improve Young People's Mental Health Services.
- Care City Innovation Test Bed Site and the progress made on the bid preparation.
- VizBuzz, which was a simple way to make and receive video calls on a computer tablet, and its potential to combat loneliness or isolation of individuals.
- EPG Development Session on 13 August.
- Accountable Care Organisation, which could provide the opportunity for devolved control of health, wellbeing and social care to local areas.

## **27. Forward Plan**

The Board noted the draft Forward Plan.

## **28. Retirements - Gillian Mills and Bruce Morris**

The Health and Wellbeing Board wished to place on record its thanks to Gillian Mills, NELFT, and Bruce Morris, LBBD, for the support they had given to the Board and also the work they had done to improve the lives of residents of the Borough over many years and wished them both a long, happy and healthy retirement.

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## HEALTH AND WELLBEING BOARD

20 October 2015

<b>Title:</b>	<b>Healthwatch Annual Report 2014-2015</b>
<b>Report of the Healthwatch Board</b>	
<b>Open Report</b>	<b>For information only</b>
<b>Wards Affected:</b> All	<b>Key Decision:</b> No
<b>Report Author:</b> Marie Kearns, Contract Manager, Healthwatch Barking and Dagenham	<b>Contact Details:</b> Tel: 0208 526 8200 E-mail: mkearns@harmonyhousedagenham.org.uk
<b>Sponsor:</b> Frances Carroll Chair, Healthwatch, Barking and Dagenham.	
<p><b>Summary:</b></p> <p>This report is for the Board to review the work of Healthwatch Barking and Dagenham during 2014 2015.</p> <p>This paper is a summary of the Annual Report of Healthwatch Barking and Dagenham. It outlines the work that has been undertaken by the Healthwatch team during the year and highlights our achievements and challenges. Above all it shows how we interact with the public, capture their opinions and reflect them back to commissioners of both Health and Social Care services.</p> <p>This year Healthwatch have reported the service users view's in 13 areas of service delivery in addition to the 6 Enter and View visits undertaken.</p>	
<p><b>Recommendation(s)</b></p> <p>The Health and Wellbeing Board is recommended to:</p> <ol style="list-style-type: none"> <li>1. Consider the report, noting the impact that Healthwatch has had in the last year.</li> </ol>	
<p><b>Reason(s)</b></p> <p>To bring to the attention of the Board trends in public opinion with regard to health and social care services in Barking and Dagenham. To advise the Board of the impact Healthwatch has had throughout the year.</p>	

## **1. Introduction and Background**

- 1.1 This is the second annual report of Healthwatch Barking and Dagenham. The report sets out the work findings, and recommendations of the team. During the year we have looked at 13 areas of service provision, as well as completing six Enter and View visits. Healthwatch have looked at both health and social care services.
- 1.2 All of our reports have received responses from the service providers, with many good outcomes ensuing for the service users.
- 1.3 All the work from last year's annual plan was completed with the exception of one item, the Community Wound Dressing Service. This has now been completed as part of this year's work.
- 1.4 All the work undertaken by the Healthwatch team is driven by public opinion or where we have been asked specifically to look at a service as was the case with BHURT casualty which was requested by the Local Authority.

## **2. Public Consultation**

- 2.1 Healthwatch Barking and Dagenham have a variety of ways in which we advertise our services to the public: ensuring they can make contact with us if they wish to do so. Throughout the year we have had an advert in the local paper each week, as well as two large posters in Vicarage Fields shopping centre.
- 2.2 Healthwatch Barking and Dagenham have a Twitter feed with 619 followers: our followers have doubled since last year.
- 2.3 Healthwatch has a Facebook page with 333 followers
- 2.4 During the year Healthwatch has posted 55 notices on Streetlife, a local on line portal. Streetlife has 3908 contributors. Feedback from Streetlife shows it has been a good channel for consultation, with contributions made on the health appointment system, blood testing services and a hydrotherapy pool for the borough.
- 2.5 This year Healthwatch has undertaken 10 large public events, at which we have engaged with the public.
- 2.6 Through all our engagement activities Healthwatch has made over 272,279 contacts with members of the public. It is from these engagements that we discover what the public is concerned about, and from here we formulate our annual work plan.

## **3. Networks and Partnerships**

- 3.1 Healthwatch Barking and Dagenham are regularly represented on;
  - The Health and Wellbeing Board
  - The Children and Maternity Sub Group



- The Learning Disability Partnership
- The Mental Health Sub Group
- The Safeguarding Adults Board
- The Health and Adult Services Select Committee
- The London Healthwatch Group and Healthwatch England

3.2 Healthwatch Barking and Dagenham has assisted both the local CCG and BHRUT with their public consultation. The team has attended over 300 meetings between them.

## **4. Mandatory Implications**

### **4.1 Joint Strategic Needs Assessment**

When developing our annual plan Healthwatch Barking and Dagenham has been mindful of the content and data of the Joint Strategic Needs Assessment (JSNA) In particular the work completed on Stroke Services reflects the high priority and inequalities associated with this condition for residents of Barking and Dagenham.

### **4.2 Health and Wellbeing Strategy**

All the topics chosen for the Healthwatch work plan fall within the four themes of the four themes of the Health and Wellbeing Strategy.

### **4.3 Integration**

Healthwatch Barking and Dagenham is particularly interested in helping to promote joint working between health and social care service. This is reflected in many of the topics chosen for the 2015/16 work plan such as the Joint Assessment and Discharge Team and the Intensive Rehabilitation Team.

### **4.4 Financial Implications**

Healthwatch Barking and Dagenham is commissioned by the Local Authority and is funded until March 2016.

(Implications completed by: Marie Kearns, Contract Manager for Healthwatch Barking and Dagenham)

### **4.5 Legal Implications**

Under the Health and Social Care Act 2012 local Healthwatch organisations have the authority to undertake announced or unannounced “Enter and View” visits to both health and social care settings.

(Implications completed by: Marie Kearns, Contract Manager Healthwatch Barking and Dagenham)

### **4.6 Risk Management**

All those undertaking Enter and View visits are authorised representatives who have undertaken specific training and have DSB clearance.

#### **4.7 Patient / Service User Impact**

The Healthwatch programme is designed to reflect the views of the users of health and social care services in Barking and Dagenham. The main annual report highlights the specific impact that the views of service users have had in each area.

### **5. Non-mandatory Implications**

#### **5.1 Safeguarding**

All staff and volunteers of the Healthwatch team are given awareness training on Safeguarding issues. A Healthwatch representative sits on the Safeguarding Adults Board.

#### **5.2 Property / Assets**

Healthwatch Barking and Dagenham is based at Harmony House and, therefore, does not rent or own property in its own right.

#### **5.3 Contractual Issues**

Healthwatch Barking and Dagenham is commissioned by the Local Authority and is funded until March 2016

#### **5.6 Staffing issues**

Healthwatch Barking and Dagenham has a team of two full time equivalent (fte) staff and eight volunteers

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

None

### **List of Appendices:**

**Appendix A - Healthwatch Barking and Dagenham Annual Report 2014/15**



# healthwatch

Barking and Dagenham



 Healthwatch Barking & Dagenham  
Annual Report 2014-2015 







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## Note from the Chair Frances Carroll

Welcome to the second annual report of Healthwatch Barking and Dagenham.

Our second year has been a busy one! We are pleased to highlight the achievements we have made this year and the impact we have had on health and social care services. We have undertaken a number of different projects which have been summarised within the report.

Our Board, “Enter & View” representatives and office volunteers, have all given many hours which have contributed towards our achievements. They help in the office, visit health and social care sites, help with events and have represented Healthwatch on relevant boards and at meetings. Thank you all very much.

We have developed stronger working relationships with commissioners and providers this year, ensuring that the views of the local people have been heard and listened to. We have made recommendations to services when they have not met the needs of service users.

In most areas we have had a real impact whilst in others there is still work to do.

We are especially pleased with the positive outcomes we have had from our Enter and View visits.

Our recommendations, based on patient and user comments, have been welcomed and acted on by providers. These include the Fern and Amber Ward visits and our visit to the George Crouch Centre.

We have also helped a number of people navigate the health and social care complaints system and have found that many have difficulty in finding out who to complain to when the need arises.

Healthwatch have continued to engage with the public by organising public events and undertaking outreach stands. Social media has played a big part in the success of our increased engagement with local people.

This year we have undertaken a consultation about ourselves. We wanted to know if people knew about Healthwatch and what impact our work was having. We had some positive feedback, in particular from residents we had helped to progress their complaints.

We were told that we need to engage more with young people and showcase more of our achievements in the local press. These two areas of work will be included in the work plan for the coming year.

I would like to thank all the partners who have worked with us to make this a successful year, and we look forward to the challenges of the year to come.



# About Healthwatch

We are here to make health and social care better for ordinary people. We believe that the best way to do this is by designing local services around their needs and experiences.

Everything we say and do is informed by our connections to local people and our expertise is grounded in their experience. We are the only body looking solely at peoples' experiences across all health and social care.

We are uniquely placed as a network, with a local Healthwatch in every local authority area in England.

As a statutory watchdog our role is to ensure that local health and social care services, and the local decision makers, put the experiences of people at the heart of their care.

The aim of Healthwatch Barking and Dagenham is to give our citizens and communities a stronger voice to influence and challenge how health and social care services are provided in the borough.

We engage with local people to understand what is working well and where improvements need to be made within services.



It is our statutory duty to champion the needs of local people to enable us to do this:

- We train local individuals to become “Enter & View” representatives, equipping them to visit health and social care services and assist in making recommendations for change.





- We obtain the views of the local community by being out and about.
- Signpost people to information about local health and social care services and how to assess them.
- Signpost people to advocacy services and provide information about their choices and what to do when things go wrong.
- Monitor trends from what people are telling us to take things forward on a particular issue or area.
- Provide evidence based feedback to those who are responsible for commissioning or delivering services.
- Alert Healthwatch England, or CQC where appropriate, to concerns about specific care providers of health or social care matters
- Have a seat on the Health and Wellbeing Board, ensuring that the views and experience of patients, carers and others are taken into account when local needs assessments and strategies are prepared.
- Involve local people in the work areas we will be focusing on.

Under the Health and Social Care Act 2012 Healthwatch Barking and Dagenham have the rights below to:

- Have a seat on the Health and Well being board
- “Enter & View” premises
- Request information from providers and commissioners
- Write reports containing the views of local people on health or social care services

- Make recommendations and request a response.

## Our vision

The vision for Healthwatch Barking and Dagenham is to ensure that the views of the local community influence decision makers who commission and provide health and social care services.

We hope to empower local people to get involved with Healthwatch become a part of the network influencing changes for the better.

## Our strategic priorities

- Champion the voice of the local community ensuring that we are inclusive and visible to all.
- Use evidence based feedback and make recommendations to service providers and commissioners.
- Continue engaging with vulnerable and disadvantaged groups
- Enable people to monitor and review the commissioning and provision of local care services relating to: the standard of provision; whether they could be improved and how they ought to be improved.
- Promote and support the involvement of people in the commissioning, provision and scrutiny of local care services (Health Care and Social Care).



# Engaging with people who use health and social care services





# Understanding Peoples' Experiences

Healthwatch Barking and Dagenham believe that it's only by asking those who use the services about their experiences that, we will get a true reflection of they are working and what areas need to be improved.

In order to obtain the views of the community and to better understand their experiences, Healthwatch Barking and Dagenham have taken a pro-active role across the borough, providing opportunities where people can share their experiences of health and social care services.

## Targeted Engagement

When we have needed to speak to a particular group of people, targeted engagement has taken place. Examples of these are below:

- Whilst undertaking the stroke project the views of stroke survivors were needed. We visited the stroke club to speak directly with people who had suffered a stroke and been through the system.
- We asked the council if they would send out questionnaires to people in receipt of a personal budget. This was to ensure that all those receiving a personal budget had a chance to share their experiences.
- Healthwatch Barking and Dagenham visited Axe Street Child Development Centre in order to

Speak to parents on a clinic day about the speech and Language therapy service they receive.

- Barking Havering Redbridge Hospital Trust welcomed and supported us, whilst we were undertaking the Accident and Emergency projects. Staff and volunteers attended the department to speak directly with patients who were using the service.

## “Enter & Views”

We have undertaken 6 “Enter & Views” across health and social care services: ensuring people who are receiving in-patient care or are resident at a care or nursing home, have the chance to speak to us.

## Outreach Stands at Queens Hospital

Outreach Stands at Queens Hospital have enabled Healthwatch to directly receive feedback from patients, friends and family.





## Working with others

We have worked in collaboration with a number of statutory organisations to obtain the views of the public on particular areas of work: including the Clinical Commissioning Group on their priorities for the coming year. More information for each of these can be found on the working together section page 46.

## Public events

This year we undertook four public events, each one at a different venue; Vicarage Field Shopping Centre, Kingsley Hall, Dagenham Library and Barking Learning Centre. The events gave members of the public the opportunity to find out more about Healthwatch, get involved in projects and share their experiences.

Organisations from across the borough were also invited to come along and promote their services.

## Outreach and Promotional stands

Over the last year we have continued to build on our engagement activities, and have had stands at a number of events including the World Mental Health Day. This was a real chance to speak to mental health service users and their families and friends about the services they receive and aspirations for those in the future. We spoke to over 60 people.

Healthwatch have also had outreach stands at other events including;

- CVS Voluntary Sector Open Day;
- Be Healthy Stay Safe Day
- International Day of Disabled People
- North East London Foundation Trust Sports Day
- Learning Disabilities Week

All of which have contributed to obtaining the views of the public.





## Associates

Healthwatch Associates are organisations or groups which are formed around their service users' needs on a particular area of health or social care. We currently have 25 Healthwatch Associates.

Associates share information about Healthwatch projects with their service users' enabling us to capture the views of some individuals who may not have otherwise engaged. In working in partnership with the Associates, some have advertised the Healthwatch service through their e-bulletins and newsletters.


This year we held an Associates Day. There were seven representatives from organisations in attendance. The meeting was to clarify the role of Healthwatch to Associates; the intention to forge closer working links and request input and feedback to issues that affect their organisations and the people they represent.

The day went well and Healthwatch were able to obtain the views from our Associates about what specific issues their service users were having in relation to health and social care services.

## Your Voice Cards

Healthwatch Barking and Dagenham have "Your Voice cards" which are cards that are used for people to write down their stories. We have found that where people do not feel comfortable in talking about their experience of health or social care service, they like to write it down.

Through all our engagement activities we have engaged with over 272'279 members of the public. This includes all our projects, consultations and events and signposting service and social media.

<p><b>healthwatch</b> Barking and Dagenham</p> <p><b>Your Voice Counts</b></p> <p>Healthwatch give children, young people and adults a powerful voice locally and nationally. Healthwatch Barking and Dagenham is all about local voices being able to influence the delivery, design, quality and standard of local health and social care services.</p> <p><i>Every voice counts when it comes to shaping the health and social care services of today, and improving them for the future.</i></p> <p><i>Have you used any of these services within the last 8 months?</i></p> <p><b>Make your voice count and tell us about your experience!</b></p> <p>All information will be kept confidential.</p> <p>We may need to contact you to clarify information you have provided, if are happy for us to do this then please provide contact details below.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> 	<p><b>Make your voice count and tell us about your experience!</b></p> <p><b>What service are you going to tell us about? (please indicate where you accessed the service)</b></p> <p><b>When did you use the service?</b></p> <p><b>Please tell us your experience of using the service?</b></p>
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# Social Media & Communication

Healthwatch uses a wide range of communication methods. They are developed not only to promote Healthwatch but keep the local community updated on opportunities for involvement and to influence service change.

Our communication methods have also been used to encourage service users to call us and tell us about their experiences of using services especially if they are unsure where to turn to when things don't go so well.

## Website

We have continued to develop the website this year. It contains information on projects that Healthwatch have undertaken including "Enter & View" reports, Executive Board minutes and national and local news in relation to health and social care.

We have had a number of enquiries through the "Contact Us" section of the website. These have included areas such as volunteering, experiences that people have encountered and responses to consultations we are running. Some individuals prefer to use the website as a way of expressing their concerns and views.

### Posters in the Vicarage Shopping Centre

Posters of Healthwatch are displayed in the shopping centre. Members of the public have seen the poster and called us as a result.

## Twitter and Facebook

The sites are used to promote activities and relevant health and social care news and updates. We have used both to ask questions directly to followers and have also received feedback through this mechanism. This year the involvement for users has been more active than the previous year and we have had more retweets and likes!

*Our followers on Twitter have doubled since last year and now we have 619 followers and 333 Facebook friends.*

## Streetlife

Healthwatch have been using Streetlife over the last year. There are currently 3908 members on Streetlife. We have had increased interest from the local community and discussions have taken place online on a number of issues such as, the appointment system at the local hospital, blood test services and hydrotherapy services in the borough. Streetlife has proved to be successful in engaging with members of the public. In total we have put up 55 notices.

Feedback from Streetlife users shows that Healthwatch has kept them informed and it has been a good portal for consultation when they are unable or do not want to attend a specific event but would like to share their views.



April 2015 - Issue 5

**healthwatch**  
Barking and Dagenham

**Special Points of Interest**

- Report: Stroke Services
- "Have Your Say" Event
- Public Event Opportunity

You will soon be able to read our reports on:

- The London Ambulance Service
- Duty of Candour Consultation
- Wendfordale Service
- Adults and Children A&E
- Surgical Dressing
- Enter & Views
- Adults and Children with Hearing Impairment

**REPORT: Patient and Carer Experiences of Using Local Stroke Services**

Healthwatch consulted with patients at Grays Court Stroke Rehabilitation Service, members of Parkside Stroke Club, Barking and Dagenham Stroke Club, Carers of Barking and Dagenham Stroke Group and a Stroke Association volunteer champion.

This is a summary of our findings: (please see the full report [here](#) for more complete information):

- The quality of services, especially when discharged, seems to be dependent on how severe a stroke is and how well informed and prepared other support services are to meet an individual patient's needs when they return to the community.
- Reasonable periods of notice for discharging patients are inconsistent. Indications are that those patients with longer stays in hospital get more notice and better organised aftercare support.
- Patients coming through the service haven't had discharge plans completed thoroughly to include all their needs. Some patients have not had discharge plans done at all. The majority of plans do not take into consideration the support and information needs of patients' carers/family members.
- Patients' GPs are not contacting them in a timely way to address their changed health requirements. This causes stress and difficulties for newly disabled individuals with no medical support mechanism in place.
- Compared with neighbouring boroughs - Havering and Redbridge - Barking and Dagenham does not have a commissioned community based service working specifically for stroke patients that can provide support, information and advice, before and after they leave hospital.

**Meet our Board Members - Lorraine Goldberg, Associate**



Lorraine is the Executive Director of Carers of Barking & Dagenham. Carers of Barking & Dagenham are the leading organisation for the borough. Lorraine works at a strategic level to ensure that Carers of Barking & Dagenham offer quality services to informal carers and their families.

Lorraine was on the Executive Board of the LINK.

Lorraine is a valuable Associate on the Healthwatch Board and will ensure that carers voices are heard and included to help inform the decisions that are made to improve health and social care services.

**healthwatch**  
Barking and Dagenham

Tuesday 28<sup>th</sup> October 2014  
10am-2pm  
Dagenham Library  
Heathway  
RM10 9QS



*Come and tell Healthwatch about your experiences and views of any health and social care services you, a loved one or someone you care for has used recently.*

**Free massages**  
**Free Nail Painting**  
**Information stands from various organisations**

### E-bulletin

The e-bulletin is another way of keeping stakeholders and people who are interested up to date. Regular e-bulletins have been sent to the members and various other stakeholders.

### Bookmarks

To ensure that people, who have repeat prescriptions and are housebound, know about Healthwatch: we worked with The North East London Pharmaceutical Committee and local pharmacies to put our bookmarks in the repeat prescription bags. We have had members of the public call us after receiving the bookmarks.

### Local Media

We have had a 6 month run in the local paper advertising Healthwatch aswell as a number of events and consultations.

**your voice counts**

Your doctor, Your hospital,  
Your care home, Your mental  
health services.

We need to hear your experiences;  
what's good, and what  
needs to improve.

Get in touch and let us know your views.

**healthwatch**  
Barking and Dagenham

Tel: 020 8526 8200

W: [healthwatchbarkinganddagenham.co.uk](http://healthwatchbarkinganddagenham.co.uk)

E: [info@healthwatchbarkinganddagenham.co.uk](mailto:info@healthwatchbarkinganddagenham.co.uk)

HealthwatchBD

HealthwatchBD



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# Disadvantaged, Vulnerable and Seldom Heard Groups

## Safeguarding Project

During our adult life we may find ourselves vulnerable through illness, frailty or old age, disability, mental illness, learning difficulties or dependency on others in some way. These situations may mean that others could take advantage of us. It has been known for vulnerable people to be physically and emotionally abused as well as financially exploited.

It is the responsibility of the Local Authority and Health Services to ensure they have measures in place to prevent abuse from happening or to deal with it effectively when it does.

In order to know if the Local Authority is doing their part well enough, Healthwatch were asked by the Safeguarding Board to work on a project. More information on the findings of the report can be found on page 30.

We spoke to a wide range of people some who found themselves vulnerable.

## Hearing Impairments

We have undertaken two projects which capture the views of people with hearing impairments; one is focused on adults and the other is on parental views of the services provided to their children.

We went to the audiology department at the Axe Street Children and Family Centre; to talk to the parents about their children and the services they receive.

The summary of these reports can be found on page 32 and 33.

## People with Learning Disabilities

Healthwatch have developed a good relationship with people with Learning Disabilities, who have been encouraged and supported to take part in a number of areas including the “Have your say event”, which focused on the priorities for the CCG in the coming year and the Refresh of the Health and Well Being Strategy.

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**“The event was really good and we said what we thought on the video, this was easier for us because we did not have to write our feelings and could just say it! Healthwatch told us about the event and we were happy to come and say how we felt about things that matter to us.”**

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## Mental Health

Healthwatch has worked very closely with mental health services users and were able to get some of them involved with the Mental Health sub-group. The summary of the report can be found on page 44.





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# Engaging with People Volunteering or Working in the Borough but may not Live in the Borough

We have found that people working or volunteering in the borough but do not live in the borough are passionate about the services that are available to residents.

There are a number of ways in which Healthwatch have captured the views of this group and given them a voice.

## Duty of Candour Project

The Duty of Candour project looked at the duty that all staff in health & social care settings has, to speak up if they suspect that another staff member is mistreating patients or residents. For this project staff at the nursing home were given surveys to obtain their views in relation to the duty of candour. Staff were also given details of how to make contact with Healthwatch in the future if they would like to share their views on other health or social care matters.

## Voluntary Sector Open Day

Healthwatch attended the Voluntary Sector Open Day, which is run by the Council for Voluntary Services. The day offered Healthwatch an avenue to speak to volunteers and staff members working in the borough as well as consult with the general public.

## Enter and Views

When undertaking Enter and Views, staff are given the option to share their opinions of the care being provided and assured that information will stay anonymous.

## Associates and Interested Individuals

Anybody can sign up to Healthwatch Barking and Dagenham. Signing up means receiving updated news on local and national health and social care services, receiving our e-bulletin and information on our projects. We have a number of professionals and individuals who have signed up who do not live in the borough but want to be kept informed. Currently we have over 100 interested individuals.

## Volunteering Week Celebration

This year Healthwatch Barking and Dagenham took part in the Volunteer Celebration day. Healthwatch had an outreach stand and spoke to volunteers obtaining their views on a number of issues. Some volunteers lived in the borough whilst others did not.

## Streetlife

Healthwatch have used Streetlife over the last year to consult and inform community members. Some members do not live in Barking and Dagenham and are from the neighbouring boroughs.



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## Engagement with Young People under 21



In order to capture the voice of young people we have a young person's representative on the Executive Board. This year Healthwatch have engaged with young people to obtain their views on a number of projects.

Healthwatch undertook a project on Safeguarding; we engaged with a wide variety of people and are pleased to say that 40% of the responses came from young people who use the services of the Vibe youth centre. For this valuable contribution we are grateful to our Associate Board member Grace Kihu who represents young people.

Healthwatch have also attended the BAD Youth Forum, to speak to young people about the role of Healthwatch and the projects being undertaken.

We undertook an evaluation to look at how many people have heard of Healthwatch and the impact we have had for them, 66 of the overall questionnaires were received via our young people's representative, Grace Kihu, 64% said they had not heard of Healthwatch.

This highlights that more work needs to be done with young people in the borough. Therefore next year Healthwatch will be attending the BAD Youth Forum on a more regular basis and also producing young people friendly material.



We have engaged with older people in a number of ways to ensure their views and experiences are taken seriously and not missed. We have not only provided opportunities at events across the borough but have ensured that “Enter & Views” give older people the chance to express their opinions.

### **Enter and View**

We have undertaken 6 “Enter & Views” across health and social care services this year, one of the visits was at Fern Ward, mainly for older people. The majority of the patients on the ward were over 65 years of age. Patients feedback, informed the recommendations made in the report, all these were taken up by the provider and the voice of the older people was heard.

Kallar Lodge was also mainly older residents with dementia.

### **Older Peoples Day Event**

Healthwatch Barking and Dagenham took part in the Older People’s Event which was organised by the London Borough of Barking and Dagenham.

We had a stand with information on who we are and spoke to the older people about the service they receive and how they feel about them. This was a fantastic event where older people had a chance to voice their concerns but also the chance to celebrate Older People’s Week.

### **Healthwatch Public Event**

Healthwatch ran an event at Kingsley Hall Community Hall. The day was spent by staff speaking with the older people about their experiences and opinions of the health and social care services they had used recently. The Barking Bathhouse was with us and offered free massages and nail painting which was something the older people loved.

### **Older People’s Representative**

We also have an older person’s representative on the Board, Barbara Sawyer. Barbara gives a lot of time volunteering for the local community. She is an authorised representative for “Enter & View” and brings a lot of experience from the lay person’s perspective. Barbara ensures that the older people’s views are heard at Healthwatch Board meetings.



# Enter & View

“Enter & View” is carried out under Section 186 of the Health & Social Care Act 2012. It imposes duties on certain health and social care providers to allow authorised representatives of local Healthwatch organisations to enter premises and carry out observations for the purposes of Healthwatch activity.

Authorised representatives observe and speak to service users about their experiences of the visited home or ward in order to collect evidence of the quality and standard of the services being provided.

To do this we:

- Enable people to share their views and experiences and to understand that their contribution will help build a picture of where services are doing well and where they can be improved.
- Give authoritative, evidenced based feedback to organisations responsible for delivering and commissioning services.
- Are able to alert Healthwatch England or the Care Quality Commission, where appropriate, to concerns about specific service providers of health or social care.

Healthwatch have 6 “Enter & Views” representatives, all staff are trained to deliver the “Enter & View” programme and undertake visits.

## Authorised Representatives



Frances  
Carroll



Barbara  
Sawyer



Val  
Shaw



John  
Southall



Mary  
Parish



Tayo

All staff are “Enter & View” trained



## Fern Ward, Older People's Medicine and Medical Ward, BHRUT

Last year Healthwatch undertook an "Enter & View" visit to Sunrise A & B ward that provides in-patient hospital services for older people - Healthwatch made relevant recommendations. BHRUT had taken on the changes and a follow up visit was undertaken to evidence that the changes had been made.

Healthwatch undertook the visit to Fern ward to determine if changes previously recommended were implemented on other wards across the trust. This was part of the wider work plan.

The purpose of the visit was to find out patients' views on the choice and quality of the food and drink they receive; to ask patients and their visitors about the staff interaction with them and to get views and comments about the quality of personal hygiene support that patients receive.

Taking into consideration the views of patients and relatives Healthwatch made recommendations focusing on the improvement of catering staff distributing tea and coffee, assistance with filling out food options and reading menus, bedpans and the amount of time patients are waiting and lastly recommendations on repairs of call buttons.

We are pleased to report that BHRUT responded positively with an action plan to implement the changes.





## Amber Ward

This was an announced visit to find out from in-patients about their experiences of using the wards' services. Healthwatch Barking and Dagenham were given feedback by people from the borough, concerned about some of their experiences of using the services on these wards.

The areas that Healthwatch representatives focused upon were: Nutrition, Personal Hygiene, Patient and Staff Interaction.

The patients we spoke with were in the main complimentary about the service and support they had received however there were areas that could be improved.

Taking into consideration the feedback from patients Healthwatch recommended;

- Better communication between ward staff and catering staff
- protocols to be in place to check finger nails of immobile patients in case of infection
- more checks on patients who are bedridden to prevent pressure sores
- clear communication between ward staff, consultants and doctors where a relative has the power of attorney for the patient.

We are pleased to report that BHRUT responded positively with an action plan to implement the changes.





# George Crouch Day Centre & Lodge Avenue Care Home

Both “Enter & View” visits were part of a wider programme of work being undertaken by Healthwatch Barking and Dagenham - to gather views and experiences from residents about the standard and quality of care and support being provided to them.

At both visits Healthwatch looked at four areas;

- personal hygiene,
- nutrition,
- social activities
- staff interaction.

## George Crouch Day Centre

In all areas service users made positive comments about George Crouch Day Centre. Service users were happy with the staff, food and leisure activities.

The Centre is well recommended by those who attend it and feedback shows it’s a good resource within the community.

Taking into consideration the feedback Healthwatch concluded that this is a very good service and is underused.

An “Enter &View” visit has also taken place at Alexander Court; currently the findings are unable to be shared.

Healthwatch wrote to the manager overseeing George Crouch Day Centre.

We received a response from the manager.

The response from the manager states

“In 2015 we will be implementing an action plan to involve more services with George Crouch so as to widen our referral routes.”

## Lodge Avenue Care Home

Healthwatch representatives felt this was a positive visit.

There were no negative points about the standard and quality of the care and support being provided.

The residents Healthwatch spoke with said they were well looked after, had no complaints and didn’t want their support changed.

Although residents have choice and control over their lives from day to day, it did emerge that individual circumstances inhibited access to some activities for some residents.

From the feedback received from them, conversations with staff and observations carried out Healthwatch Barking and Dagenham made no recommendations for the 4 areas of enquiry focused upon during this visit.



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# Kallar Lodge Residential Lodge

Healthwatch Barking and Dagenham undertook a visit to Kallar Lodge Residential Home, to gather and record service users' views on 4 areas: nutrition, personal care, social activities and hobbies and staff interaction.

Healthwatch representatives found that the service users spoken to on the day were happy with all four areas that were being looked at. However, due to the nature of their disability (dementia), their views did not always seem clear or completely accurate.

As this group of people are particularly vulnerable, it is important that their views are fully evaluated.

From the feedback and the observations, it was clear that Kallar Lodge Residential Home provide a very good service which provides a pleasant and comfortable life to its residents.

Taking into consideration all the feedback received Healthwatch recommended

- Current bi-annual meetings with friends and family of residents should take place more frequently.
- Information on proposed regular and exceptional leisure activities should be advertised on posters pinned in the communal areas and/or at reception on a notice board.
- Exceptional outings or events could also be circulated on a website/social media such as Facebook as well as via letters to those especially interested.



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## Response from Manager at Kallar Lodge.

“Thank you for the report and the suggestions, I only wished our families were better represented at the time of your visit as we do have activities that include puzzles and painting. We arrange annual events through the hire scheme of a community bus that takes our residents out on day trips and these are advertised on all unit boards and invites relatives and friends to attend. These are summer events are advertised nearer the time.

I hope you enjoyed your visit and thank you again for your prompt report.”

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## Impact Stories

### *Involving Lay people in Statutory Duties*

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Val has been volunteering with Healthwatch Barking and Dagenham for over two years. She also volunteers for other services in the Borough.

She has a lot of knowledge of local services in the borough which is an asset for when she takes part in Healthwatch activities.

Val is involved in the statutory duties that we undertake especially Enter and View. Val says that the training for “Enter &View” representatives was delivered in a way that was easy for lay members to understand, and that support has always been available when needed.

She feels that it is important that we do follow up visits as this enables the team to see if changes have really taken place or not.

#### Quote from Val Shaw

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“The training provided by Healthwatch Barking and Dagenham gave me a good understanding of what the law says about what I can do as a representative and what I should be looking for during a visit. The impact of visits depends on the provider, sometimes they do make changes and at other times they say they will but similar situations still occur.

I got involved in “Enter & Views” to help services have an insight of how people really feel and to make a difference.

I think that people who have an interest in talking to the local community about health or social care services should consider being an “Enter & View” representative. You can be involved as little or as much as you want, sometimes we do one visit in 3 months”

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# Providing Information and Signposting for People to Health and Social Care Services





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# Helping People Get what They Need from Local Health and Social Care Services

As part of the statutory service we offer information and signposting to the local community. People can contact us in a number of ways, by phone, post, email, through the website and social networking sites.

## Public Events

We have invited organisations who provide health and social care services to promote their service at our public events, giving the public the chance to find out about what is available to them. Some of the organisations, who have taken part in our public events, include Voiceability, Carers of Barking and Dagenham, DABD UK.

## Website

There is a dedicated section on our website which provides information on local and national services, including advocacy services. This is split up in order to make it easy for those who are looking for services.

## Volunteers

Our volunteers who assist with outreach are trained and are aware of the different services available in the borough to help signpost people. We also keep leaflets on other services on our stands.

Where a new service is being provided we are happy to add this to the website promote the service to our associates and through the e-bulletin.

## Communication and Social Media

Healthwatch Barking and Dagenham are on Twitter, Facebook and Streetlife, so people are able to make contact with us through all three. We also have a regular E-bulletin which is produced every two months.

More information on social media and the use of this can be found on page 12.

## Working in Partnership

We have worked in partnership with a number of organisations to ensure that people better understand the health and social care system and voice their concerns. Feedback from these events show that members of the public have not only enjoyed the events but their knowledge has also increased on how the system works.

## Associates

New services are promoted to our Associates to ensure the word is spread as widely as possible.



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# How we helped people to find local services and take control of their own health and social care

One of our main areas of work is to provide local people with the correct information in order for them to take control of their own health and social care. Sometimes things go wrong and people want to be signposted to the correct service to assist them. We have assisted and signposted many individuals through our service, in total around 450 people.

Through feedback Healthwatch Barking and Dagenham found that a number of people were frustrated as they had tried to establish where to go for assistance and were not always given the correct information. Many of the cases that came through to Healthwatch had initially contacted other organisations and were signposted to us.

We have assisted or signposted individuals to a number of services.

The following is a breakdown:

## GP related - 71 (51%)

A number of people told us about their issues in relation to their GP practice, a number of areas were mentioned, such as files going missing, issues with prescriptions, patients not being able to get through on the telephone and staff rudeness. A large number of requests for assistance were from people unable to get an appointment at their surgery in a timely way. We are limited to the kind of advice and signposting we can give in that situation, individuals were given details on the complaints process and the contact details of how to make a complaint. The information we gave enabled individuals to choose the route they would like to take and who to contact if they needed assistance in writing the complaint or support to do this.

Quote from lay member trying to get a GP appointment:

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**“Getting an appointment when I need it is ridiculous - waiting 9 days is too long”**

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## Hospital Appt issues - 104 (23%)

A total of 104 people told us about hospital appointments issues including; receiving letters for appointments and then the appointment being cancelled numerous times and two or three letters coming through for the same appointment. People also told us their appointments were being cancelled and no notification was given, and lastly the attitude of staff at the call centre was dependent on who you spoke to.



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One individual told us:

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**“On 3 occasions my appointment has been changed without any reason given on the letter, when I eventually get to speak with someone, they tell me it’s changed by the clinic but don’t know why”**

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The patient was advised to refer to the contact number on the appointments letter that they received concerning their query. This was cause for their comment and the alternative suggested speaking with their consultant’s secretary directly about it. They were also given the details of how to make a complaint should they wish to do so.

### **Local Authority Services - 27 (6%)**

There were a small amount of people who spoke about services provided by the local authority. Areas that people did contact us about included, who they should contact about housing, where to go for support as their parents need help and who to contact in regards to having an assessment for a personal budget. Some people wanted to be signposted to certain departments of the council and just wanted different department names.

An individual accessing local authority service told us:

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**“Although the help did eventually happen - waiting for someone to make a decision about the assessment was very slow - too many people involved”**

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### **Help with Housing Issues - 4 (3%)**

Only 4 people contacted us to find out where to go for housing issues.

Comment made by lay member who we assisted:

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**‘I didn’t know who to speak with, but thank you for the information for the local advice bureau’**

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### **Mental Health Needs - 41 (9%)**

The people who contacted us were mental health users and their families and carers. There were a variety of issues brought up including, housing, advocacy services, what support groups are available and the feeling that services do not listen to what they have to say.

### **Advocacy Services - 11 (8%)**

We had a small amount of people who contacted us for details on who could advocate for them. They were mainly signposted to Voiceability, Citizens Advice Bureau, Carers of Barking and Dagenham and DABD UK.



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There were 40 people who contacted Healthwatch and made complaints about services. The below gives figures in terms of the percentage of complaints we received for each service.

- GPs - 23 (58%)
- Local Hospitals - 5 (13%)
- Mental Health Services -4 (10%)
- Appointment Waiting Times -4 (10%)
- Social Care Services - 2 (5%)
- Dental Service - 1 (2%)
- Community Services - 1

Quotes from service users who made contact with Healthwatch

### Examples of people Healthwatch have supported:

*Mrs O contacted Healthwatch on behalf of her elderly mother who relied on regular delivery of continence nursing products. These hadn't been delivered, causing much stress to her and leaving her mother vulnerable in the circumstance. Healthwatch provided her with current contact details for the Continence Team dealing with patients from the borough and also gave advice to contact her mother's GP initially, to complain about the service.*

*Mr R contacted Healthwatch via a colleague - he contacted his GP by phone to book an appointment and was told there wasn't one available for 2 weeks. He was appalled by this - although his need was not urgent; having to wait for 2 weeks to see a GP could make it so. How can the NHS say prevention is better than cure, then set services up like this where getting a cure is a struggle, let alone help with prevention? Healthwatch provided him with contact details for Voiceability and how to contact NHS England.*

*Mrs S had cause to visit her Dentist 5 times in 6 weeks because of the same issue and still it wasn't resolved. She said she did not know who to turn to or contact and so contacted Healthwatch B&D. She was provided with the contact details for the local representative of the London Dental Committee to assist with her complaint and also the contact details for Voiceability.*



# Influencing Decision Makers with Evidence from Local People





## Reports

We have produced 20 reports including all our projects, "Enter & Views" and reports on consultations we have undertaken in partnership.

## Safeguarding Project

This Safeguarding project contributed to the public consultation undertaken by the Safeguarding Adults Board (SAB) as part of drafting the Adult Safeguarding Strategy for the London borough of Barking and Dagenham.

We received 149 questionnaires and from talking to members of the public it became clear that people do care about the abuse of vulnerable adults. The injustice of it and a keen dislike of it were often expressed.

Broadly speaking two thirds of respondents were confident they would recognise if an adult was either suffering abuse or at risk of abuse, whilst a third thought they might not recognise the signs.

Whilst a wide variety of answers was given for where the abuse might be reported, 40% of respondents did not know or were unsure of where or who they would report it to.

Two thirds of respondents said they felt confident to report an incident of possible abuse, and a third said they did not with the main reason being a fear of reprisals against themselves.

A large number of respondents (84%) felt there wasn't enough information around to help the public to report incidents.

In response to the results of this survey Healthwatch Barking and Dagenham made two recommendations; one for more information to be made widely available to the general public to recognise the signs of abuse and who to contact. The second to address the public's fears of possible reprisal, it would be helpful if literature could contain a statement about confidentiality.



These recommendations were taken on by the Adult Safeguarding Board for future publicity material.





# Speech and Language Therapy Services

In past years, Barking and Dagenham has had a history of delays in providing Speech and Language Therapy (SALT) services to the children in the borough. Healthwatch therefore decided to investigate the current service to see if the remodelled service of 2008 had been able to keep up with the increased pressure caused by the increased number of children now resident in the borough.

Healthwatch looked into the history of the service and interviewed parents, carers and SALT professionals and found that:

- The area of need has shifted from gaps in specialism to one of capacity. When in the past there were not enough specialist Speech Therapists (ST) it has now been remedied and the SALT team has access to enough specialism within their team and nationwide.
- The difficulty now resides with a longer waiting time than the expected 18 weeks between referral and treatment. The SALT department aims to keep an 18 week wait between referral and initial assessment as there is not enough staff to see all patients within a shorter time frame.

- Parents and carers, whilst happy with the quality of the service, have to wait for up to 8 months for the therapy to start. Parents also requested more therapy sessions as they felt that an increase, in what is given as standard, would improve the outcomes for their children.
- The lack of capacity within the SALT team has meant that keeping up with increased demand, created by the increase in population and the new schools opening in the borough, has added to their pressure. It is proposed that between now and 2020, 11 new schools (6510 places) will be provided in the borough.

Healthwatch therefore recommended that the borough of Barking & Dagenham:

- Continues to fund the Early Intervention service.
- Continues to fund Teaching Assistants within schools.
- Continues to fund two teaching posts for speech and language within The Education Inclusion Team.

Healthwatch also recommended that the Clinical Commissioning Group:

- Increases its funding to the SALT team in line with increased referrals to the team. This should reflect the increase in the child population of the borough and the undoubted increase in the number of school sites between now and 2020. The complexity of need is a further pressure.



# Hearing Impairments Adults

We took this project forward after individuals with hearing impairments chose to tell us about their experiences of GP services, audiology services, urgent care and services provided by the Local Authority.

In gathering the views of service users Healthwatch asked the participants about their experiences in these four specific areas:

- Experiences of the Audiology department(s) at Queens and King Georges Hospital and Broad Street.
- Access to the individuals GP surgeries
- Participants experience of council lead services.
- Access to Urgent Care

The findings highlight that there are issues with not only accessing GP appointments but also confusion over treatment and diagnosis.

Majority of respondents (52%) go to their surgery to make an appointment and 33% call the surgery.

Nearly half of the respondents (45%) said that they would prefer an alternative method to make appointments which is not available.

It was highlighted that a visual screen with the patients' name is a better way of communicating when it's the patients turn to be seen by the GP/nurse.

In terms of audiology services, issues highlighted were about the access to repairs and batteries for hearing aids.

53% said they did not find it easy to make an appointment when they had issues with their aid. The main reason highlighted was the waiting time for the appointment.

Participants' main area of concern was accessing urgent care services.

Feedback about Local Authority services varied; for some people the experience was positive and for others the services needed to make some improvements. Positive comments were made in terms of some people's experiences accessing equipment and signposting to other services. Questions were raised about the London Borough of Barking and Dagenham and the website, mainly on the fact that there was no test phone or Mincom number.

We have made recommendations to service providers and are currently waiting for a response.



# Hearing Impairments Children

Once receiving feedback from adults with hearing impairments and the issues they were having accessing health and social care services, Healthwatch decided to see what it was like for parents accessing services for children with hearing impairments.

Some of findings from the report were:

- Three quarters of (76%) of parents were happy with the staff at the audiology department (Axe Street Child and Family Centre).
- Parents (29%) told us that their experience was positive when they accessed the service for issues with equipment. Only 5% felt that the service could improve. (52% did not comment and 14% were unable to comment as they had experienced no problems with the equipment)
- A large number of parents felt that when you attend for an appointment the waiting times are far too long. Parents would like to see the time reduced.
- Feedback also highlighted that parents would like to see the same consultant when they take their children for their appointments.
- Parents spoke about different support mechanisms in place at school; these included the speech therapy service at school once a week, children sitting at the front

of the classroom and the positive experience of the Additional Resource Provision School.

- The majority (76%) of the parents feel that the school their child attends meets the needs of their child.

Taking into consideration the feedback, Healthwatch Barking and Dagenham made recommendations to North East London Foundation Trust :

- To consider if children can have the same consultant whenever they attend.
- To investigate why clinics are not running on time and find a way forward.
- To see if the T.V can be put on and provide small activities for children.

Healthwatch asked LBBB to consider the recommendations below:

- To continue to fund both the Teacher of the Deaf for children in school and the Teacher of the Deaf for the pre-school children.
- Additional Resource Provision (ARPS) sites to continue in the borough and consider increasing the provision when needed.
- With the support of LBBB, all ARPs to run a monthly/bi- monthly parent group as a pilot.

This report has been sent to the service providers and we are waiting for a response.



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## Adults A&E

All trusts have to meet the four hour waiting time limit which is currently at 95%. Our local trust Barking Havering Redbridge University Hospital Trust (BHRUT) was number other trusts at the end of 2014, who were not reaching their target of the four hour A&E wait.

Healthwatch wanted to find out why people choose to go to A&E, if they were aware of alternative services that could be used and how long they waited for.

Generally patients told us they did not have to wait too long to be seen and were waiting for test results. Overall most patients were seen in less than 2 hours.

Patients were asked how they felt unnecessary A&E attendance could be reduced and if anything could be done in the local community to help. Respondents told us that there needs to be better access to GP appointments and there should be more x-ray facilities available in the borough.

Patients who were sent by a professional felt justified in being there and felt they were in the right place.

Taking into consideration the feedback from patients Healthwatch recommendeds:

- The x-ray facilities within the borough need to be promoted more widely to ensure that patients and health professionals are aware of the choices. We recommend the CCG to send updated content to health professionals/services about local facilities to be shared with their patients and for professionals to use when signposting.

- The CCG need to work with the GPs to address the access issues that have been raised.

We sent the report to the CCG and have received a response

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“Thank you for sharing your report looking at why people go to A&E. This is a very helpful report which gives us an insight into the way people view A&E and the reasons they attend”.

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Please see response below in relation to the x-ray recommendation.

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“X-ray facilities - as you know there are X-ray facilities at the Walk in Centre at Barking Community Hospital. The service has had some technical difficulties over the last few months which may account for some patients needing to attend A&E. We believe these difficulties have now been resolved and on that basis we will be raising the profile of the X-ray facilities at the WIC as part of our ongoing development work with the service to manage more minor injuries and fractures at Barking Hospital.”

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## Children's A & E

The Child Health Profile of Barking and Dagenham (March 2014) indicates that in 2011/12 there were 12,152 attendances at Accident and Emergency Units (A&E) by children aged 4 years and under and resident in the Barking and Dagenham area. This rate is higher than the England average.

There were also discussions at the Child and Maternity sub-group about the high attendance rates of under 4 year olds at A&E and this was a concern for the sub group.

Healthwatch Barking and Dagenham wanted to look at the reasons behind parents attending A&E and also if they are aware of alternative services they can use instead.

Barking Havering and Redbridge University Trust (BHRUT) runs two paediatric emergency care departments. We attended both the emergency departments and children's centres to speak to parents.

In conclusion, parents choose to attend the A&E department for various reasons.

Some of the reasons given by parents were that they were unable to get a GP appointment for their child, they had called 111 and were told to go to A&E or they were sent an ambulance, their child needed an X-ray or everywhere else was closed. 42% of parents went straight to A&E before trying another service and gave different reasons as to why.

Parents (28%) felt that more needs to be done in terms of the promotion of services that can be used. This includes clear information for example "can you have an x-ray at a Walk-in Centre for under five year olds".



Furthermore, parents wanted to know what else is available for the under 2s as they felt the only option is for parents to take their child to their GP or A&E.

Taking into consideration feedback from parents Healthwatch recommended that the CCG produces information, with the involvement of parents, focusing on the options of urgent care available.

Clarity is needed for what is available for under 2s and to consider a drop in centre specifically for children.

One recommendation was made to the North East London Pharmaceutical Committee: to work with the local pharmacies that offer the minor ailments scheme and to promote this to their residents.

This report has been sent to the CCG and we have received the response below:

"We welcome the report by Healthwatch - improving urgent care services is a priority for the CCG and it is important that we hear about patient experiences of urgent and emergency care. The report identifies some recommendations for the CCG which we will feed into our plans to improve access to urgent care services."



# London Ambulance Service

Healthwatch Barking and Dagenham decided to look into the London Ambulance Service (LAS) as we had received feedback from service users about long waiting times. The LAS have also received a lot of bad press recently and have frequently been in our local newspaper.

Healthwatch Barking and Dagenham met with the Head of Patient & Public Involvement and Public Education at the LAS and with the Lead Duty Station Officer at the Romford Complex. We also spent a day with an ambulance crew.

We gathered patients' feedback on Streetlife and surveyed people at both the A&E departments who had used the ambulance service.

We found that:

- There is a difference in views between the managers and staff within the London Ambulance Service.
- The effectiveness of NHS 111 is disputed by staff. However we are not able to comment on the service as we were not given any official figures from the PELC.
- The general feeling is that the LAS service is good. A minority of people complain mainly when displeased with the waiting time. There seems to be a misunderstanding about what a life-threatening emergency really is.

- The LAS are experiencing a significant lack of staff. This is thought by crew to be a result of the training being too long and overqualifying for the job.
- Transfer times from an ambulance to A&E are problematic in BHRUT and a cause of frustration for the staff.

Healthwatch therefore recommended that:

- There needs to be an increase in publicity to define the proper use of the ambulance services.
- It is difficult for Healthwatch to comment on the effectiveness of the 111 service. However it remains the firm conviction of staff that NHS 111 has contributed to the increased demand of the LAS service.
- It would be helpful if this mismatch of perceptions could be addressed by the managements of both LAS and 111.
- Transfer times at the A&E department at Queens Hospital remain high and should be addressed by both the LAS and the A&E department.

The report has been sent to the London Ambulance Service and we await a response.



## Duty of Candour Project

The Duty of Candour project looked at the duty that all staff in residential settings have, to speak up and be open and honest if they see or suspect that their fellow employees are mistreating patients or residents. We wanted to discover how the duty of candour is understood and applied in one of the care homes.

Healthwatch found that there needed to be one easy message that communicates clearly to all staff working in the service - whether permanent or bank staff - what the duty of candour is and when it is appropriate to use the policies and procedures set out by the employer.

The findings showed that not all staff are made aware of what the outcome to a referral and what this means. Staff were also unclear that reading the policies and practices is part of their terms of employment.

The findings also highlighted that some staff are concerned about reporting incidents, out of fear of being penalised, isolated or bullied in their jobs. There should be written assurances, that for any incident they report, their managers will fully support them through the process.

This report has been sent to Adults Safeguarding Board and we await a response.





# Orthotic Services

The orthotic services for both adults and children in the borough of Barking and Dagenham have had a history of long delays in providing patients with their required support. Healthwatch decided to enquire and find out whether they are meeting the needs of the residents.

## Children

We spoke with professionals and interviewed 17 parents or carers of children between the ages of 18 months and 15 at Axe Street Child and Family Centre.

Overall we found that parents were happy with the service. Most parents had to wait no more than 2 months to receive their first orthotic support from the initial assessment and felt it had made a positive difference to their child's life.

All parents commented positively regarding the staff and said they felt listened to.

We discovered there is a big issue with 'Did Not Attends' regardless of all the efforts to encourage patients to keep appointments.

Based on the feedback we received, two recommendations were made; one was for the service users to be contacted after the appointment has been missed, this was to see if a trend could be identified. The second was to work with other services who have similar issues to look at ways to

bring the percentage of Do Not Attends down.



## Adults

We found it more challenging to gather the views of adult service users. We tried to engage those using the services of the Long Term Medical Centre in Harold Wood.

We provided 100 questionnaires with stamped addressed envelopes which were distributed to patients, but no responses came back.

Attending the clinic in person to interview service users was decided not to be time efficient, because Havering as well as Brentwood and Barking and Dagenham patients use the service at this location.

Taking these reasons into consideration, Healthwatch decided not to pursue the enquiry but will reconsider whether this service requires further investigation if residents give us negative feedback in the future.





# Maxillofacial

Healthwatch Barking and Dagenham carried out a 1 day consultation with patients using the Maxillofacial Service after some concerns were raised by members of the public from the borough.

The Maxillofacial service treats diseases, injuries and defects to the head, neck, face, jaws and the hard and soft tissues of the face region.

The views of service users highlighted areas of concerns, especially in terms of appointments.



The issues, and recommendations, have been highlighted below:

- The number of people having their appointments cancelled and re-booked was noted to be extremely high. The appointment process and for the Maxillofacial Service should be reviewed to reduce the number of re arranged appointments.
- Service users said that the time they had to wait for their first appointment to access the service was too long: Healthwatch recommended that a review should be carried out by the hospital trust, to reduce this waiting time.
- Consideration should be given to providing the option for patients who might prefer the choice, to choose and book their appointment on-line.

- The exchange of patient information between the Maxillofacial department and the appointment booking centre is reliant on a manual postal service. The hospital trust should consider putting a process in place that exchanges patient information for this service, without the use of a paper based system.

The report has been sent to the trust and we are waiting for a response.



# Personal Budgets Social Care

**This project was taken forward as a direct result of information given to us by personal budget holders. One example being individuals in receipt of personal budgets were unhappy with the influence their social workers have over how their budgets were spent.**

Personal Budget holders told us they were not fully aware of what they could use their budget for. Others told us they were not happy with the way their budget was managed. Therefore Healthwatch Barking and Dagenham wanted to find out more about the views of personal budget holders.

Feedback from the questionnaires shows that personal budgets are having a positive impact on the lives of the respondents. It has made a difference to many aspects of their daily life. For the majority of individuals it has given them choice, control and independence.

Respondents were asked if there were services/activities they wanted to access but were unavailable. Many of the respondents said there was nothing else they wanted to access. Some residents mistakenly named services that they thought were restricted to them.

There were 10% of respondents who said they wanted to access hydrotherapy sessions.

Many respondents said they did not have enough information on what services are available. This highlights the need for communication and promotion of what can be accessed.

Taking into consideration the views of the respondents we recommended:

- Adult Social Care services in the borough, needs to promote the Care and Support Hub to all personal budget users, as there is lack of awareness of it.
- The boroughs Arts and Leisure department could consider offering hydrotherapy sessions, locally, even on a trial basis to gauge local support.

We have written to the Head of Leisure Services and await a response on the hydrotherapy sessions.



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# Personal Health Budgets

*What are they?*

*When are they coming?*

*What does this mean?*

During this year we have been monitoring the transformation of primary care services in the borough and the impact this might have for local people in future.

Healthwatch wanted to understand the way services might be offered to patients in the borough i.e. individuals with long term and enduring health needs. One emerging way, was the provision of personal health budgets from NHS England, to be commissioned by the local Clinical Commissioning Group (CCG).

What we found was that uncertainty surrounds the criteria that will be used to decide who will be eligible to be offered a personal health budget beyond April 2016.

There is concern that people in Barking and Dagenham could be subject to inequality if service provision for personal health budgets is shared across Barking and Dagenham, Havering and Redbridge.

Healthwatch have produced a summary report which consists of what we found and the conclusions please visit [www.healthwatchbarkinganddagenham.co.uk](http://www.healthwatchbarkinganddagenham.co.uk)





# Stroke

This project emerged as Healthwatch received concerns about the borough not having enough provision in terms of stroke services. Furthermore there were issues raised about the two neighbouring boroughs having additional services that Barking and Dagenham do not commission.

The main aim of this project was to find out from stroke patients their experiences of using discharge services from hospital.

Areas highlighted from the service users included issues with discharge plans, information being exchanged between the stroke departments and primary care and the need for better community based services.

Taking into consideration the views and feedback received Healthwatch recommended:

- When a patient record has been created on the SSNAP system, an administrative follow up action should be put in place to ensure that patients who might eventually be diagnosed as not having a stroke, have that flagged up on their medical records or the record removed entirely.
- All patients should have a personalised, clearly understood and completed discharge plan that includes consideration for the needs of their family/carers. This should be shared with their GP.

- A robust and seamless method of exchanging patient information between Stroke and Primary Care GP services should be put in place for when stroke patients are discharged home. Timely prompts should be implemented - perhaps using IT systems - to alert GPs about a patient's changing clinical and social support needs.
- Consideration should be given to providing a community based service with dedicated support co-ordination and advice for stroke patients and their carers from Barking and Dagenham. The gap and inequality in service for stroke patients from the borough, compared with those living in Havering and Redbridge who access the same hospital stroke pathway should be closed.





# Putting Local People at the Heart of Improving Services

We have promoted and supported the involvement of local people in the commissioning, provision and management of local health and social care services. We use all our communication methods to promote news and events in relation to commissioning. We also ensure that people have adequate information to get involved.

Healthwatch have supported mental health users to get involved in the Mental Health Needs Assessment, a case study and the impact of this can be found on page 44.

We have trained individuals to become “Enter & View” representatives. The involvement of the representatives has influenced the recommendations made to providers and the changes that have been made to service provision.

For more information on the “Enter & View” visits we have conducted, please go to page 18 of the report. Alternatively, you can see a full report and the response from the providers on our website: [www.healthwatchbarkinganddagenham.co.uk](http://www.healthwatchbarkinganddagenham.co.uk)

Healthwatch were also involved in consulting with the public on the Clinical Commissioning groups priorities for the coming year and the Health and Well Being Strategy refresh, both documents will play a role in what is commissioned.

## Quote from a lay member

“I heard about Healthwatch through Streetlife. Yes I have given my views on lots of different aspects of health and social care. I have also attended the event on the Health and Well Being strategy where I had my say on the priorities for next year. Through Healthwatch I have had a chance to give my views.”

You are cordially invited to the first Barking and Dagenham event on our forthcoming **Mental Health Needs Assessment**

**time to listen time to change**

on World Mental Health Day  
Friday 10 October 2014 1.30-5pm

This is your opportunity to contribute your knowledge and experience on mental health needs and services in the borough - do please come along!

Conference Room, Barking Learning Centre, 2 Town Square, IG11 7NB

Lunch will be available from 1pm and the official event will start at 1.30pm

To register for this event, please contact:  
Marion Deacon on 07947 614235 or [marion.deacon@abflevents.com](mailto:marion.deacon@abflevents.com)  
by Friday 3 October 2014

Please also come along to our open event to see what services and resources are on offer in the borough

**time for world mental health day**

stalls free complementary therapies light refreshments

Friday 10 October 2014 10am-2pm  
The Gallery, Barking Learning Centre, 2 Town Square, IG11 7NB

We're supporting **time to change** let's end mental health discrimination

London Borough of **Barking & Dagenham**



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## Impact Stories

### *Involving Mental Health Service Users in Decision Making*

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#### The mental health needs assessment

For the mental health needs assessment, Healthwatch was involved in the initial planning for the event and ensured that 2 service user representatives were included at the planning stage.

This influenced the scope of who should be consulted within the borough; who should be invited to the events and what their format should be. Healthwatch made sure a reasonable lead-in time for invitations was in place for people to be able to plan to attend. Healthwatch was consulted during the needs assessment and had a stand at the World Mental Health Day events.

The outcome for Healthwatch Barking and Dagenham has been to influence the addition of 2 further patient representatives onto the HWBB MH Sub-Group.

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“I had no idea that Healthwatch existed. I was first informed about Healthwatch after I contacted the Mind organisation and spoke to a member of staff in their legal team.

Since, I have been in touch with Healthwatch I have felt supported and understood. Healthwatch gave me the opportunities to take part in important events which have changed my life.

When I contacted Healthwatch for the first time it was after I had exhausted all other avenues for some help. I felt that I had got to the point in my life when I started to realise

that no one really cared about mental health.

My opinion soon changed after my first phone call to Healthwatch.

The officer I spoke to was understanding and took the time to listen to what I had to say, but most importantly was never judgemental.

*Quote from a mental health user who wished to remain anonymous.*

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## Supporting our representative on the Health and Wellbeing Board to be effective.

The chair of Healthwatch Barking and Dagenham is our representative on the Health and Well Being Board (HWBB). The Chair attends the Board and the contract manager attends in a supporting role.

The agenda for the Health and Well Being Board consists of a lot of items, therefore to support the Chair, the agenda is taken to the Healthwatch Executive Board where items are distributed between staff and Board Members, and feedback is then given to the chair with any comments or queries on the particular areas that will be discussed at the HWBB.

The Chair has attended meetings where representatives from a number of Healthwatches get together to discuss challenges they are having in being a representative on the Health and Well being Board. This is a support mechanism for the chair and is valuable for sharing good practice.

Staff meet with the Healthwatch chair on a regular basis to discuss trends, concerns, reports and best practice, enabling the chair to raise health or social care issues at the Health and Well Being Board. The chair is also kept updated with any responses received from commissioners or service providers so she is able to use the evidence to influence change or question where necessary, during discussions at the Health and Well Being Board.

All Board members are also sent notices of national and local news including training, events, consultations and information days. Where members attend these, they report back to the whole board and team by providing a summary of the day. This method of communication is effective and the whole Healthwatch Team are kept updated.

The Health and Well Being Board have sub-groups which report back to the HWBB, Healthwatch have a representative on each sub-group. Representative's feedback at the Board meetings, so the chair has an update on the contribution from Healthwatch and can therefore offer constructive feedback when items are brought forward at the Health and Well Being Board.



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# Working with Others to Improve Local Services

Healthwatch have continued to develop partnerships this year to engage with various providers, stakeholders and commissioners.

We have worked in collaboration with local statutory organisations on a number of topics, including the Health and Wellbeing Strategy, The Barking and Dagenham Clinical Commissioning Group (CCG) priorities for next year, BHRUTs listening event and the Mental Health Needs Assessment.

The entire Healthwatch programme is designed to have the maximum impact on the service user's experiences of the health and social care services in Barking and Dagenham. By reporting back the views of the public to this and other relevant Boards we can ensure that the consumer is at the heart of all decisions made about their health and wellbeing,

## The Hub Event

Barking and Dagenham Clinical Commissioning Group (CCG) asked Healthwatch Barking and Dagenham to host a focus group to listen to and give feedback about, proposals to set up and provide additional GP services in the borough.

The group was attended by 18 people made up of local residents; other service providers; Healthwatch representatives; General Practitioners (GPs) and staff from the CCG and the Nuffield Trust.

A summary report of participants' feedback and of the questions raised during the session was produced.

The CCG have provided a written response to the questions raised and these are included in the summary.

## Quality Surveillance Group (QSG)

Healthwatch attends the QSG on a regular basis. The QSG brings together commissioners, regulators, local Healthwatch representatives and other bodies on a regular basis to share information and intelligence about quality across the system. The aim is to proactively spot potential problems as early as possible.

## Barking and Dagenham Clinical Commissioning Group (CCG)

We have met with the Chief Operating Officer and the Lay representative of the CCG a number of times and also have a non-voting seat on the Clinical Commissioning Group Patient Engagement Forum which we regularly attend.

## North East 'London Foundation Trust (NELFT)

NELFT are the providers for community health services and Mental health Services in the borough. We are involved in the mental health sub-group to ensure that the patients' voice is taken into account.

This year we were invited to attend the Integrated Patient Experience Partnership Meeting. Only one meeting has taken place so far. Healthwatch anticipate attending on a regular basis.





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## Impact Stories

### *Working in Partnership with the Local Clinical Commissioning Group and Public Health Influencing Plans for the Future*

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#### Have your Say

Earlier this year Healthwatch hosted an event to give local people a say on the Council's Health and Wellbeing Strategy and the Clinical Commissioning Group's plans for 15/16. This was delivered in partnership with the Clinical Commissioning Group (CCG) and the council.

The event was attended by over 100 local residents and organisations. A number of key themes emerged from the day.

The main areas highlighted were:

- Access to GP appointments needs to be addressed for example; some GPs open their doors at 8.30am but their phone lines open later which means people who are unable to get to their GP practice are unable to see their GP for an urgent appointment.
- Consideration needs to be given to re-using aids and equipment. It was felt that some equipment can be cleaned easily and should be re used.
- There needs to be clear communication with the public about new services. Participants felt this is crucial if the borough wants to improve the health and well being of local residents.
- Physical and mental health are seen as separate issues by services and professionals rather than having an impact on each other.
- There were both positive and negative comments about to the Intensive Rehabilitation Teams. Some participants felt that there is a clear choice when choosing to stay in hospital or going home and others felt that there is no real choice.

The feedback will contribute to inform the commissioning priorities and the outcomes of the Health and Wellbeing Strategy.

Quote from Clinical Commissioning Group, Senior Member

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**“We were delighted with the really high turnout at this event facilitated by Healthwatch and to hear so many different views from people about their health services.”**

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## Barking Havering Redbridge Hospital trust (BHRUT)

**healthwatch** Barking, Havering and Redbridge **NHS**  
Barking and Dagenham University Hospitals  
NHS Trust

**Your listening events with  
King George and  
Queen's Hospitals**

**You talk, we'll listen**

Monday 20th October 2014  
2pm to 4pm  
Wood Lane Baptist Church,  
Wood Lane  
Dagenham,  
RM9 5SL

Please join us at our first series of listening events to share your views about our hospitals with our Chief Executive Matthew Hopkins and your local Healthwatch.

If you would like to attend, email [communications@bhrhospitals.nhs.uk](mailto:communications@bhrhospitals.nhs.uk) or call 01708 503466

### “Enter & Views”

Both King George Hospital and Queens Hospital come under BHRUT. We have undertaken 2 “Enter & View” visits at the trust this year.

The trust accepted all the recommendations for both visits and have put an action plan in place, to ensure the changes take place.

Please see pages 18 and 19 for a summary of both visits or alternatively visit our website for a full report.

[www.healthwatchbarkinganddagenham.co.uk](http://www.healthwatchbarkinganddagenham.co.uk)

### Listening Event

Together with BHRUT we co-hosted the event and did a presentation to the public about Healthwatch and our work in relation to the services provided at the trust and how local peoples' views are represented.

Several senior staff from the trust were present including the CEO Matthew Hopkins.

It was a good opportunity for the public to pose direct questions to decision makers about different elements of the service.

The outcome for Healthwatch was a positive message in terms of people understanding what we do and our role.

The feedback from the event has prompted the trust to hold a follow up event in the borough in July 2015, to let local people know what action they have taken based on what people said.

**healthwatch**  
Barking and Dagenham

**Enter & View Visit  
Amber 'A' & 'B' Wards  
Queens Hospital  
Romford, Essex.**

For further copies of this report, please contact:  
[info@healthwatchbarkinganddagenham.co.uk](mailto:info@healthwatchbarkinganddagenham.co.uk)  
Or  
Telephone: 0208 526 8200

[www.healthwatchbarkinganddagenham.co.uk](http://www.healthwatchbarkinganddagenham.co.uk)



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## Health and Wellbeing Board

The Healthwatch Chair has a seat on the Health and Wellbeing Board. The Health and Wellbeing Board have five sub groups:

- Children and Maternity Sub-Group
- Public Health Programmes Board
- Learning Disabilities Partnership Board
- Integrated Care Sub-Group
- Mental Health Sub-Group

For each of the sub-groups except the Public Health Programmes Board a Healthwatch representative attends, contributes to discussions and ensures the voice of the service users is not missed.

## London Borough of Barking and Dagenham (LBBD)

We have a seat on the Safeguarding Adults Board, which we attend on a regular basis. At the end of last year Healthwatch were asked to engage with the local community to find out if they know how to raise a safeguarding concern. This work was completed and the Board have accepted the recommendations made.

## Joint Overview Scrutiny Committee (JOSC) - North East London

Healthwatch have attended JOSC meetings and given input at these.

## Health and Adult Services Select Committee (HASSC)

Healthwatch attend the HASSC on a regular basis. This year we presented the “Enter & View” report on Fern Ward to the committee. This was well received

and members would like to be kept updated future developments.

## Care Quality Commission (CQC)

We ensure that the CQC are up to date with our findings from “Enter & View” visits as well as other services they monitor. We have had no need to escalate reports for action, although have shared “Enter & View” reports to representatives from the CQC who attend the Quality Surveillance Group.

We have not made recommendations to the Care Quality Commission and they did not undertake special reviews or investigations following our recommendations.

## Healthwatch England

We have continued to keep Healthwatch England informed of the work we have undertaken.

We also attend The London Healthwatch Network. This gives a perspective on issues that Healthwatches are facing across London. It is an opportunity to share information and tackle issues London wide, cross borough organisations.

Other points to note.

- Where we requested information from Barking Havering Redbridge Hospital Trust and North East London Foundation Trust we have received a positive response. None of the providers refused us information.
- We have shared our reports with Healthwatch England; we have found no reason to escalate any matters to Healthwatch England.





# Have you Heard of Healthwatch



Healthwatch Barking and Dagenham (HW) believe it is only by listening to people who use the services that we can discover where improvements can be made. We use this information to hold services to account and share with the community where services are working well. In order for Healthwatch to assess if we are taking the right steps to engage with the local community, we undertook a survey “Have you heard of Healthwatch?”

Healthwatch Barking and Dagenham undertook this project to look at a number of things listed below: *If people have heard of us, how they heard of us, if they have used the service and what*

*the outcome was for them. We asked them if they have any ideas on what Healthwatch could do to reach the local community.*

We spoke to 176 people, out of those 48% had heard of Healthwatch and 52% had not.

66 of the questionnaires received were from young people. From the responses received from young people only 36% were aware of HW. This highlighted the need for targeted engagement with young people.

The main ways in which people had heard about Healthwatch were:

- 23% found out from the Youth worker at the Vibe
- 12% of respondents came to know of Healthwatch through the advert in the post.
- 8% came to know about HW through the stand at the Vicarage Shopping Centre

Themes also showed how people used the Healthwatch service, the main areas were:

- finding out how to make a complaint (23%),
- involvement with the personal budget survey (6%) and giving their views on
- health and social care services (6%)

Questionnaires also consisted of information on how HW made a difference to the service users. Many of the respondents (22%) made contact to find out how to make a complaint. Their feedback indicated that HW provided them with the information needed enabling them to make an informed decision and receive the help they needed.



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Furthermore 16% of respondents felt that HW gave them the opportunity to have their say on health and social care issues and 13% felt that they were given the chance to set priorities for the CCG. As part of the survey, respondents had the opportunity to tell HW how we could improve in the future. The three main areas highlighted were:

More adverts in the local paper about the results of what HW have done.

Larger advert in the paper

Marketing material for young people needs to be friendlier.

Taking into consideration the feedback received we are planning to:

- To establish better working links with the BAD youth forum. To meet with the forum every three months.
- Work with the BAD youth forum to design young people's friendly your voice card.
- Work with the BAD forum to see what areas of health/social care Healthwatch could potentially look at in the future.
- We will also take steps to ensure our work is showcased to the local community.
- Continue to have 4 public events per year.
- Continue to have stands across the borough in various sites, ensuring that there is a mixture of venues, including care homes and community centres.
- Have editorials within the paper which highlights reports from projects and "Enter & Views" inform the public of what Healthwatch has found and changes we have made.

## Opportunities and Challenges for the Future

Every year Healthwatch Barking and Dagenham look at the feedback received from the local community to help us plan work for the following year.

Healthwatch created a work plan from the trends that emerged. We asked the public, professionals and organisations to comment on the project areas identified and any changes they would like to make.

Projects included in the draft work plan are. (These may change once the feedback period ends.)

- Phlebotomy Service
- Saint Francis Hospice
- NHS private treatment
- BHRUT Appointment System
- Duty of Candour
- Mental Health: Young People
- The HUB
- Intensive Rehab Service and Community Treatment Teams
- Have you heard of Healthwatch?
- Healthwatch Project follow ups.
- "Enter & Views" at Health and Social Care Services

# Our Governance and Decision-Making





# Our Board

Our structure looks to ensure that local residents and stakeholders can influence how decisions are made and what priorities are taken forward. The Board takes the strategic lead in developing priorities of Healthwatch Barking and Dagenham ensuring the views of the community are listened to.

The Executive Board is set up with 8 seats. Membership is broken down into two main areas to ensure broad representation including lay members.

This includes the Chair, Executive Directors and Associates. There are 4 seats for Executive Directors. These seats are open only to individuals and not organisations or groups.

Each Director represents one of the areas below: • Health • Social Care • Children and Young People • Older people Associates

There are 3 seats for Associates. These seats are for organisations or groups representing a particular health/social care issue.

Board meetings take place on a monthly basis and are open to the public; dates are published on the website, through the e-bulletin and the social networking sites.

## Staff

The Chief Executive of Harmony House is the Contract Manager for Healthwatch.

We have three staff members who are Healthwatch Officers.

## The Board & Staff



**Marie Kearns**  
Contract Manager



**Frances Carroll**  
Chair



**Grace Kihu**  
Associate Director



**Lorraine Goldberg**  
Associate Director



**Harjinder Jutle**  
Executive Director



**Barbara Sawyer**  
Executive Director

## Healthwatch Officers



**Manisha Modhvadia**



**Claire Gooch**



**Richard Vann**





# How we involve lay people and volunteers

## Workplan

Healthwatch is all about local voices being able to influence the delivery and design of local services. We believe that the work we choose to undertake should come from local people.

Every year Healthwatch Barking and Dagenham look into the feedback we have received from the local community in order to plan projects for the following year. We then produce a work plan; which goes out to consultation to seek views from lay members and stakeholders. From the comments received a final work plan is produced for the year.

## “Enter & Views”

We encourage lay members to inform us of any services they feel we should “Enter & View” and why. We are very clear that they can stay anonymous as we are fully aware that for some they fear this will have an impact on service they receive.

We have received feedback from lay members which in turn has led us to undertake “Enter & Views” at various health and social care settings.

Our “Enter & View” representatives influence the questions and areas that will be looked at when the decision to undertake a visit is made!

The representatives come together for a pre-meeting to discuss how the visit should be taken forward and a group decision is made. They also play a big role in the recommendations that are made, once looking at the evidence gathered from visits.

## Executive Board

We have lay members who represent the local community at strategic level. They are involved at Board level ensuring the lay perspective is listened to and influence the work of Healthwatch.

## Interested Participants

We also have lay members who have registered their interest with Healthwatch. They give their opinions on the work-plan, consultations, receive e-bulletins and feedback to Healthwatch on health and social care services they have accessed. They also share Healthwatch information to groups and family members.

## Healthwatch Projects

When Healthwatch are undertaking projects, we ask the public to see if they are interested in volunteering for a particular area of work. For example whilst undertaking the Hearing Impairments project a lay member heard about the project and came forward to help us complete questionnaires and gather feedback from people using the services. She played an active role in ensuring people knew that Healthwatch were undertaking the project and their views were important.

Interested in volunteering  
Call us on 020 8526 8200



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## Case Study

### *Volunteering Impact*

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**Penny has been volunteering with Healthwatch Barking and Dagenham. Penny is deaf and has not been in work for over 10 years.**

She saw our volunteer advert at Barking and Dagenham Council for Voluntary Services, Penny was very interested and took the advert to the job centre to show her advisor. Her advisor made contact with our volunteer lead and passed on Pennys contact details informing us to use email as a way of contacting Penny as she has a hearing impairment and prefers text or email.

The volunteer lead arranged with Penny to come in for a Penny for an informal chat, we ensured there was a BSL interpreter to support her. She now comes to volunteer once a week and has been with us for over 6 months.

Penny volunteers in the office and is slowly learning about office skills, she also feeds back about the services her friends and family have accessed.

She is currently taking a typing course and feels she needs to improve her typing skills; we have therefore worked with Penny to work with her on the areas she would like to develop.

We are glad Penny has chosen to volunteer for Healthwatch and we hope that we will be able to support her in the understanding the system better and to meet her future ambitions.

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**Penny says “I have gained knowledge about services for example I’m beginning to understand more on how clinics across the borough offer the same services and who they are run by. Volunteering at Healthwatch is helping me to understand more about Health and Social Care Services. I am keen to update my administration skills and volunteering at Healthwatch is helping me to work towards my goal. I still have a lot to learn and need to build my confidence but the Healthwatch team support me and this is helping me, there are challenges because of my hearing but we overcome them as they come”**

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# Financial information

INCOME		£
Funding received from local authority to deliver local Healthwatch statutory activities		£125000
Additional income		£0
<b>Total income</b>		<b>£125000</b>

EXPENDITURE		
Staffing and associated costs		£83,950
Accommodation costs		£20,000
Equipment and stationary		£3550
Consumable/Administration		£5,000
Other Overheads		£2,500
Marketing costs		£5000
Engagement and outreach costs		£5000
<b>Total expenditure</b>		<b>£125000</b>
Balance brought forward		£0

# Contact us

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Dagenham  
RM9 6XN

Phone number: 020 8526 8200

Email: [Info@healthwatchbarkinganddagenham.co.uk](mailto:Info@healthwatchbarkinganddagenham.co.uk)

Website: [www.healthwatchbarkinganddagenham.co.uk](http://www.healthwatchbarkinganddagenham.co.uk)



# Making our report available

We will be making this annual report publicly available by 30th June 2015 by publishing it on our website and circulating it to Healthwatch England, CQC, NHS England, Clinical Commissioning Group/s, Overview and Scrutiny Committee/s, and our local authority.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format please contact us at the address above.

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## HEALTH AND WELLBEING BOARD

20 OCTOBER 2015

<b>Title:</b>	<b>Health and Adult Services Select Committee's Scrutiny Review on Local Eye Care Services</b>		
<b>Report of the Health and Adult Services Select Committee</b>			
<b>Open Report</b>		<b>For Decision</b>	
<b>Wards Affected:</b> None		<b>Key Decision:</b> No	
<b>Report Author:</b> Masuma Ahmed, Scrutiny, Legal & Democratic Services		<b>Contact Details:</b> Tel: 020 8227 2756 E-mail: <a href="mailto:masuma.ahmed@lbbd.gov.uk">masuma.ahmed@lbbd.gov.uk</a>	
<b>Sponsor:</b> Anne Bristow, Strategic Director for Service Development and Integration			
<b>Summary:</b>			
<p>At the start of the 2014/15 municipal year, the Health and Adult Services Select Committee agreed to undertake an in-depth scrutiny review into local eye care services. Appended to this cover report is the final report arising from this scrutiny, which makes six recommendations to the Health and Wellbeing Board to help improve the eye care pathway and raise the profile of eye health in the borough. The Committee's report (at Appendix 1) provides the background to why Members chose to review this area, the methodology for the scrutiny, what the scrutiny found in relation to the eye health of Barking and Dagenham residents, and the evidence base for six recommendations made to the Health and Wellbeing Board to improve the delivery and take-up of local eye care services.</p>			
<b>Recommendation(s)</b>			
<p>The Health and Wellbeing Board is recommended to agree the following recommendations made by the Health and Adult Services Select Committee in its Scrutiny Review report on Local Eye Care Services 2014/15:</p> <p>That the Health and Wellbeing Board:</p> <ol style="list-style-type: none"> <li>1. Oversees a review by the Barking and Dagenham Clinical Commissioning Group (CCG) of the local eye care pathway, given that: <ul style="list-style-type: none"> <li>• The current arrangements seem complex and difficult for patients to understand;</li> <li>• It is not clear that everyone who should have a sight test is getting one; and</li> <li>• It was not clear to the HASSC that the pathway currently fully promotes choice and control by service users;</li> </ul> </li> <li>2. Oversees a review by the CCG which considers the clinical benefits of community optometrists (high street opticians) being able to refer patients directly to hospital eye clinics and other services rather than having to do this via GPs;</li> </ol>			

3. Asks the CCG to consider the benefits of commissioning an 'Eye Care Liaison Officer' for local residents, to ensure that people with newly acquired sight loss are provided with support at the point of diagnosis and signposted to appropriate services;
4. Asks the CCG to consider whether cost-effective improvements could be made to local low vision services, given that the HASSC found that in other parts of London these services are delivered closer to where people live and provide tailored support to ensure that visually impaired people are able to make ongoing, beneficial use of magnifiers and other equipment provided to them;
5. Oversees a local communication campaign undertaken by the Council's Public Health Team emphasising the importance of having regular eye tests, whilst also delivering other important eye care messages as part of the future programme of public health campaigns; and
6. Considers a range of options to 'make every contact' count and introduce a scheme or schemes to encourage and possibly incentivise parents to arrange an eye test for their child prior to starting school.

#### **Reason(s)**

This report relates to the Council's priority to enable social responsibility and under it the objectives to "ensure everyone can access good quality healthcare when they need it" and "protect the most vulnerable, keeping adults and children healthy and safe."

## **1. Introduction and Background**

- 1.1 In September 2014 the Health and Adult Services Select Committee (HASSC) agreed to undertake an in-depth scrutiny review into local eye care services. There were a variety of reasons for this; Members hypothesised that the cost of glasses was deterring local residents from having an eye test every two years and they also felt that eye care was an important area to review due to the very serious impact sight loss can have on lives. Furthermore, Members noted that people in the borough were more likely to experience health conditions that could lead to sight loss than was the case in most other areas of the country.

## **2. Proposal and Issues**

- 2.1 During the Review, although Members came to the view that there was a good range of eye care services in the borough, they received evidence suggesting that the eye care pathway was more complicated than it needed to be and that the availability of certain services in the community could potentially improve the experience of those living with sight loss. National research suggested that the take-up of free NHS eye tests in poorer areas was lower than in affluent areas; given the borough's economic profile, Members felt this would also be applicable locally. Members noted that NHS glasses and eye tests for children were free but there was no 'systematic' way of ensuring that all children were having regular eye tests; it was down to parents to take their children to a local optometrist practice



for a test. This could potentially lead to variability in the numbers of children from different backgrounds having regular eye tests. The report arising from this Review therefore makes six recommendations to the Health and Wellbeing Board to help address these issues.

- 2.2 Members received a number of presentations, took part in a workshop with local stakeholders, considered local data and research provided by the Council's Public Health Team, commissioned surveys and received submissions from local stakeholders on the eye care pathway as part of the methodology for the Review. Pages 8 to 10 of the HASSC's report provides further detail on the Committee's methodology.
- 2.3 It is good practice for the select committees to request updates on the progress of recommendations arising from scrutiny reviews. In response to previous HASSC scrutiny review recommendations the relevant sub-group of the Health and Wellbeing Board has produced and overseen the action plans on how the recommendations will be implemented. 'Monitoring' reports were subsequently presented to the HASSC approximately six months after the approval of the recommendations. This principle is supported by the Department of Health's 'Local Authority Health Scrutiny' guidance document (2014) which says that "Relevant NHS bodies and health service providers to whom scrutiny reports have been presented should be prepared for this kind of follow-up and be able to report on progress and improvements resulting from scrutiny reviews." Should the Board accept the recommendations of the Local Eye Care Services scrutiny review report, the HASSC would request that a progress report be submitted to it in approximately six month's time in order that the Committee can evaluate the impact of the review.

### **3. Consultation**

- 3.1 Members engaged with the following groups and individuals as part of this Review which supported them with the formulation of the recommendations:
- The Local Optical Committee (representing local opticians);
  - The Vision Strategy Group
  - Ophthalmologists from Queen's and Moorfields Hospitals
  - Edward Watts Opticians - providing a Low Vision service at Queen's Hospital
  - Choices Independent Living Agency
  - Thomas Pocklington Trust
  - East London Vision
  - Macular Disease Society
  - VIPERS (local organisation of visually impaired people)
  - The Magnifier and Lighting Workshop
  - Bridge to Vision
  - The Council's Sensory Impairment service
  - Electronic visual aids

## **4. Mandatory Implications**

### **4.1 Joint Strategic Needs Assessment**

The priorities for consideration in this report align well with the strategic recommendations of the Joint Strategic Needs Assessment. It should be noted, however, that there are areas where further investigation and analysis have been recommended as a result of this year's JSNA. The purpose of the ongoing JSNA process is to continually improve our understanding of local need, and identify areas to be addressed in future strategies for the borough.

### **4.2 Health and Wellbeing Strategy**

This report aligns and supports our Health and Wellbeing Strategy delivery plan on the need to promote eye health and prevent sight loss across the life course.

### **4.3 Integration**

One of the outcomes we want to achieve for our Joint Health and Wellbeing Strategy is to improve health and wellbeing outcomes through integrated services. The report makes several recommendations related to the need for effective integration of services and partnership working.

## **5. Financial Implications**

5.1 The Health and Wellbeing Board is being asked to consider six recommendations made in this report. Recommendations 1 to 4 are to the Clinical Commissioning Group (CCG) and therefore, at this stage, not expected to have a financial implication to the Council. If this recommendation is agreed by the Health and Wellbeing Board, future reports to the Board on the implementation of the recommendations will need to set out any potential financial costs and benefits to the Council and to the CCG.

Recommendation 5 (overseeing a local communication campaign) will affect the Council in terms of officer time and the recommendation suggests that funding would be from the Public Health Grant. If the recommendation is agreed, the funding would need to be confirmed and contained within existing Public Health budgets.

The financial implications of recommendation 6 (making every contact count) to the Council need to be determined. Again, if this recommendation is agreed by the Health and Wellbeing Board, future reports on how the recommendation will be implemented will need to set out any potential financial costs and benefits to the Council.

(Implications completed by: Carl Tomlinson, Group Finance Manager, LBBD)

5.2 The allocation of CCG management resource to implement recommendation 1 would need to be considered in the context of other programmes of work that have been prioritised for this financial year.

The financial implications of recommendations 2, 3 and 4 would need to be determined. CCG investment is subject to Governing Body approval which would take into consideration the available resources and potential benefits of investment alongside other priority areas.

(Implications completed by: Rob Adcock, Deputy Chief Financial Officer, Barking and Dagenham CCG)

## **6. Legal Implications**

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 under the National Health Service Act 2006 (governing the local authority health scrutiny function) give the Council the power to review and scrutinise matters relating to the planning, provision and operation of the health service in the borough and make reports and recommendations to NHS bodies; the expected response time is within 28 days. The Council's Constitution delegates these duties to the Health and Adult Services Select Committee. The Select Committee has made six recommendations to the Health and Wellbeing Board as the body which would oversee any changes arising as a result of this report.

(Implications completed by: Dawn Pelle, Adult Care Lawyer, Legal & Democratic Services)

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

None.

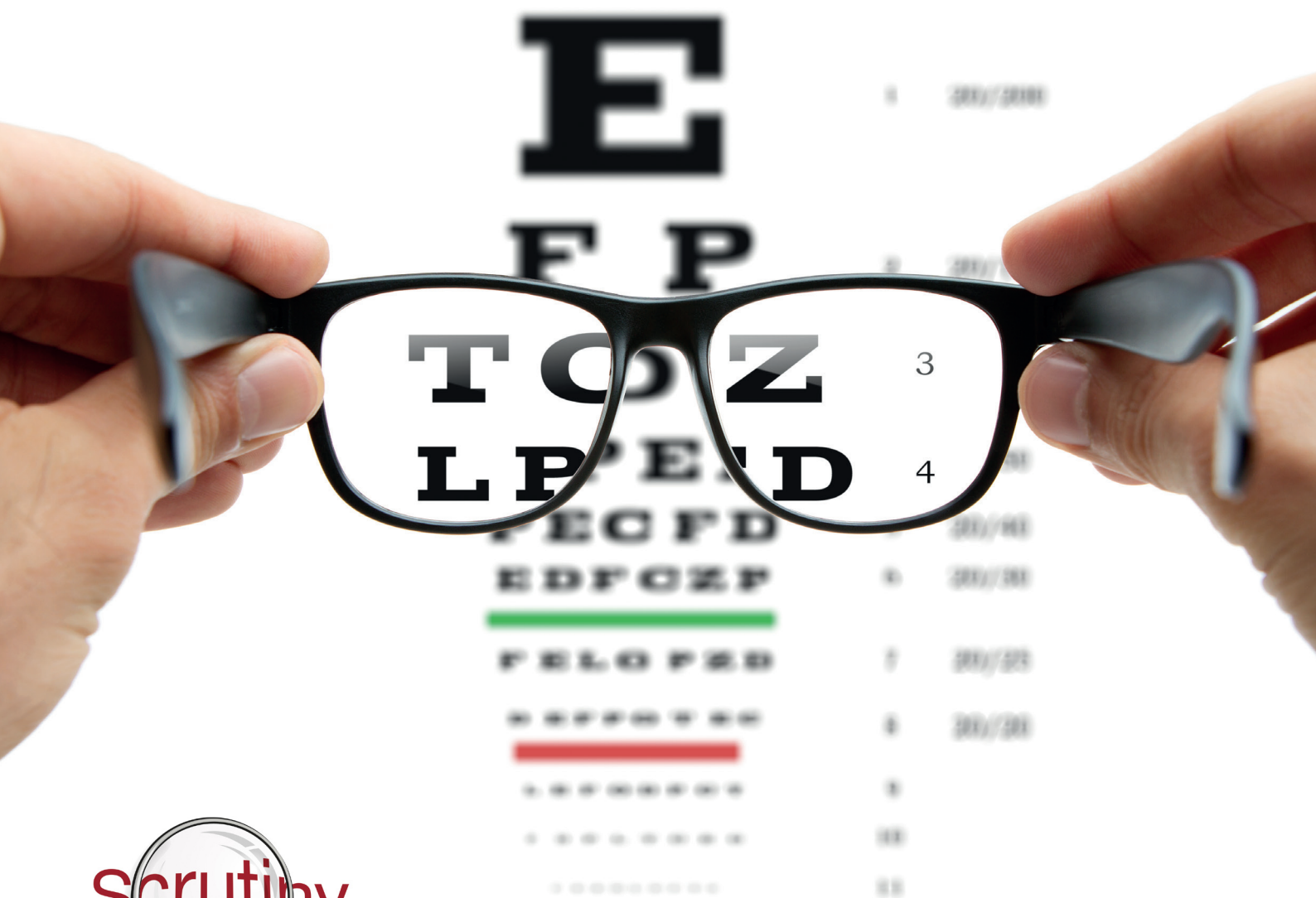
### **List of Appendices:**

**Appendix 1 -** Scrutiny Report of the Health and Adult Services Select Committee on Local Eye Care Services 2014/15.

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# Health and Adult Services Select Committee

Local Eye Care Services:  
In-depth Scrutiny Review 2014/15



**Contact:**

Scrutiny  
Legal & Democratic Services  
Civic Centre  
Dagenham  
Essex RM10 7BN

**Email:** [scrutinyinbox@lbbd.gov.uk](mailto:scrutinyinbox@lbbd.gov.uk)



## Lead Member's Foreword

The Health and Adults Services Select Committee (HASSC) is a scrutiny committee made up of local councillors who want to help improve health and social care outcomes for the borough's residents by working with the Council and its partners to improve services and hold decision makers to account.

In 2014/15, as the Chair of the Committee, I oversaw an in-depth review into Local Eye Care Services. We chose to review this area as we felt that the fear of having to pay a high cost for glasses was possibly putting local people off having regular eye tests, which could mean that many people were missing out on early diagnosis of eye diseases, such as diabetes and glaucoma. We were concerned that there needed to be more public awareness around the importance of eye health to ensure that eye care services are accessed in a timely manner by those who really need them.

We felt that eye care was an important area to review due to the serious impact sight loss can have on people's lives. Dealing with the emotional, social and financial impact of sight loss can be extremely difficult, which can be made worse by barriers to accessing services such as housing, education, leisure and travel.

Our Review found that there are a good range of eye care services available locally. However, research told us that the fear of having to pay for expensive glasses is acting as one of the barriers to people having an eye test as often as they should and this view was supported by a survey we did of local residents. Furthermore, we found that the pathways involved in accessing eye care services seem complicated and difficult to understand. We feel that changing the role of primary services could help simplify pathways, leading to a better experience for people using eye care services.

In this report we have made recommendations which seek to raise the profile of eye health and strengthen the way eye care services are delivered to local people. We will review the progress of the recommendations six months after publishing this Report. We hope that the Health and Wellbeing Board, the Council and the Barking and Dagenham Clinical Commissioning Group support our recommendations so that as partners we can make a tangible, positive difference to the eye health outcomes of our residents.

*Eileen Keller*

**Councillor Eileen Keller**

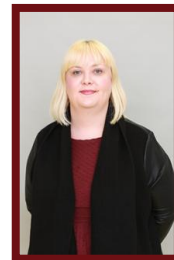
Lead Member, Health & Adult Services Select Committee 2014 - 2016

# Members of the HASSC 2014/15 and 2015/16

The HASSC members who carried out this Review were:



**Councillor E Keller** (Lead Member)



**Councillor D Lawrence**  
(Deputy Lead Member)



**Councillor S Ahammad**



**Councillor S Alasia**



**Councillor A Aziz**



**Councillor S Bright**



**Councillor P Chand**



**Councillor F Choudhury**



**Councillor E Fergus**



**Councillor H S Rai**



**Councillor A Oluwole**

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## Recommendations arising from this Review

For ease of reference all the recommendations are provided below.

### The HASSC recommends that the Health and Wellbeing Board:

- 1.** Oversees a review by the Barking and Dagenham Clinical Commissioning Group (CCG) of the local eye care pathway, given that:
  - The current arrangements seem complex and difficult for patients to understand;
  - It is not clear that everyone who should have a sight test is getting one; and
  - It was not clear to the HASSC that the pathway currently fully promotes choice and control by service users;
- 2.** Oversees a review by the CCG which considers the clinical benefits of community optometrists (high street opticians) being able to refer patients directly to hospital eye clinics and other services rather than having to do this via GPs;
- 3.** Asks the CCG to consider the benefits of commissioning an 'Eye Care Liaison Officer' for local residents, to ensure that people with newly acquired sight loss are provided with support at the point of diagnosis and signposted to appropriate services;
- 4.** Asks the CCG to consider whether cost-effective improvements could be made to local low vision services, given that the HASSC found that in other parts of London these services are delivered closer to where people live and provide tailored support to ensure that visually impaired people are able to make ongoing, beneficial use of magnifiers and other equipment provided to them;
- 5.** Oversees a local communication campaign undertaken by the Council's Public Health Team emphasising the importance of having regular eye tests, whilst also delivering other important eye care messages as part of the future programme of public health campaigns; and
- 6.** Considers a range of options to 'make every contact' count and introduce a scheme or schemes to encourage and possibly incentivise parents to arrange an eye test for their child prior to starting school.

## Executive Summary

The Health and Adult Services Select Committee undertook an in-depth scrutiny review into local eye care services between September 2014 and July 2015. Members felt strongly that this was an important area to review due to the impact sight loss can have on people's lives.

Sight naturally deteriorates as people grow older and for this reason it is important that everyone has a sight test with an optometrist at least once every two years to ensure that problems are identified at an early stage, that people are prescribed appropriate glasses, and get any medical treatment that they require.

The prevalence of severe sight loss is high in people over the age of 70. The most common causes are:

- Age related macular degeneration;
- Cataracts;
- Diabetic retinopathy; and
- Glaucoma.

Regrettably, people who develop these conditions often wait too long to get the help that they need. This can lead to:

- Loss of independence;
- Falls, resulting in injury;
- Isolation;
- Depression; and
- Suicide.

This scrutiny review revealed that eye care provision locally is generally very good and compares well with the standards set by the UK Vision Strategy and the 'Seeing it My Way' Charter. Take up of retinal screening is high and although the rate of registration of people as 'Sight Impaired' and 'Severely Sight Impaired' is much lower than the actual numbers predicted, figures are higher than Barking and Dagenham's Statistical Partners.

Further optimising the rate of registration of people as Sight Impaired and Severely Sight Impaired would benefit people with sight loss because the process acts a referral to the Council's Sensory Service and ensures that people receive the information and support that they need, including specialist mobility training and rehabilitation.

The Scrutiny also identified some areas of concern that warrant further investigation.

Members noted that the eye care pathway seems complicated and confusing in places. Although high street optometrists are pivotal and the first point of contact in the eye care journey for most people, they are currently unable to refer people directly to the eye clinic at the hospital or to the stand-alone retinal screening service. Currently all referrals must be made via GPs, which can lead to delays and confusion.

Members asked consultant ophthalmologists from Moorfields Eye Hospital and the eye department at Queen's Hospital whether patients could opt to transfer between the two services. Members noted that this is possible but that due to systems issues it is difficult to do in practice. This raises questions about the degree to which patients are able to exercise real choice and control.

Written submissions from the Local Optical Committee (LOC), and the Thomas Pocklington Trust pointed out that community optometrists have the necessary training to provide many primary eye care services, including diabetic and glaucoma screening. They argued that if optometrists were commissioned to provide these services this could improve access, simplify processes for patients, avoid delays and even reduce costs.

Figures provided by the LOC show that 19% of people in Barking and Dagenham had a sight test last year. This rate is significantly lower than the rates in Havering and Redbridge and well short of the optimum rate of about 50% (everyone should have a sight test every two years and at risk groups more often).

A survey of local people demonstrated that the fear of the cost of buying glasses is an obstacle to having a sight test done in practice for some people. This mirrors the findings of national research which showed that the take-up of free NHS sight tests is substantially lower in areas with high levels of social deprivation.

Written submissions pointed out that there is no longer an 'Eye Care Liaison Officer' at Queen's Hospital. This post used to help ensure that those faced with the shock of newly diagnosed severe sight loss were provided with immediate support and referred on to relevant services. The loss of this post raises questions as to whether increasing numbers of visually impaired people are being left without the help and support that they need.

# 1. Background & Introduction

## Why did the Health and Adult Services Select Committee (HASSC) choose to undertake an in-depth review on Local Eye Care Services?

1.1 The Council's scrutiny committees decide what topic to undertake an in-depth review on based on the 'PAPER' criteria. The section below explains why according to this criteria 'local eye health services' was a good topic to review.

### PUBLIC INTEREST

Sight loss can have serious emotional, social and financial impacts on lives – clearly a review into this area and how better access to services could help prevention, would be in the public interest.



### ABILITY TO CHANGE

Members questioned whether services were capable of change for the better. We presumed they were but wanted to test this by engaging with local groups and professionals.



### PERFORMANCE

Informal feedback told us that many people were not going for eye tests regularly and that the eye care pathway was complicated.



### EXTENT OF THE ISSUE

We knew that people living in the borough were more likely to experience health conditions that could lead to sight loss than was the case in most other areas of the country and that predictions about the numbers of people with low vision underestimated the level of local need.



### REPLICATION

We considered that a member-led review into eye care services would produce useful recommendations and would not replicate the work of other local bodies.



## **2. Scoping & Methodology**

2.1 This section outlines the scope of the Review which includes the areas the HASSC wished to explore and the different methods the HASSC used to collate evidence for potential recommendations.

### **Terms of Reference**

2.2. Having received a scoping report at its meeting on 20 January 2015, the HASSC agreed that the Terms of Reference for this Review should be:

- Whether there are gaps or obstacles in current service and pathways;
- How supply and take-up of optometry and other eye services compares with other London boroughs and the national average;
- Whether local low vision services for blind and partially sighted people are fit for purpose and whether take-up is appropriate;
- The Clinical Commissioning Group's plans regarding eye care services;
- The role of GPs;
- Emotional and other support for people newly diagnosed; and
- How well local services for blind and partially sighted people rate when benchmarked against the national "Seeing it My Way" Charter.

### **Overview of Methodology**

2.3 The Review gathered evidence during the Committee's meetings held between 30 September 2014 and 16 June 2016. Details of stakeholders and their contributions to this Review are outlined below.

### **Presentation – the National Picture**

2.4 On 20 January 2015 Peter Corbett (Chief Executive) and Phil Ambler (Director of Policy) from the Thomas Pocklington Trust delivered a presentation to the Committee outlining the eye care picture from a national perspective.

This considered:

- The current prevalence of sight loss;
- Future demographic changes;
- The relationship between sight loss and public health;
- The impact of sight loss; and
- Problems visually impaired people face.

### **Simulation Spectacles**

- 2.5 Members had the opportunity to try on simulation spectacles which give an impression of the impact of the most common uncorrectable eye conditions.

### **Presentation – the Local Picture**

- 2.6 At the HASSC meeting of 4 March 2015 Matthew Cole (Director of Public Health) delivered a presentation providing the local picture on eye care. This covered:

- Local prevalence of major eye care conditions;
- The relationship between eye care and other local health issues;
- Prevention of sight loss and eye health; and
- Local services and pathways.

### **Workshops with local stakeholders**

- 2.7 Mr Cole's presentation was followed by a participative, exhibition-style workshop which gave members the opportunity to gauge the extent and depth of local eye care services.

### **Surveys**

- 2.8 During April 2015 an online staff survey was undertaken by the Public Health Team. This asked LBBT staff questions about the frequency of their eye tests and gauged their awareness of eye care issues.
- 2.9 This was followed up by a survey of local residence completed during July 2015.

### **Submissions**

- 2.10 During the Review Jig Joshi, Chair of the Local Optical Committee, and the Thomas Pocklington Trust submitted statements to the

HASSC expressing views about current provision and pathways and potential areas for service improvement.

## Research

2.11 During the Review Council Officers considered the following pieces of research.

- Sight - the most critical sense for public health? (Journal of Public Health. 2015)
- Geographical inequalities in take up of NHS-funded eye examinations: small area analysis of Leeds (Shickle D et al. Journal of Public Health. 2014)
- Certifications for sight impairment due to age-related macular degeneration in England (Bunce C et al. Journal of Public Health. 2015)
- Estimated prevalence of visual impairment amongst people with a learning disability in the UK (Emerson E et al. Learning Disabilities Observatory. 2011)
- Prevalence, causes and impact of sight loss in older people in Britain (Research findings. Thomas Pocklington Trust. 2005)
- Older people and eye tests – Don't let age rob you of your sight (Cowan L et al. RNIB Publications. 2007)
- Addressing inequalities in eye health with subsidies and increased fees for General Ophthalmic Services in socio-economically deprived communities: a sensitivity analysis (Shickle D et al. Journal of Public Health. 2015)
- Improving patient access to prevent sight loss: ophthalmic electronic referrals and communication (Khan A et al. Journal of Public Health. 2015)
- The UK Vision Strategy
- The Barking and Dagenham Vision Strategy – “Excellent Eye Care for Local People”
- The Joint Strategic Needs Assessment
- Seeing It My Way (RNIB)
- Public Health and adult social care performance data published by the Department of Health.
- Data from the National Epidemiology of Eye Health and Local Optical Committee Support Unit data bases.

## 3. Sight Loss – the National Picture

### 3.1 What does good eye care look like?

The national ambition for eye care is set out in the Vision 2020 UK Vision Strategy.

Eye care services should aim to minimise preventable sight loss, support those with unavoidable vision impairment, correct refractive error, and preserve or restore sight where possible - enabling people to live their lives as fully and independently as possible.

Eye health should not be considered in isolation to wider health and wellbeing. Public health has a key role in ensuring this, through its role in local authorities, CCGs, Health and Wellbeing Boards, and working with Local Eye Health Networks, by providing objective dialogue and interpretation of eye health needs, information and intelligence in the context of broader population health and public health interventions for health improvement. 'Securing the best value for financial investment means that sight is preserved where possible, and that people are able to care for themselves, in their own home, for as long as possible. 'Integrated working between health and social care supports the best use of resources as well as supporting patients and people to have better outcomes. Integrated systems between health and social care are essential.'<sup>1</sup>

The "Seeing it My Way" Charter, drawn up by the Royal National Institute for the Blind (RNIB) and a range of Stakeholders (including Bill Brittain from LBBD, representing the Association of Directors of Adult Social Services), sets out the standards for services for visually impaired people with sight loss that cannot be corrected with glasses.

### 3.2 What is meant by sight loss?

Sight loss can be seen as a continuum with refractive error that is easily corrected with glasses at one end of the scale, and total blindness at the other. Refractive errors such as short and long sightedness are very common amongst adults over 40 and are general wholly correctable with glasses or contact lenses.

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<sup>1</sup>Response to Improving eye health and reducing sight loss –a call to action, Clinical Council for Eye Health Commissioning, 13 October 2014: <http://www.college-optometrists.org/en/utilities/document-summary.cfm?docid=BEFADCCE-92A9-4352-8E8D74C3264570D6>



### 3.3 The Impact of Sight Loss

RNIB estimates that two million people in the UK are living with some level of sight loss, which equates to about three percent of the population.

Prevalence of sight loss increases with age and it is estimated that 20 percent of those over 75 have sight loss, rising to 60 percent in those over 90.



As much as 50 percent of all sight loss can be prevented if sight problems are identified early enough. For this reason it is really important that everyone has a sight test with an optometrist at least once every two years.

Depending upon the severity, visual impairment can have a variety of negative consequences for people experiencing it. This can range from eye strain and headaches for people who do not realise that they need glasses to loss of independence, social isolation and severe depression for people who develop severe sight loss.

The HASSC considered a range of research to form 'the national picture' and also heard evidence from Phil Ambler, Director of Policy at the Thomas Pocklington Trust, on the severity of the impact of sight loss. Notes from this session are provided at Appendix 1.

### 3.4 Eye Care Terms

Throughout this report certain terms are defined in a yellow box. Below are some terms used throughout this report.

#### **Optician**

A general term used to describe optometrists (see below) and dispensing opticians who are professionals qualified to undertake sight tests, identify diseases of the eye and prescribe and supply spectacles and contact lenses

#### **Optometrist**

An optician trained to undertake sight tests, identify many diseases and problems of the eye and prescribe glasses and contact lenses. They are very often based in high street optician shops.

#### **Consultant Ophthalmologist**

A senior doctor who specialises in the medical and surgical care of the eyes and visual system, and in the prevention of eye disease and injury.

### 3.5 Common Eye Care Conditions and their Impact on Vision

Members had the opportunity to try on simulation spectacles, which give an impression of the impact of common eye conditions. Below are images which depict how these conditions can affect vision (for definitions see paragraph 4.15 onwards).

#### Macular degeneration



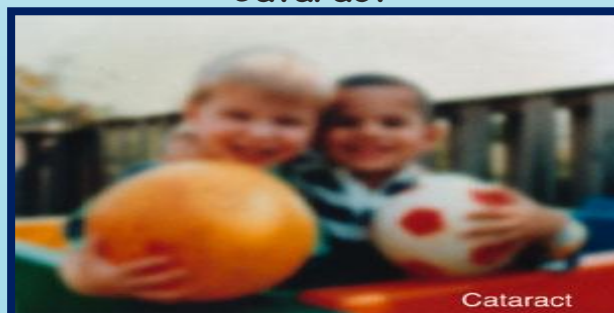
#### Diabetic retinopathy



#### Glaucoma leading to tunnel vision



#### Cataract



## 4. The Local Picture in Sharper Focus

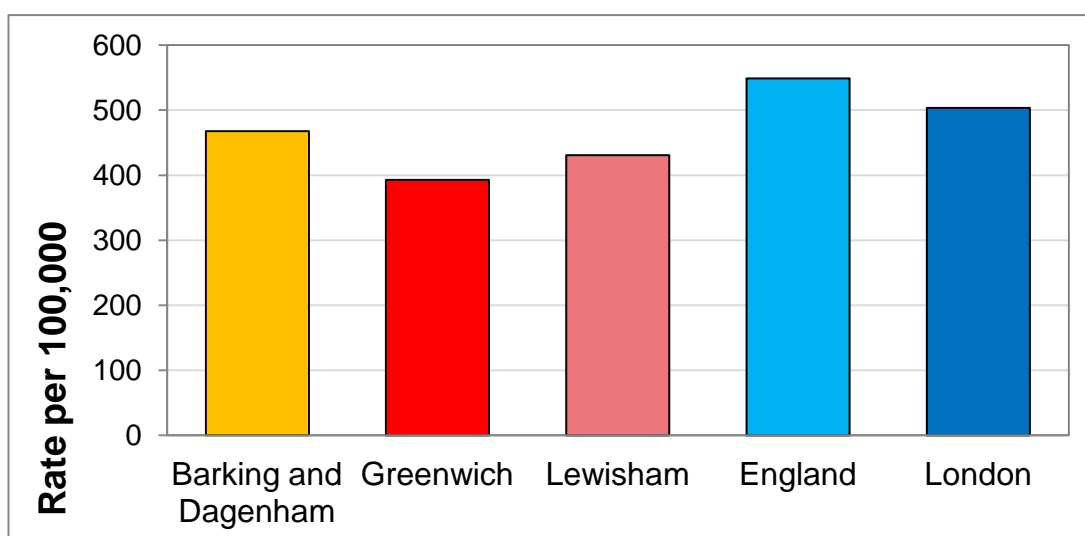
4.1 The Council's Public Health Team provided the HASSC with data to help members obtain a clear picture of local eye health needs. This section discusses what local data tells us about eye health in Barking and Dagenham.

### Registration of people who are Sight Impaired or Severely Sight Impaired

4.2 It is important that local authorities know which of their residents have sight problems so that they can be provided with the right support. This means those who are Sight Impaired (partially blind) or Severely Sight Impaired (blind) should be supported to register themselves. The Council's sensory team largely relies on the hospital eye clinics to tell them about people with newly diagnosed sight loss who need services. This is done when one of the consultant ophthalmologists completes a Certificate of Visual Impairment which, when passed to the Council, forms the basis for a person being registered as Sight Impaired or Severely Sight Impaired.

This section analyses the rate of registration in Barking and Dagenham compared to the borough's statistical neighbours, Greenwich and Lewisham.

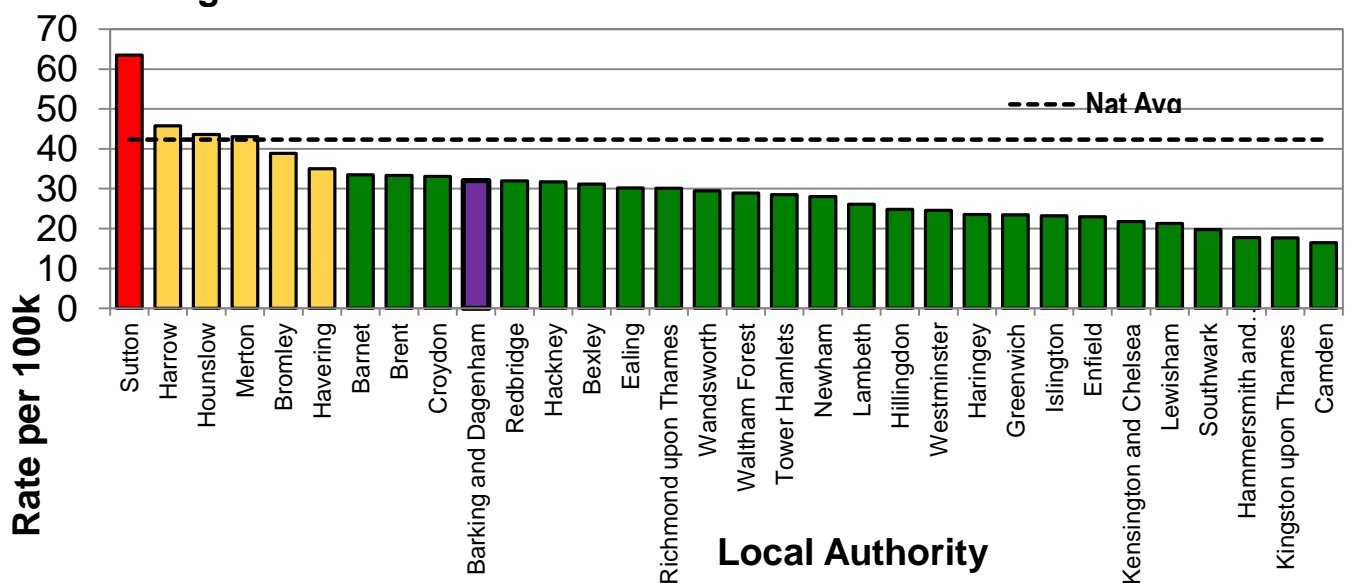
**Graph 1: Rate of registration as severely Sight Impaired (Blind) and Sight Impaired (Partially sighted) per 100,000 population 2013/14**



Source: Department of Health

4.3 As shown in Graph 1, In Barking and Dagenham a lower proportion of people are registered as having visual impairments per 100,000 than the average for England and London. However, as we have a smaller number of people over the age of 65 than other London boroughs, we compared our rate of registration with that of statistically similar boroughs such as Greenwich and Lewisham and found that Barking and Dagenham has a higher number of people, per 100,000 population, registered as Sight Impaired and Severely Sight Impaired. This is also illustrated in Graph 1.

**Graph 2: Rate per 100,000 of new certifications of visual impairment due to all causes and by all ages by LA and National Average in 2012/13**



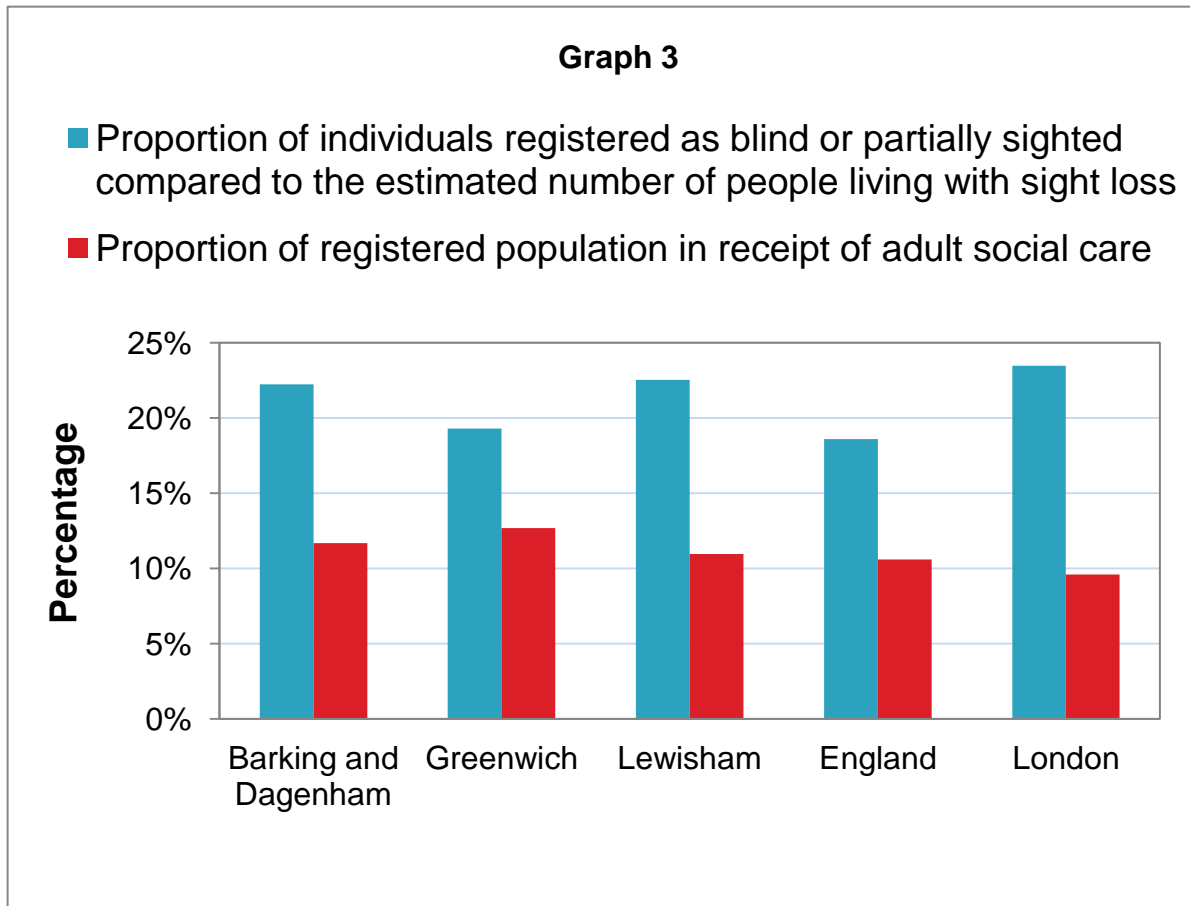
4.4 Graph 2 shows that the rate of registration in Barking and Dagenham is higher than the majority of other London boroughs – with Barking and Dagenham having the tenth highest rate of registration of the 32 boroughs. Interestingly, despite this the rate of registration in the borough is lower than the England and London average. It is likely that this is merely a reflection of the fact that in Barking and Dagenham the proportion of older people is lower and the proportion of younger people, much higher than most areas.

**FINDING**

The rate of registration as Severely Sight Impaired and Sight Impaired in Barking and Dagenham is good when compared with other boroughs with a similar proportion of older and younger people. This is good because the registration process ensures that the Council’s sensory workers are alerted to people who have recently lost their sight.

*Source: Department of Health*

4.5 **Graph 3: the proportion of LBBB residents in receipt of adult social care compared to proportion of registered partially sighted or blind, 2013/14**



**FINDING**

The proportion of people who are registered as having visual impairment and receiving adult social care is higher in Barking and Dagenham than the England and London average.

*Source: Department of Health*

## Adult Eye Health

### Eye Tests

- 4.6 One of the main objectives of the Review was to gauge the degree to which local residents are accessing sight tests at the recommended frequency. This is important because up to 50 percent of all sight loss can be prevented if problems are detected early enough (by glasses or medical treatment). Also, given that a visit to a high street optician is the start of the eye care journey for most people, optometrists are in a pivotal position to refer people on to the service they need.
- 4.7 The NHS recommends that all people should have an eye test every two years but that people over 70, people who are diabetic, people with a family history of glaucoma and certain other groups have a test more often.
- 4.8 RNIB recommend that people over the age of 60 have a sight test every year. Research conducted by RNIB (2007) found that just under 50 percent of people in this age group do visit the optician once per year.
- 4.9 Given the recommended frequency, the optimal number of yearly sight tests in Barking and Dagenham would be about 90,000.
- 4.10 Table 1 shows the numbers of people during 2013-14 and 2014-15 who received a free eye test at a local optometrist practice in the borough and two neighbouring boroughs.

**Table 1: NHS Eye Tests in Barking and Dagenham, Havering and Redbridge**

Year / borough	Total No. of NHS Eye tests taken up
<b>2013-14</b>	
Barking and Dagenham	37914
Havering	60723
Redbridge	65363
<b>2014-15</b>	
Barking and Dagenham	35236
Havering	64762
Redbridge	64288

*(Source: Local Optical Committee)*

4.11 According to the above data, the ratio of population to numbers of people receiving an sight test are:

- 1 in 4.4 for Redbridge
- 1 in 3.7 for Havering and
- 1 in 5.2 for Barking and Dagenham

4.12 These figures showing the actual number of NHS sight test completed in the borough indicate that the take-up of sight tests in Barking and Dagenham is lower than neighbouring boroughs. They also suggest that the proportion of people over 60 who receive a regular sight test may be lower in Barking and Dagenham than found elsewhere by RNIB.

#### ***FINDING***

At least 90,000 eye tests should be done in Barking and Dagenham each year. During 2014-15 35,236 free NHS eye tests were undertaken in the Borough. This suggests that about 1 in 5 (19.2%) of all men, women and children in Barking and Dagenham had an NHS eye test during 2014-15. The corresponding figures were 1 in 3.7 people in Havering (27%) and 1 in 4.4 in Redbridge (23%). This suggests lower take up of free eye tests in Barking and Dagenham compared to other areas

*(Source: Local Optical Committee Support Unit)*

### **The Prevalence of Common Eye Conditions in Barking and Dagenham**

4.13 The number of people with eye health issues increases with the age, with the vast majority of visually impaired people being over the age of 65.

4.14 There are five major causes sight loss in adults living in the borough:

1. Long and short sightedness and other refractive errors;
2. Age- related macular degeneration;
3. Glaucoma;
4. Diabetic retinopathy; and
5. Cataracts.



4.15

### **Refractive error**

Refractive errors, conditions where there is a problem with the focusing power of the eye, are very common. They are usually corrected by glasses or contact lenses. 'The most common types of refractive error are 'myopia' (short-sightedness), 'hypermetropia (long-sightedness) and 'astigmatism' (causes blurry vision up close and in the distance)'.  

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*Source: NHS website*

#### **FINDING**

There is little information available on the numbers of adults in Barking and Dagenham who have refractive errors and need glasses. This is because this information is not collected by the borough or the Government. This is also the case across London and England.

*Source: National Epidemiology of Eye Health database*

4.16

### **Age-related macular degeneration (AMD)**

Central vision is used to see what is directly in front of you. In AMD, your central vision becomes increasingly blurred, leading to symptoms such as difficulty reading, colours appearing less vibrant and difficulty recognising people's faces.  

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*Source: NHS website*

#### **FINDING**

In Barking and Dagenham it's likely that there are approximately 5354 adults who are or have been affected. The rate of new certifications of people with macular degeneration is in line with the expected rate of registration for the population of Barking and Dagenham.

*Source: National Epidemiology of Eye Health database*

4.17

## **Glaucoma**

Glaucoma develops when the fluid in the eyeball cannot drain properly and pressure builds up, known as the intraocular pressure. This can damage the optic nerve and the nerve fibres from the retina (the light-sensitive nerve tissue that lines the back of the eye).

*Source: NHS website*

### **FINDING**

In Barking and Dagenham it is likely that there are approximately 1565 adults who are or have been affected. LBBB has a lower rate of glaucoma certifications than England (11.2 per 100,000 compared with 12.5 in England aged 40 +). This suggests that people with glaucoma may not be aware that they have it and may only discover that they have it when an emergency happens, which means the opportunity for early intervention is lost.

*Source: National Epidemiology of Eye Health database*

4.18

## **Diabetic retinopathy**

Diabetic retinopathy is a common complication of diabetes. It occurs when high blood sugar levels damage the cells at the back of the eye (known as the retina). If it isn't treated, it can cause blindness.

*Source: NHS website*

### **FINDING**

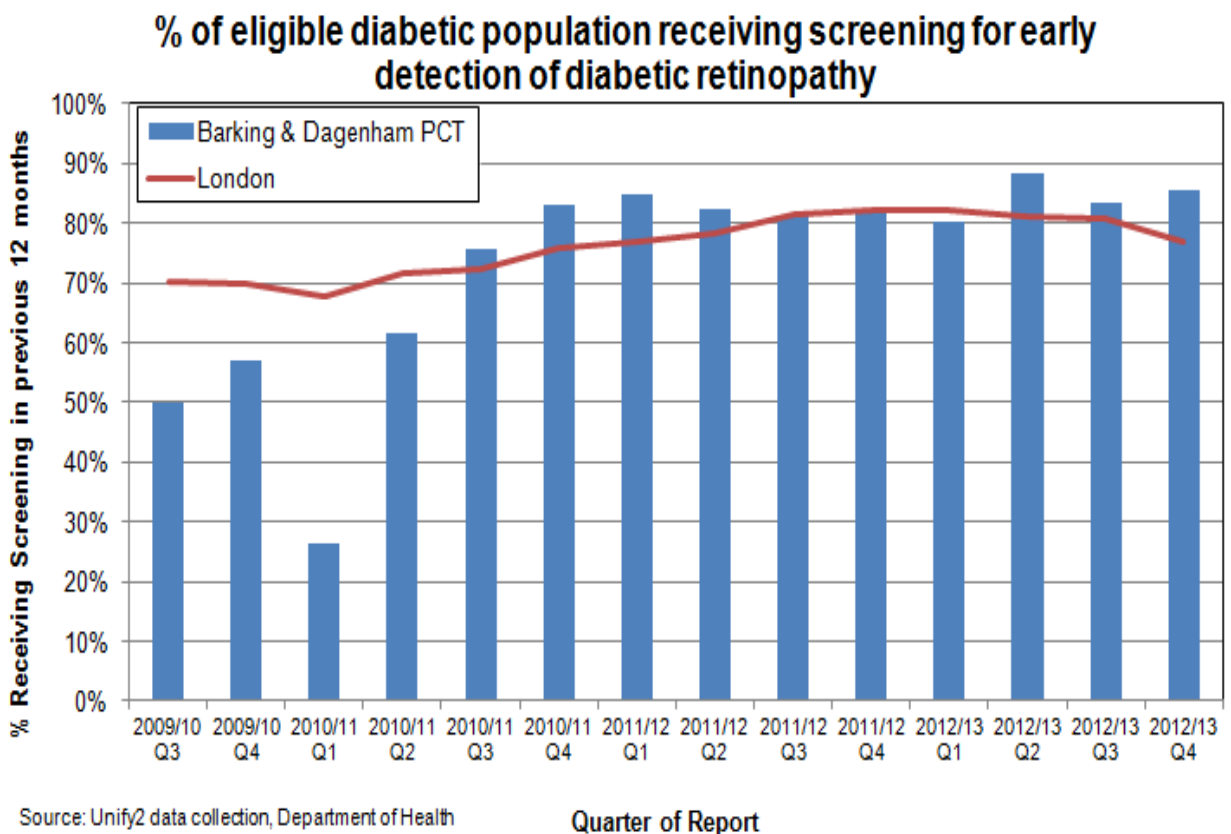
Diabetic retinopathy is a common complication of diabetes that is not controlled. In Barking and Dagenham it is likely that there are approximately 2834 adults with the condition.

*Source: National Epidemiology of Eye Health database*

## Prevention of Diabetic Retinopathy

- 4.19 Diabetes is the leading preventable cause of sight loss and this can be detected via the Diabetic Retinopathy Screening Programme Screening, which is provided for all people with diabetes. In this way damage is detected early, at a stage where sight loss can be avoided.
- 4.20 Graph 5 shows the percentage of the diabetic population receiving screening for early detection of diabetic retinopathy over the last four years.

**Graph 5**



### **FINDING**

This shows that in Barking and Dagenham the uptake of retinal screening is good at 79% of those offered (Graph 4). This can still be improved and it is important that residents with diabetes know that being screened could help to stop them becoming visually impaired.

*Source: National Epidemiology of Eye Health database*

4.21

### **Cataracts**

A cataract is cloudiness of the lens (the normally clear structure in your eye which focuses). They can develop in one or both eyes.

The cloudiness can become worse over time, causing vision to become increasingly blurry, hazy or cloudy.

Most cataracts develop with age, although rarely babies are born with cataracts or children develop them while they are still young

*Source: NHS website*

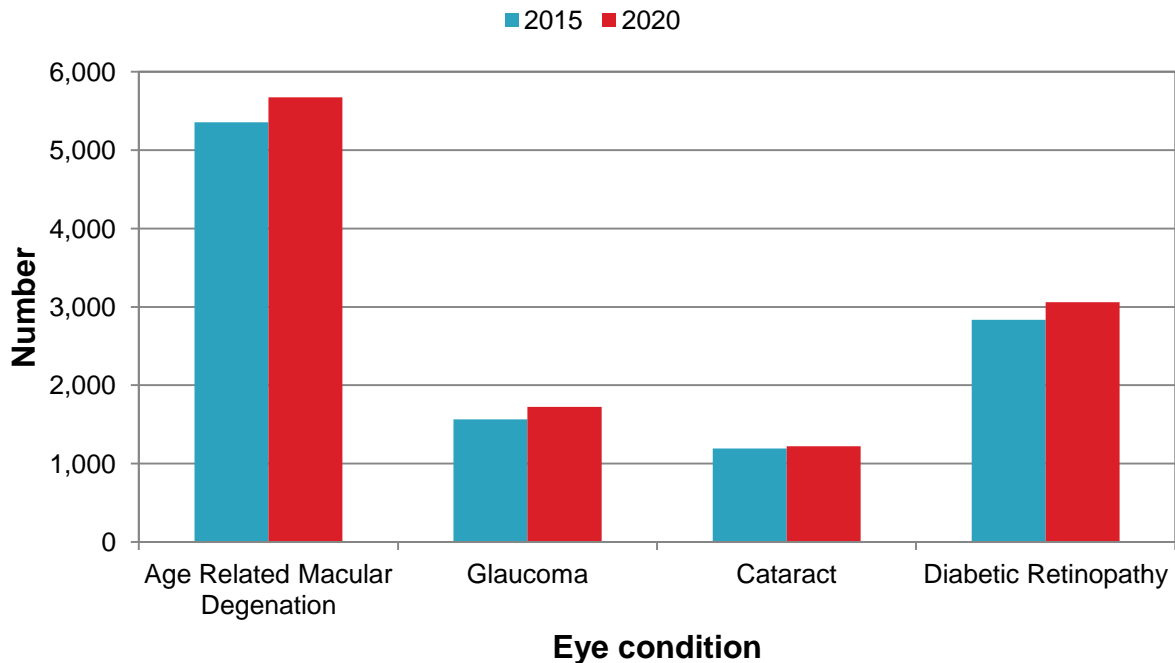
### ***FINDING***

In Barking and Dagenham it is estimated that there are approximately 1195 adults who have cataracts.

*Source: National Epidemiology of Eye Health database*

## Future Prevalence of Common Eye Conditions

4.22 **Graph 4: Eye conditions – estimated number of LBBB residents aged 20+ years with selected eye conditions, 2015 compared with 2020**



### ***FINDING***

As Graph 4 shows, it is predicted that there will be a modest increase in the number of residents living with these eye conditions by 2020. Whilst the predicted increase is lower than that for other boroughs (because the rate of increase in older people in the borough is projected to be modest) it is still essential for service providers to think about prevention and early intervention because by 2020, the number of people living with the following conditions is likely to increase to:

- Macular degeneration - 5673
- Glaucoma - 1723
- Cataract - 1221
- Diabetic retinopathy - 3000.

*Source: National Epidemiology of Eye Health database*

## Eye Health in Childhood and Adolescence

### Eye Tests in Children

- 4.23 Children in the borough are screened for eye defects shortly after birth, when they are six weeks old and just before they go to school. The NHS recommends that all children have a sight test every two years and that children who need glasses have one more often.

#### ***FINDING***

Eye tests and glasses are free for children but are not provided routinely and it is necessary for the child's parents to initiate them.

*Source: Local Optical Committee Support Unit*

### Common Eye Conditions in Children

- 4.24 There are three major eye conditions affecting children but it must be stressed that the numbers of visually impaired children are much lower than is the case with older adults.

- 4.25 The conditions are:

- Refractive error;
- Lazy eyes; and
- Squints and problems with using both eyes together.

- 4.26 **Refractive Error**

(See definition above at 4.15).

#### ***FINDING***

It is estimated that 1,314 children in the borough experience refractive difficulties.

*Source: Local Optical Committee Support Unit*

4.27

### Lazy Eye or Amblyopia

A lazy eye, (amblyopia), is a childhood condition that occurs when the vision in an eye does not develop properly. This usually means that the child can see less clearly out of one eye and relies more on the "good" eye. A lazy eye does not usually cause symptoms. In some cases you may notice that one eye looks different to the other. However, this is usually a sign of another condition that could lead to a lazy eye, such as a squint (see below).

*Source: NHS website*

#### **FINDING**

In Barking and Dagenham it is likely that there are approximately 1,251 children affected by this.

*Source: Source: Local Optical Committee Support Unit*

4.28

### Squints (strabismus)

A Squint (strabismus) is a condition where the eyes point in different directions. They usually develop before five years of age but can appear later.

*Source: NHS website*

#### **FINDING**

It is estimated that 3,003 children in Barking and Dagenham are affected by squints.

*Source: Source: Local Optical Committee Support Unit*

## **Prevention of Eye Conditions in Children**

- 4.29 While some children are born visually impaired much can be done to prevent children and young people developing sight loss. Safe and effective maternity services help to avoid children being exposed to risks during important stages of child and infant development. Mother's can, for example, be helped to stop smoking and limit drinking alcohol so that risks such as retinopathy due to premature birth can be minimised.

## **Future Prevalence of Common Eye Conditions in Children and Vulnerable Groups**

- 4.30 The major eye health issue for Barking and Dagenham is as a result of the large growth in numbers of children in the borough, set against the increase in the number of people with moderate and severe learning difficulties (LD) surviving into adulthood. As a result we'll see a large bulge in young adults with visual impairments which makes focussing upon prevention all the more critical.

### **Vulnerable groups**

- 4.31 Research undertaken on behalf of RNIB and SeeAbility<sup>2</sup> showed that people with a learning disability are 10 times more likely to experience sight loss than the general population. Up to half of people with a learning disability have a visual impairment but this group is also the least likely to get the eye care that they need. It is often difficult for people with a learning disability to access a sight test. There are various reasons for this including the fact that tests can take much longer and often require special techniques and skills which most optometrists are not trained to use. Coupled with this the things people do in an attempt to adapt to sight loss are often misinterpreted as "challenging behaviours" that result from a person's learning disability. These findings were mirrored by the outcome of a specialist sight test pilot project undertaken in central London and published in August 2015.
- 4.32 The project, conducted by SeeAbility and Local Optical Committee Support Unit, found that 52% of those seen had an eye health problem which could have led to sight loss and two thirds needed glasses. Amongst other conditions, the project identified people with untreated eye conditions such as cataracts, glaucoma and diabetic retinopathy and keratoconus (see definition below).

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<sup>2</sup> (Emmerson et al, 2011)



## Keratoconus

A condition in which the window of the eye progressively thins causing a cone like bulge to form.

*Source: NHS Moorfields Eye Hospital website*

### 4.33 Key findings included:

- 30% of all people were referred on to their GP or Hospital Eye Service.
- Following their sight test, 63% of individuals are wearing prescribed glasses.
- 50% of people had not had a sight test within the past two years.

4.34 This is a significant issue for Barking and Dagenham which has the second highest population of people with a learning disability in London (second only to Croydon). Local residents told us that it was very difficult to find a local optician who would examine someone with a learning disability. In response to this the Local Enhanced Optometry Contract for people with a learning disability was let, as part of the Bridge to Vision Project.

**Friendly eye tests**  
For people with a learning disability

For more advice and information, please contact the Community Learning Disabilities Team: 020 8227 5432

People with a learning disability are 10 times more likely to have a sight problem.

- ✓ I must get a sight test at least every 2 years.
- ✓ I need an optician who understands and gives me more time.
- ✓ I must wear my glasses if I need them.

Barking and Dagenham Council wants to help improve eye care for local people with a learning disability.

We work with opticians to help you get the service you need.

This is a list of opticians where you can go for a friendly eye test.

 Care Optics 3 Farr Avenue, Thames View, Barking, IG11 0NY 020 3551 6070	 JH Paters 192 High Road, Chadwell Heath, RM6 6LJ 020 8590 7590
 Care Optics 527a Cole Street, Dagenham, RM9 4TR 020 8592 6060	 Shiva Opticians 433 Becontree Avenue, Dagenham, RM8 3UH 020 8586 1119
 Henry Morgan 276 The Heathway, Dagenham, RM9 0CU 020 8592 1033	

Look out for this special notice in optician windows

**Bridge to Vision**  
Friendly eye tests for people with a learning disability

## 5. The Range and Quality of Local Eye Care Services

### Performance against the 'Seeing it My Way' Charter

5.1 Seeing it My Way is a national charter which sets out what visually impaired people have said they want from eye care services, to enable them to live the lives they want. It says that services for people with partial and severe sight loss should support them to:

- Understand their eye condition and the registration process
- Have someone to talk to;
- Can look after themselves, their health, home and family;
- Receive statutory benefits and information and support that they need;
- Can make the best use of the sight they have;
- Can access information making the most of the advantages that technology brings;
- Can get out and about;
- Have the tools, skills and confidence to communicate;
- Have equal access to education and lifelong learning; and
- Can work and volunteer.<sup>3</sup>

5.2 The HASSC noted from the information it received at the workshop that the following range of services is available to local people:

- Sight tests are available at optician practices located in a number of locations within the borough;
- Diagnosis and treatment services are accessed from ophthalmologists from Queen's Hospital, Moorfields Eye Clinic at Upney Lane and Moorfields Eye Hospital in City Road;
- The Council employs two qualified Rehabilitation Officers for visually impaired people and a specialist worker for people with hearing and sight loss;
- Mutual support is available via VIPERS and the local branch of the Macular Disease Society;
- Take up of the Diabetic Retinal Screening Programme is high;

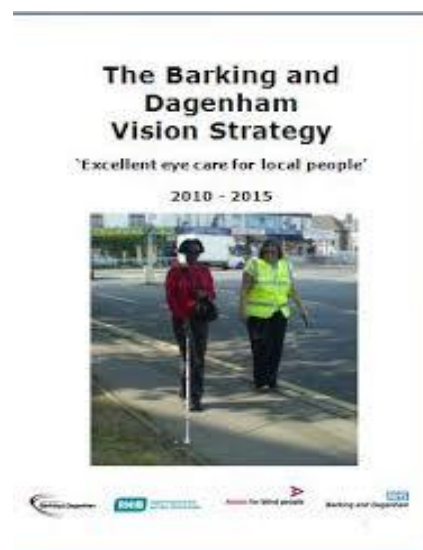
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<sup>3</sup> Seeing it my way, RNIB: <http://www.rnib.org.uk/about-rnib-what-we-do-uk-vision-strategy/seeing-it-my-way>

- Take up of Low Vision aids is supported by the Low Vision Service at Queen's and the Lighting and Magnifier Workshop (run by the Council);
- Bridge to Vision enhances access to eye care by people with a learning disability and the Thomas Pocklington and East London Vision charities are active locally; and
- The borough has a well used Diabetic Retinal Screen Programme.

## A Local Vision Strategy

5.3 In 2010 LBBDD was also one of the first London boroughs to publish a local Vision Strategy ("Excellent Eye Care for Local People, 2010-2015"), in line with the UK Vision Strategy. The Vision Strategy Group has led the development of innovative new services such as the Magnifier and Lighting Workshop and Bridget to Vision, an enhanced service for people with a learning disability. It also organises engagement events twice yearly to promote eye health, showcase services and bring the public together with professionals to improve communication.

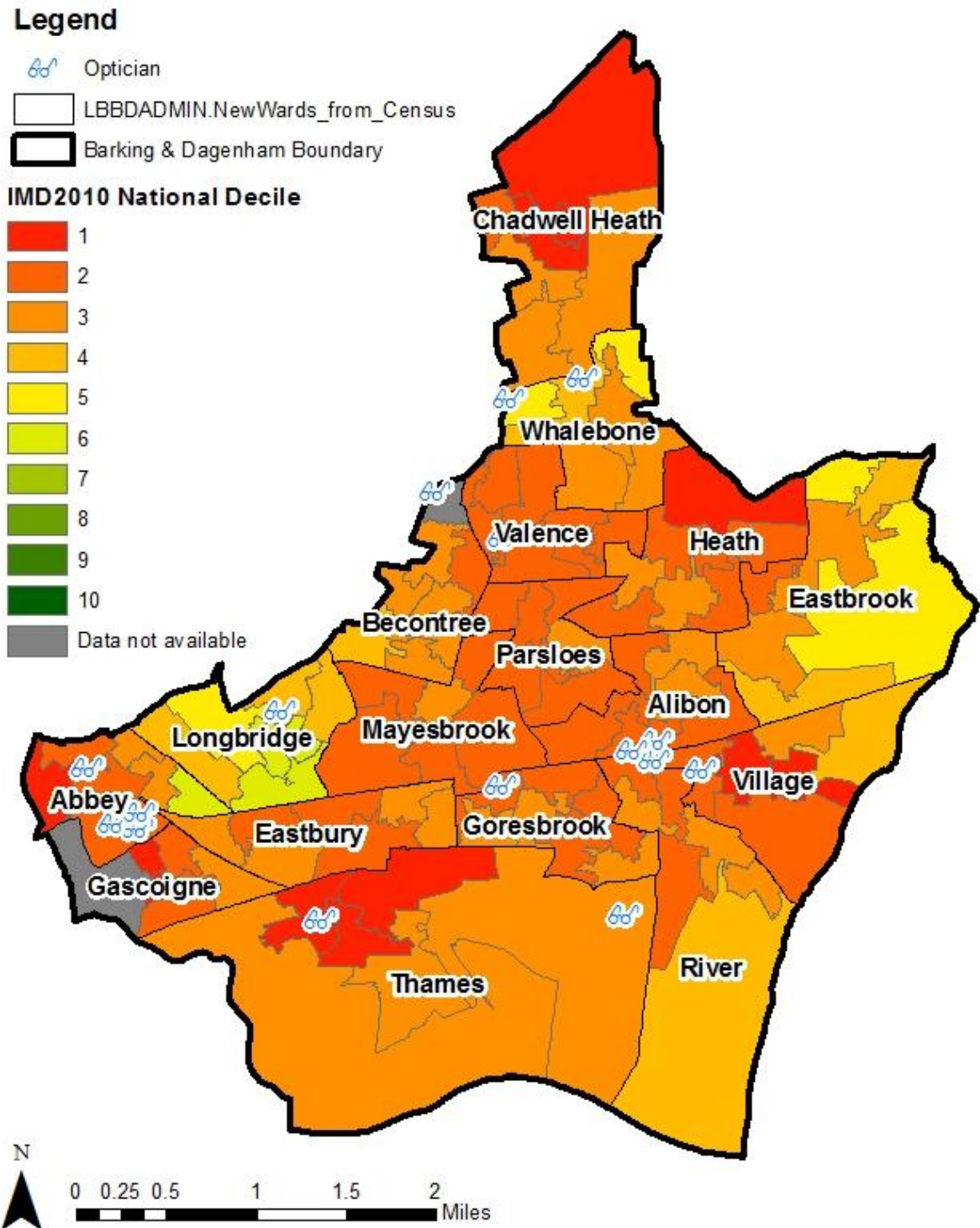


## Low Vision Services

- 5.4 Until 2013 the Council and the Clinical Commissioning Group jointly commissioned a Low Vision Service at Porters Avenue. This was inspired by the model developed by RNIB at the Judd Street Resource Centre, which combined Optometry and Rehabilitation, concentrated on goals set by service users and provided follow-up to ensure continued use of the low vision aids supplied. The service was, however, cut to achieve efficiency savings.
- 5.5 The Magnifier and Lighting Workshop was established by the Council in 2014 with the aim of partially filling the gap left when the Porter's Avenue Low Vision Services was closed. The aim is to communicate the benefits of low vision aids to the public in a clear and simple way, free from jargon. People in need of these services are supported to access the equipment that they need and offered follow-up support to assist them to use it effectively.

## Accessibility of Local Optometrists in the Borough

5.6 Members requested data showing the spread of optometrists in Barking and Dagenham to see whether all communities living in the borough have reasonable access to a local optometrist. The map below shows the spread of optician practices across the borough and levels of deprivation (red areas are the most deprived). Members felt that the spread of optometrists was reasonably good but noted that provision is however, more limited in a small number of wards.



## 5.7 HASSC's View on the Overall Range of Eye Care Services Available Locally

### ***FINDING***

Members came to the view that locally there is a range of good quality services that measure up well to the challenges set by 'Seeing it My Way' and the UK Vision Strategy.

## 6. Service Gaps, Challenges and Areas for Development

### Free Eye Tests

- 6.1 The eye care pathway starts with an eye test at a high street optometrist for most people.
- 6.2 Eye tests are free for:
- Young people below the age of 16 (or 18 if in full-time education)
  - People over the age of 60;
  - People on Income Support, Job Seekers Allowance and Universal Credit;
  - People who are registered Sight Impaired and Severely Sight impaired;
  - People diagnosed with diabetes or glaucoma;
  - People over 40 with a close relative diagnosed with glaucoma; and
  - People advised by an ophthalmologist that they are at risk of glaucoma.<sup>4</sup>
- 6.3 The Council and other large employers also pay for eye tests for staff who use Display Screen Equipment and may contribute towards the cost of spectacles.
- 6.4 The HASSC noted that eye tests are free for the majority of the residents of Barking and Dagenham, as many residents fall into at least one of the above categories.

### Barriers to the take-up of eye tests

- 6.5 A study carried out in Leeds<sup>5</sup>, on behalf of RNIB found a strong link between deprivation and the likelihood of not having a free NHS eye test at a local optometrist.
- 6.6 The research highlighted the strong relationship between optometrist practices and the sale of glasses and showed that the true cost of providing eye examinations is at least twice the amount paid by the Government via fees to optometrists. The sale of glasses, therefore, effectively subsidises sight tests by enabling optometrist practices to be profitable, which in turn, allows them to remain in business and carry on offering tests.

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<sup>4</sup> NHS website: <http://www.nhs.uk/chq/Pages/1093.aspx?CategoryID=68&SubCategoryID=157>

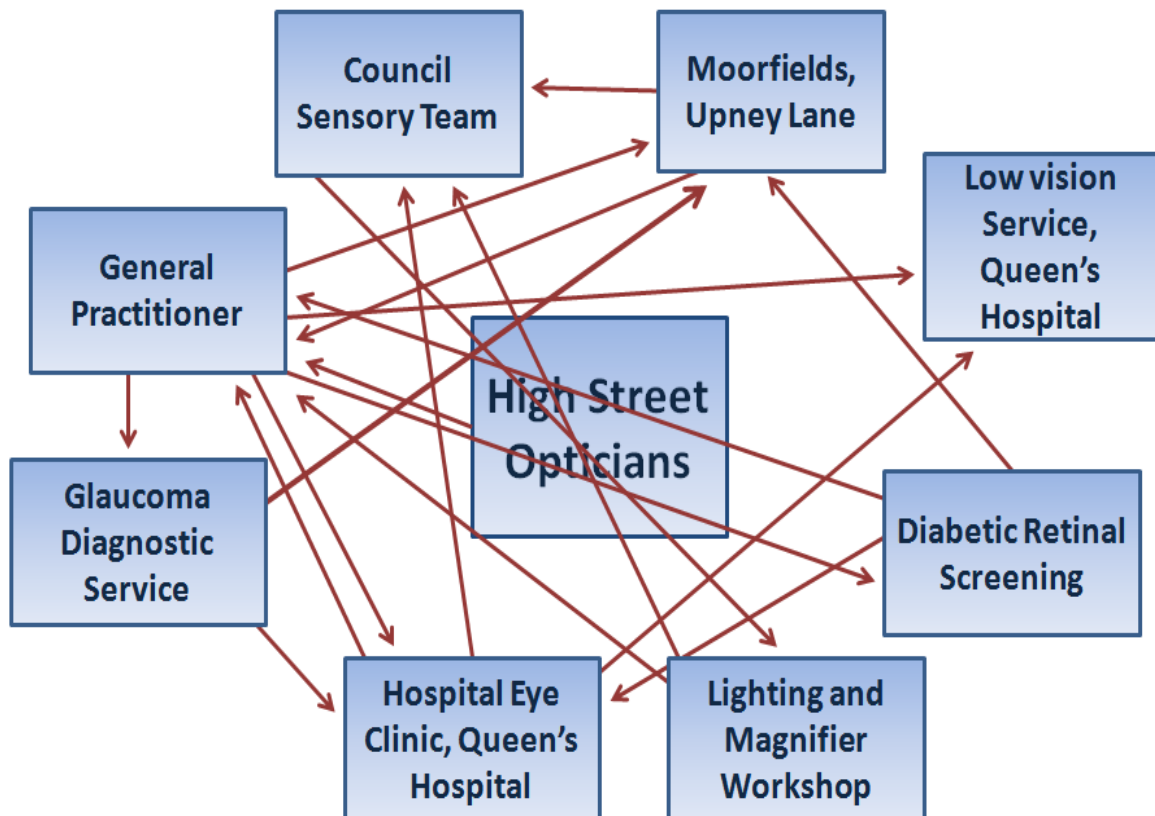
<sup>5</sup> Shickle, D. et al, Address Inequalities in Eye Health with Subsidies, Public Health 129; 2015.

- 6.7 The research found that the fear of having to buy glasses was the major reason that many people gave for not having their eyes examined regularly. Many people did not know that they were in fact entitled to a free sight test and help towards the cost of glasses.
- 6.8 The study recommended that optometrists should be provided with additional funding in boroughs with higher levels of deprivation, such as Barking and Dagenham, so that they can promote sight tests for people who might otherwise not have one.

### The Local Eye Care Pathway

- 6.9 Although this Review has revealed that there is a good range of services that measure up well to the challenges set by Seeing it My Way and the UK Vision Strategy, some stakeholders informed the HASSC that there are important service gaps, challenges and areas for potential improvement. Research also revealed potential barriers and areas for further exploration.
- 6.10 The diagram below shows that the local eye care pathway is not simple or easy to understand for people who need to use it. It is also quite fragmented.

### Barking and Dagenham Eye Care Pathway



- 6.11 Optometrists (opticians) are critical because they are often the first to identify sight problems and eye disease. However, as can be seen in the diagram, they cannot refer people directly to hospital eye clinics or the retinal screening service etc. Instead, they are required to refer people back to their GP who then refers the person on. Similarly, referrals to the low vision service at Queen's Hospital must be made by the hospital clinics or GPs.
- 6.12 Members of HASSC asked the consultant ophthalmologists from Queen's Hospital and Moorfields whether it is possible for someone to transfer their care from the one hospital to the other. Niaz Islam, Consultant Ophthalmologist from Moorfields reported that it is possible for people to transfer, under the 'Choose and Book' system, but that there are problems with the online administrative system which make this difficult to arrange in practice.

### **Low Vision Services**

- 6.13 Since 2013 the only low vision services available to the borough's residents who need special magnifiers and other low vision aids are provided solely by optometrists in a hospital setting. In other parts of the country there are services where optometrists and rehabilitation officers work together to offer general support, clear instruction about how to use equipment and follow up in the community. Research shows that without such support people often fail to use their equipment properly, if at all. This is obviously a potential waste of resources and opportunity.



## 6.14 Case Studies of People using the Local Eye Care Pathway

### ***Sally's Story – The Birth of the Bridge to Vision Project***



This case study is about Sally, who was 32 years old and had a learning disability. She lived with her dad, her brother and her mum, Maureen, in Barking. Sally had a rare genetic condition called 18P-Syndrome. People with 18P- syndrome are thought to be more at risk of developing glaucoma. This condition often develops without obvious symptoms: an eye examination is the only way to detect glaucoma early so action can be taken to prevent unnecessary sight loss.

Around five years ago, Sally, started rubbing her eyes. Maureen took her to the doctors and the GP prescribed drops for hay fever. The symptoms did not go away and Sally described an “itch” on her head - her way of saying she had a headache. Her head became sensitive to touch: Maureen took her back to the GP who suggested Sally had either a thyroid or scalp problem. There was no mention of any eye problems at this stage.

Then one day, Sally's brother offered her a sweet and as she went to take it she missed. This was when Maureen first thought that there could be a serious problem with her sight. Maureen decided to try and test her theory of a potential sight problem. She spread the sweets over a table and asked Sally to pick them up. Sally swept her hand over the sweets; she found them by touching them, not by seeing them.

Maureen called an optometry company and their sight test revealed that Sally had extremely high pressures in both eyes and was losing her sight. Maureen took Sally to the local A&E; staff found it difficult to examine her and asked her to return the next day to see a consultant ophthalmologist. At this appointment, Sally was diagnosed with glaucoma and was urgently referred to Moorfields Eye Hospital where she had surgery. The surgery was successful in managing the glaucoma, but sadly, she had already lost almost all her vision. Sally can now only see light and dark.

Maureen said, “We feel guilty about Sally’s eye condition. We wish we’d noticed it earlier. We wish we had more awareness of sight problems amongst people with learning disabilities”.

Campaigning for better eye care for people with learning disabilities has become Maureen’s passion and she has worked tirelessly to ensure others do not go through the same difficult times as her daughter.

Bill Brittain, Group Manager for Intensive Support of the Barking and Dagenham and Chair of the Vision Strategy Group, added, *“In December 2009 the Barking and Dagenham Vision Strategy Group hosted an eye health event. During a debate session Maureen stood up and told a packed room Sally’s story, highlighting the difficulties Sally had encountered in arriving at a diagnosis for her eye condition.*

*“This was powerful, and shocking. It also made the professionals amongst us “stand up and take notice” and resulted, the following year in the letting of the Learning Disability Enhanced Optometry Contract as part of the Bridge to Vision project”.*

So far, Maureen’s contribution had lead to more than 100 local people taking up the service and the identification of people who need glasses and others who have diabetic retinopathy and glaucoma or other eye conditions.

*This case study was published by the College of Optometry, 7 June 2012.*

## ***The Heathlands Day Centre Story***

People with severe or profound learning disabilities are much more likely to have serious sight problems. Six out of ten people with learning disabilities need to wear glasses.

As part of the local 'Bridge to Vision' project an enhanced optometry service is provided at Heathlands Day Centre, which serves people with moderate and severe learning disabilities. This is provided by Care Optics and started on 20 July 2010.

The service was initially set up because customers who attended Heathlands, who all had profound and complex learning disabilities, and/or autism, were generally unable to access high street opticians. This was due to:

- Lack of awareness amongst staff and carers;
- Physical access problems for people with impaired mobility or wheelchair users; or
- Behaviour difficulties (not just behaviour that challenges but many customers would shut or cover their eyes).

It was discovered that one customer had glaucoma and was going blind. This had not come to light before due to the customers' communication difficulties and a general lack of awareness regarding vision. The carer of the customer in question raised this problem at the borough's Eye Strategy Group and it eventually resulted in an enhanced service being commissioned by the Primary Care Trust (now the CCG). As part of the Bridge to Vision project staff received specialist visual impairment awareness training which put them in a better position to highlight any difficulties customers are experiencing.

The service has had a very positive impact, achieving excellent outcomes for the people who use it. Success owes much to the fact that customers are familiar with the environment at Heathlands and are supported by staff they know, which reduces anxiety.

Continuity in the staff carrying out the screenings to detect sight problems means that relationships have been developed which allows for a more thorough eye test to be carried out. Customers who were reluctant or initially showed a lack of willingness were encouraged to gradually build tolerance by going into the room every time a screening session takes place. Desensitisation work for people with autism took place which meant more people were taking eye tests.

Free trial glasses have been given to customers to build tolerance of wearing glasses prior to purchase. Glasses have changed the way some people see their world. There has been a noticeable difference. Recommendations and advice are shared with carers and staff regarding the best ways of working and supporting customers through their environment, for example, lighting, text size, distance and contrast.



This is a valuable service that has produced real outcomes for customers with profound and complex learning disabilities who attend Heathlands. When this service was first introduced very few customers were having eye tests. Now almost all are receiving one regularly. The outcomes listed below provide evidence of how a good quality service can improve the lives of people with learning disabilities:

- 38 customers have been seen by the optometrist.
- Six are now seeing by their own opticians.
- 19 customers have been issued glasses, including one pair of bifocals and one pair to support a customer who is Photophobic.
- One customer has been referred to their GP for an ophthalmic surgeon assessment.
- Two customers have been found to have cataracts.
- 11 customers are short-sighted.
- Eight customers are long-sighted.
- Two customers are long and short-sighted.
- Two customers with keratoconus who previously did not want to, had eye tests
- Two customers were already registered blind and one has been recommended to be registered blind.

*Carol Hackett – Manager, Heathlands Day Centre.*

## **Submissions by the Local Optical Committee and the Thomas Pocklington Trust**

- 6.15 The Local Optical Committee (LOC) and the Thomas Pocklington Trust made submissions to the HASSC (provided at Appendices 3 and 4) to support this Review. Their submissions are summarised here.
- 6.16 NHS funded eye care services should move away from outmoded delivery models. High street opticians are well placed to play an increased role in identifying eye disease at an early stage such as diabetic retinopathy, cataracts and glaucoma and services in the community would be more accessible for local residents than those located at the hospital, whilst potentially also being cheaper to deliver.
- 6.17 Community optometrists are not currently able to refer patients directly to the hospital for low vision and other services but are required to first refer them back to their GP. This can result in delays for patients and a failure to feed back information about subsequent treatment plans to the optometrist.
- 6.18 Service duplication would be reduced if optometrists undertook diabetic retinopathy screening and only referred people to the hospital who had tested positive for glaucoma on more than one occasion. This would be simpler for patients and reduce their anxiety levels.
- 6.19 A community based low vision service run from optometrist practices would offer adults with sight loss quicker access to low vision aids such as magnifiers and lighting, and support closer to home. It could also significantly increase the supply of low vision practitioners and make community follow-up more feasible.
- 6.20 There is a continued need for an enhanced optometry service for people with a learning disability to counteract the higher incidence of visual impairment amongst this group and the significant barrier that they face in accessing the services that they need.
- 6.21 An Eye Clinic Liaison Officer should be in place at Queen's Hospital, King George Hospital, Barking Community Hospital to provide emotional support and information at the point of diagnosis, increase the number of people registered as Sight Impaired and Severely Sight Impaired and ensure that people get the help that they need from the Council's Sensory Team and other services.
- 6.22 There should be a child screening programme for all reception aged children (5 year olds) to help identify and address eye problems early.

## 7. Conclusions and Next Steps

- 7.1 The Scrutiny has shown that eye care services in Barking and Dagenham generally compare well with national benchmarks. There is a reasonably good supply of optometrist practices spread across the borough; diagnosis and treatment is available at Queen's Hospital and Moorfields in Upney Lane, rehabilitation, support and information is offered by the Council and there are a number of local and national groups active locally.
- 7.2 The Review, however, uncovered some potential areas within the eye care pathway where it may be possible to develop services so that they are even more responsive and accessible to local people.
- 7.3 Stakeholders of this Review were of the view that if more primary eye care services were delivered from high street optometrist practices this would reduce duplication and confusion for service users whilst also making access easier and reducing costs. Stakeholders raised issues around administration systems which can make it difficult for patients to transfer from one eye care provider to another (e.g. from Moorfields to Queen's) if they wish to.
- 7.4 Stakeholders also suggested that improvements should be made to local vision services so that they focus even more on goals set by service users and provide them with the support that they need to use equipment effectively.
- 7.5 The HASSC therefore recommends that the Health and Wellbeing Board oversees reviews by Barking and Dagenham Clinical Commissioning Group (CCG) of the local eye care pathway and the clinical benefits of community optometrists being able to refer patients directly to hospital eye clinics and other services rather than having to do this via GPs.
- 7.6 The HASSC agreed that with the view that an Eye Clinic Liaison Officer should be in place at local hospitals (Queen's and King Georges) to provide emotional support and information at the point of diagnosis and to ensure that people get the help that they need from the different range of services available locally. The HASSC therefore recommends that the Health and Wellbeing Board asks the CCG to consider the benefits of commissioning an Eye Care Liaison Officer for local residents, to ensure that people with newly acquired sight loss are provided with support at point of diagnosis and signposted to appropriate services.

- 7.7 The HASSC noted that since 2013 the only low vision service available to residents who need low vision aids are provided solely by optometrists in a hospital setting. The lack of wider availability of such services could mean that people are not accessing support and advice to use their equipment properly, leading to a poorer quality of life. The HASSC therefore recommends that the Health and Wellbeing Board asks the CCG to consider whether cost-effective improvements could be made to local low vision services to ensure that that visually impaired people are able to make ongoing, beneficial use of magnifiers and other equipment provided to them.
- 7.8 Research conducted in Leeds by RNIB demonstrated that take-up of free NHS eye test in poorer areas is much lower than it is in affluent neighbourhoods. This has serious implications in terms of the prevention of avoidable sight loss. Given that many people in Barking and Dagenham live on very low incomes the same issue is likely to apply locally. The HASSC therefore recommends that the Health and Wellbeing Board oversees a local communication campaign undertaken by the Council's Public Health Team emphasising the importance of having regular eye tests, whilst also delivering other important eye care messages.
- 7.9 The HASSC noted that eye tests and glasses are free for children but are not provided routinely and it is necessary for the child's parents to initiate them. The HASSC therefore recommends that the Health and Wellbeing Board considers a range of options to 'make every contact' count and introduce a scheme or schemes to encourage and possibly incentivise parents to arrange an eye test for their child prior to starting school.
- 7.10 After the publication of this report, the report will be submitted to the Health and Wellbeing Board, who will decide whether to agree the recommendations. If the recommendations are accepted, officers and partners will work together to draw up an action plan describing how the recommendations will be implemented. In six months' time, the HASSC will receive a monitoring report explaining the progress of the implementation of the recommendations.

## **The HASSC would like to extend its thanks to the following for contributing to this Review:**

- The Local Optical Committee (representing local opticians);
- The Vision Strategy Group
- Ophthalmologists from Queen's and Moorfields Hospitals
- Edward Watts Opticians - providing a Low Vision service at Queen's Hospital
- Choices Independent Living Agency
- Thomas Pocklington Trust
- East London Vision
- Macular Disease Society
- VIPERS (local organisation of visually impaired people)
- The Magnifier and Lighting Workshop
- Bridge to Vision
- The Council's Sensory Impairment service
- Electronic visual aids

## **Officer Support for this Review**

Members also thank the following Council officers for their support during this Review:

- Anne Bristow: Corporate Director of Adult & Community Services and the HASSC Scrutiny Champion
- Bruce Morris: Divisional Director, Adult Social Care
- Bill Brittain: Group Manager, Intensive Support
- Sue Lloyd: Public Health Consultant
- Masuma Ahmed: Scrutiny Officer, Legal & Democratic Services



# Appendices

## Scene Setting Presentation by Thomas Pocklington Trust: Summary Notes

### Current and future prevalence

There appears to be a big disparity nationally between the number of people living with sight loss and the number of people registered as blind or partially sighted. Approximately two million people in the UK are living with sight loss but only 360000 people are registered as blind or partially sighted. The Royal National Institute for the Blind estimate that approximately 3910 people are living with sight loss in Barking and Dagenham but only 870 people are registered as blind or partially blind. There are a possible range of reasons for this including:

- It is recognised that certain groups are less likely to present themselves to health services in relation to their eye health.
- People may not realise that their sight is deteriorating as they were getting older.
- People may not notice that they have a refractive error which needs correction with spectacles or lenses, or that they are wearing the wrong prescription spectacles or lenses.

Older people are most affected by sight problems. One in five people aged 75 and over and one in two people aged 90 and over are living with sight loss.

Future demographic changes mean that the number of people in the UK with sight loss is set to increase in line with population ageing. By 2050 the number of people with sight loss in the UK could be nearly four million and by 2020 the number of people living with sight loss in Barking and Dagenham is estimated to increase to 4,330.

### The Impact of Sight Loss

The impact of sight loss can be multiple and the services and support available should reflect this. Individuals who have lost their sight often face significant emotional, financial, social impacts. About 66% of those living with sight loss of working age are unemployed. The vast majority of people living with sight loss wish to work but face significant barriers.

People living with sight loss are at an increased risk of injury from accidents and falls. In some cases this can be put down to them being cared for by unpaid carers who cannot provide the right level of care. Rehabilitation is therefore essential in preventing further health difficulties arising. It can also teach people key skills such as learning how to access information using a computer which can increase employability and prevent social isolation. Even where people do receive rehabilitation the time lag is often too long which means that people deteriorate emotionally and their financial situation worsens rapidly. Timely rehabilitation can result in a lower level of care being provided and is often more much more cost-effective in the long run.

People living with sight loss can face huge challenges in accessing services such as leisure, housing, transport and education. Access to transport can often make the biggest difference to the quality of life of people living with sight loss; however, to get to these services, people suffering from sight loss need to have the right early support including appropriate emotional and motivational support. People living with sight-loss can also sometimes receive a less-equal service due to communication barriers. People with sight loss have reported being asked by their GPs whether they can ask a friend to read their

private medical notes to them as they are not always available in an accessible format, which may not respect their privacy or dignity.

### **Public Awareness**

50% of sight loss conditions are avoidable. If a person has a family history of diseases that affect the eye, the sooner it is investigated, the sooner it can be addressed. Whilst smoking, obesity and hypertension are widely recognised as risk factors for cancer and heart disease, more needs to be done to raise awareness that they are also considered risk factors for certain eye conditions to improve prevention and early intervention. Proper investment in early intervention is crucial in providing good care and in ensuring cost effectiveness. It can reduce the care needs of older people and ensure that more people with sight loss remain in employment.

Research has been undertaken which demonstrates the link between deprivation and poor take-up of sight tests and, hence, the greater risk of preventable sight loss in poorer areas. There is a lack of public awareness and misconceptions regarding primary care eye health services. Many people hold the belief that glasses are unaffordable and therefore avoid visiting their local optometrist, and are unaware that in addition to refractive error, optometrists can pick up serious diseases such as glaucoma and sometimes even stroke, which are may be preventable if detected early. Certain sections of the community may be eligible for free eye tests and help towards the costs of glasses but not all those who are eligible are aware. Potentially, there is therefore less opportunity for early intervention in certain groups.

There is evidence that underprivileged communities in particular have fewer practices in their localities and that there is a variation amongst different ethnic groups when it comes to visits to optometrists. Furthermore, in people with learning disabilities the sight condition may not be picked up because certain symptoms are attributed to their disability. Services need to think of innovative ways to improve take-up of services by these groups to address eye health inequalities in communities. Local authorities can undertake a mapping exercise of optometrists in the Borough and analyse this against the profile of local communities, for example.

### **Better Integration between Services**

People suffering with eye conditions often report that they are not put at the centre of eye health services they use. They do not always receive the right level of information from key parts of the pathway and there is fragmentation in geographical areas which could be better linked-up. Primary and secondary health services, the local authority and the voluntary sector must achieve better integration and put the person at the centre to provide excellent care all the way along the person's journey. Clinical Commissioning Groups plans should reflect the principle of integration. Health & Well-being Boards which have a duty to promote integration also have an important role. *East London Vision (ELVis) cluster cited as example*

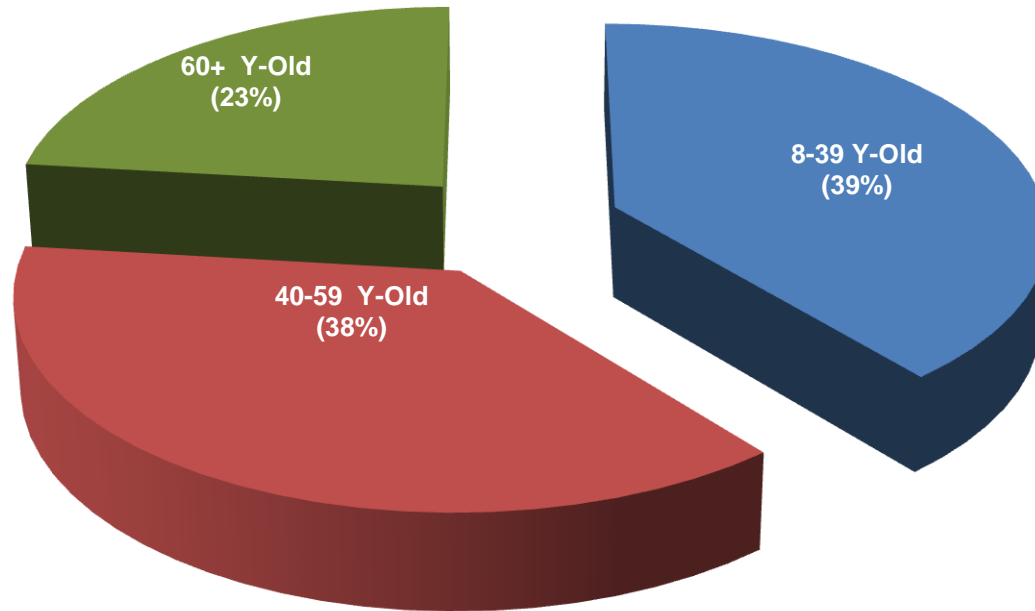
Local authorities should have a Vision Strategy that sets out how this will be achieved and has measurable targets for implementation. Every eye clinic should have an Eye Clinic Liaison Officer to signpost people to relevant services. At the moment only approximately half of eye clinics have this post.

# Eye Health Survey

Barking and Dagenham

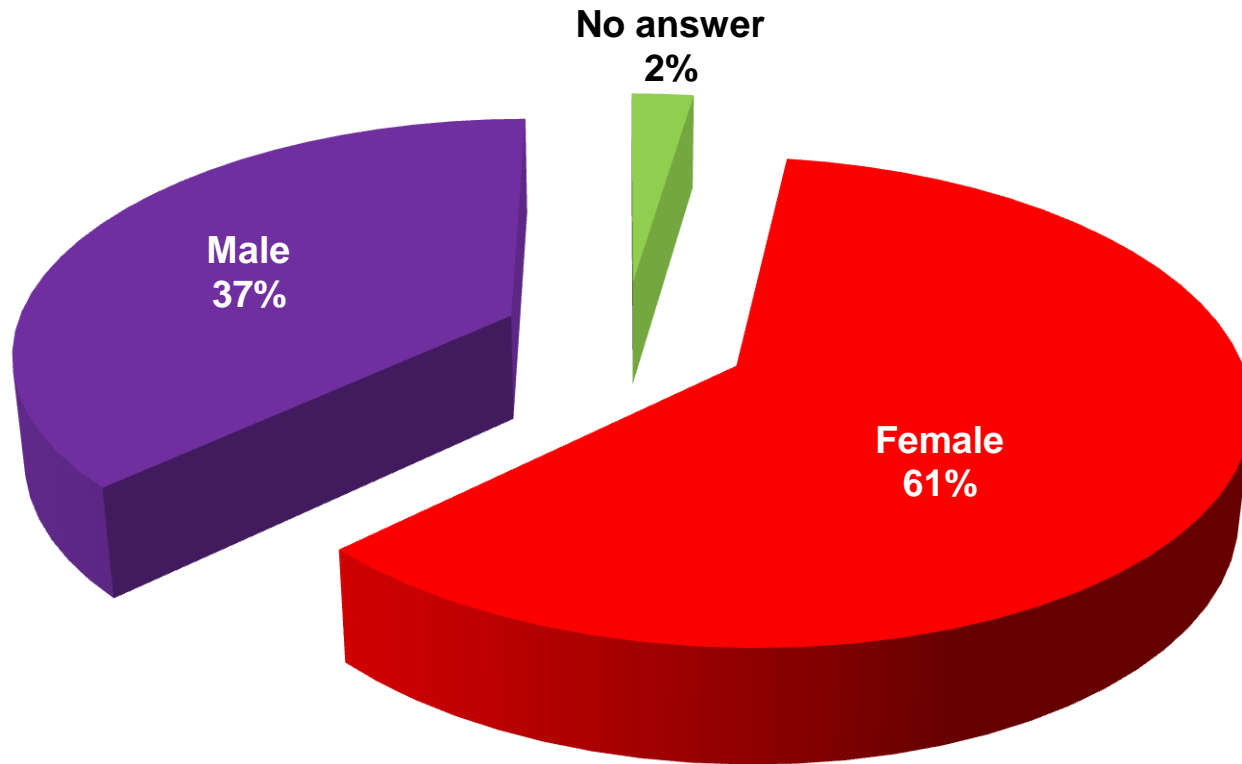
July - August 2015

# Age group



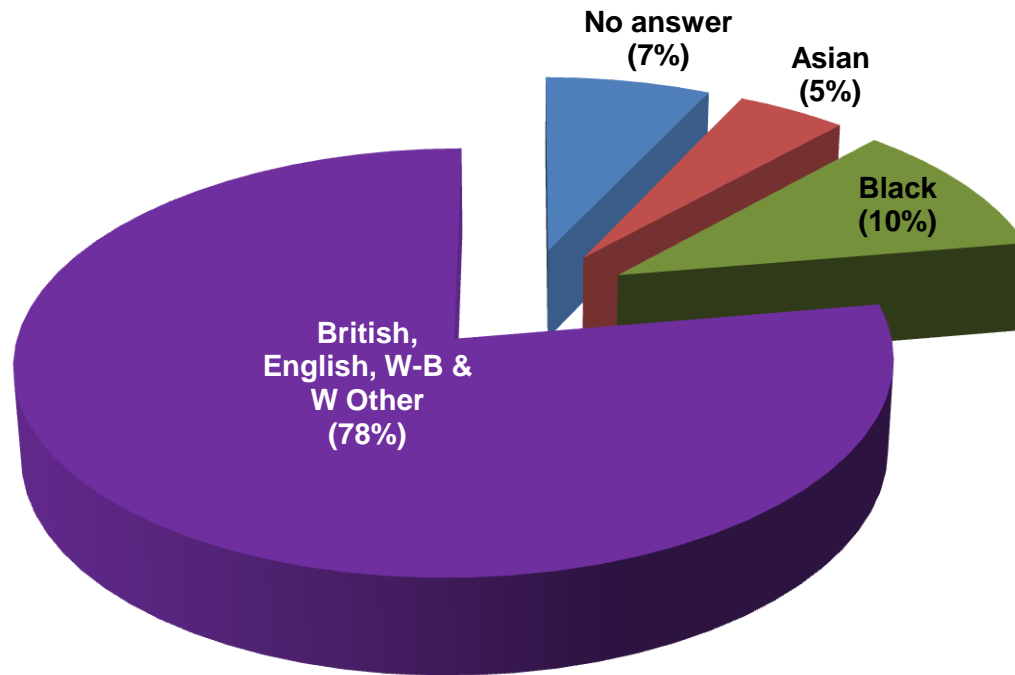
Response: 164 People

# Gender



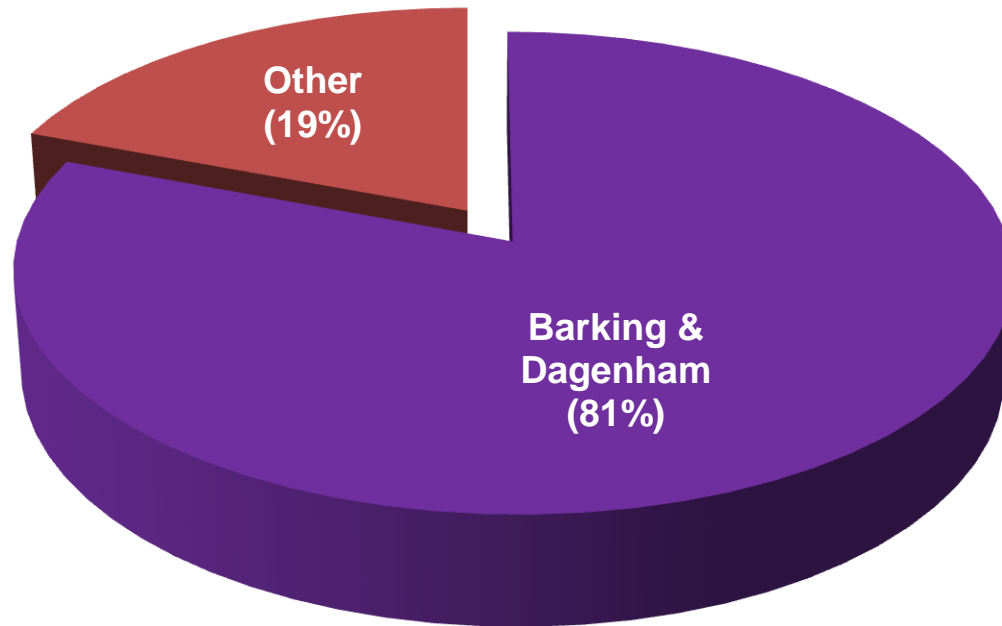
Response: 166 People

# Ethnicity



Response: 170 People

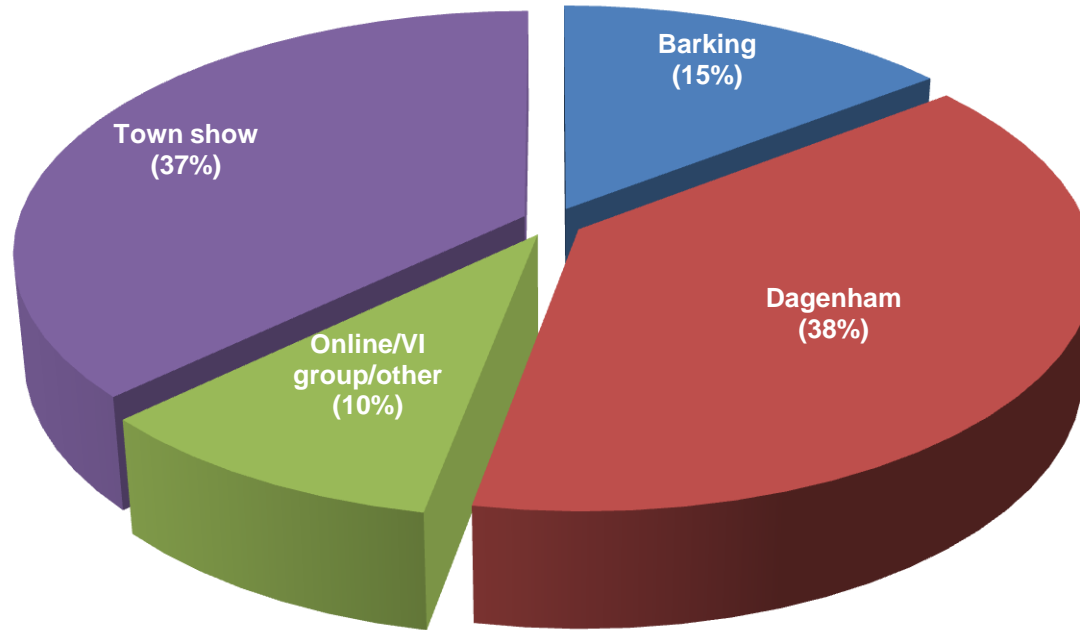
# Where do you live?



Response: 170 People

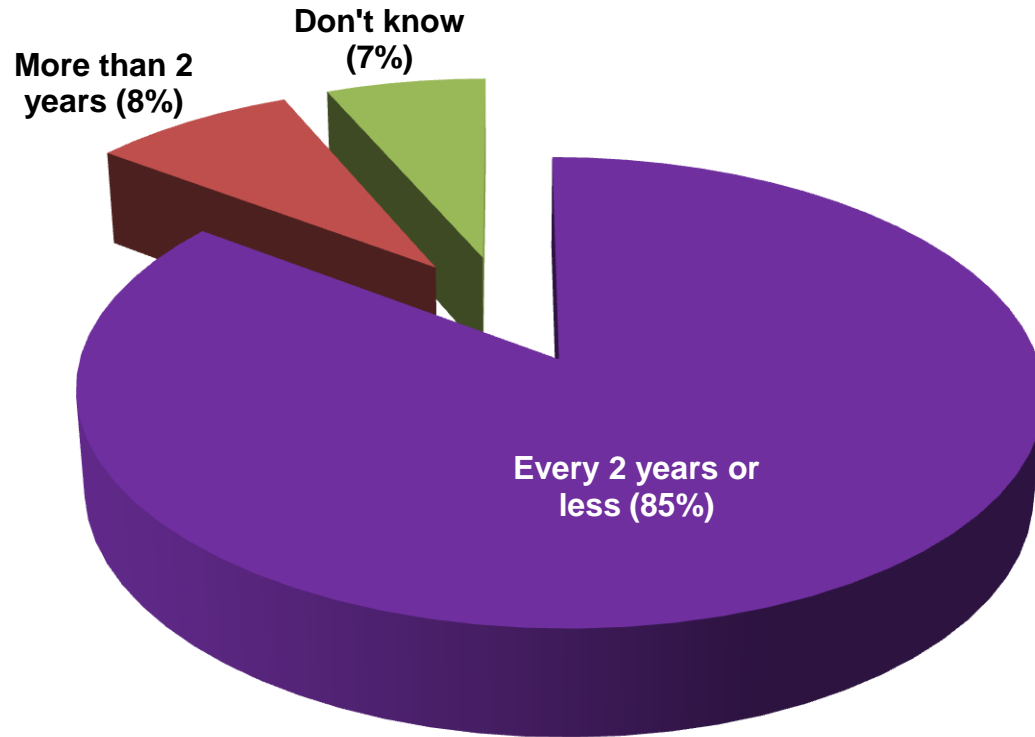


# Where did you hear about this Survey?



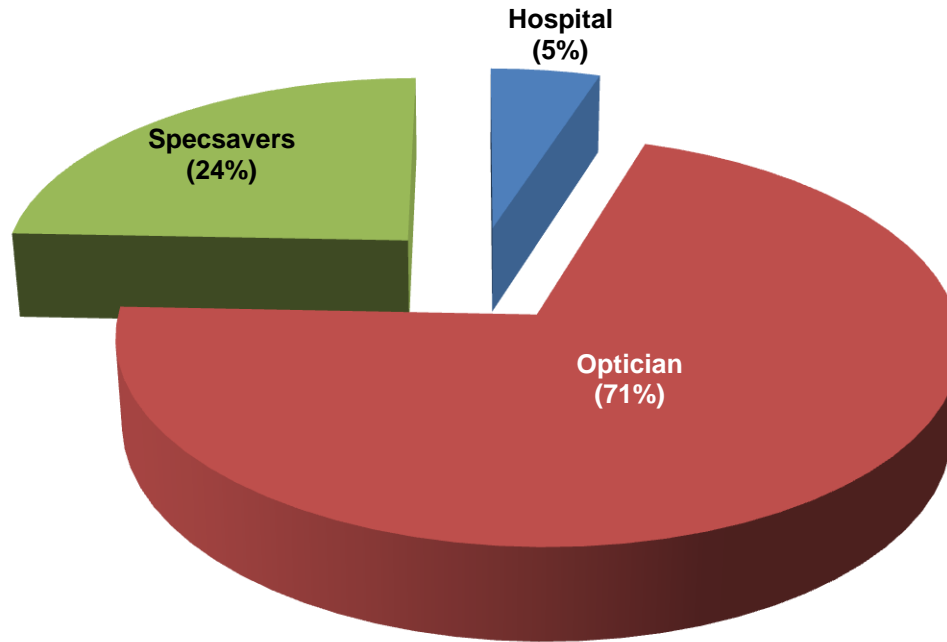
Response: 155 People

# How often do you think 40+ need to test their eyes?



Response: 170 People

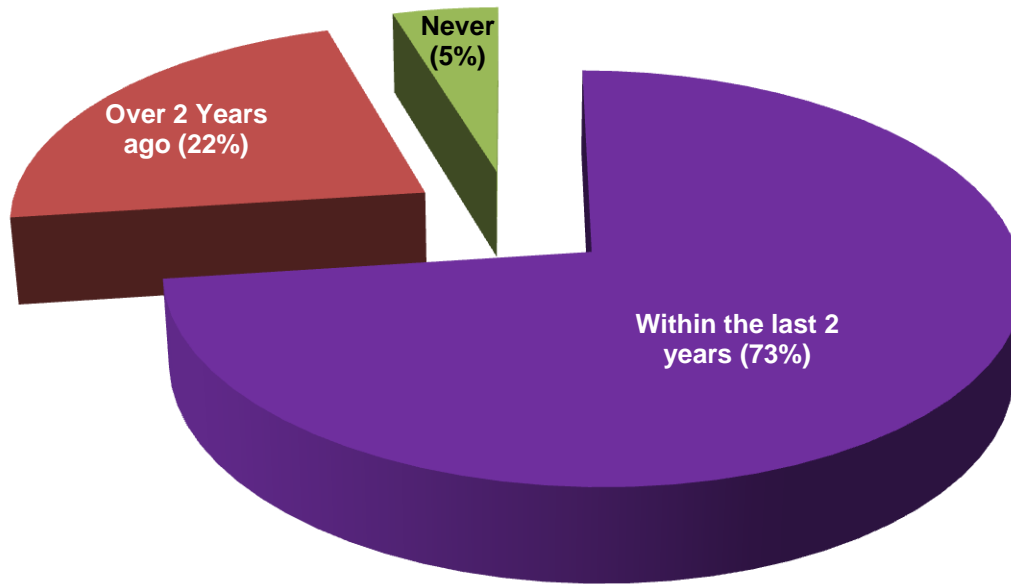
# Where do you go for test?



*Almost 1 in 4 people go to Specsavers!*

Response: 160 People

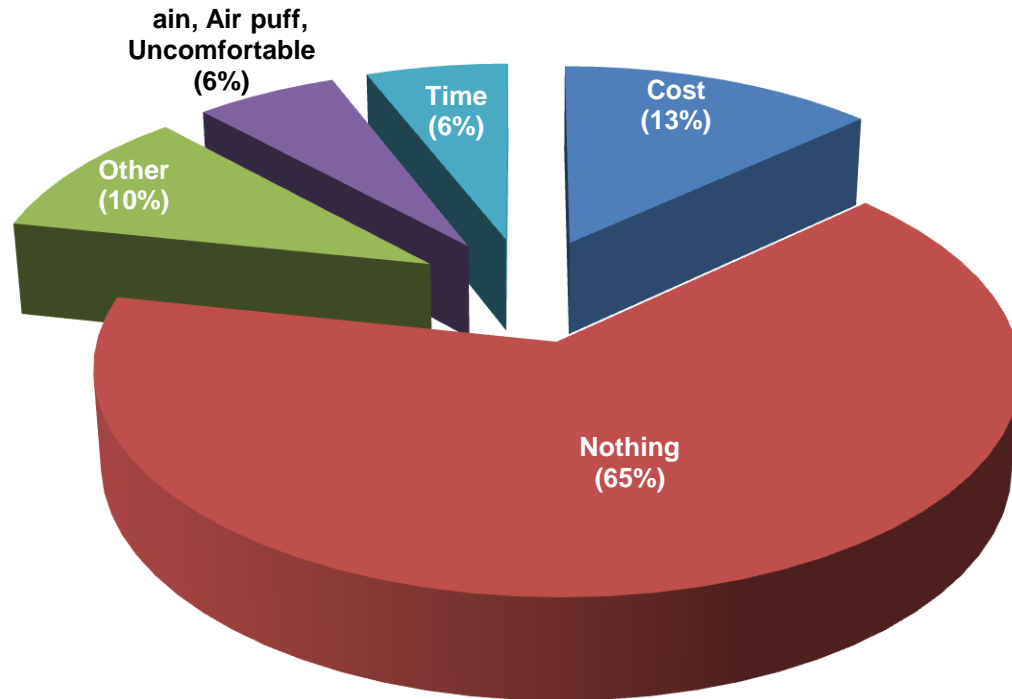
# How long ago you had your last test?



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Response: 170 People

# What put you off going for test?

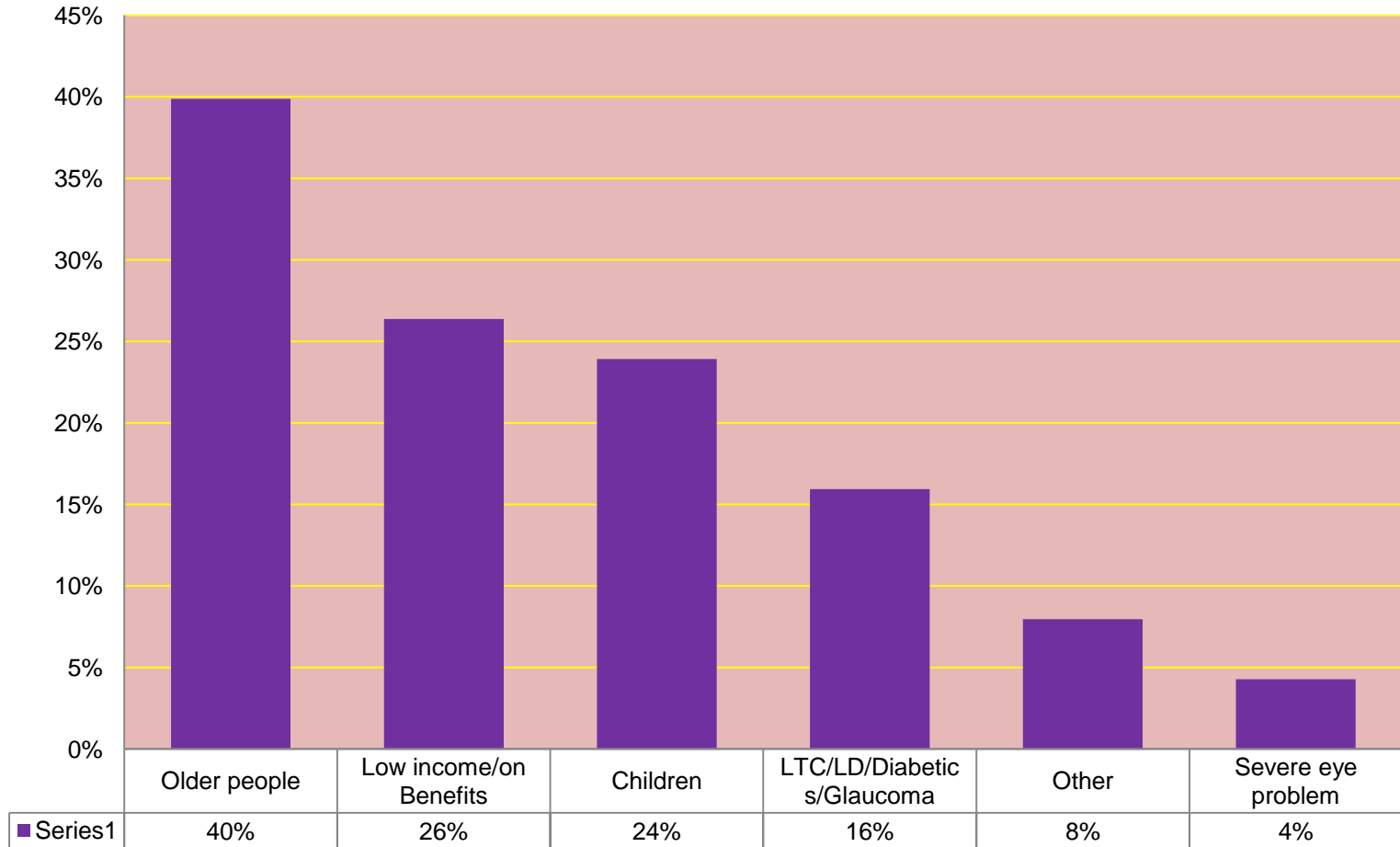


*Other category mainly includes: Optician's behaviour (N=4), Touching eyes (N=3), Ill-Health (N=2) and travelling*

Response: 152 People

# Who do you think are entitled to free eye test?

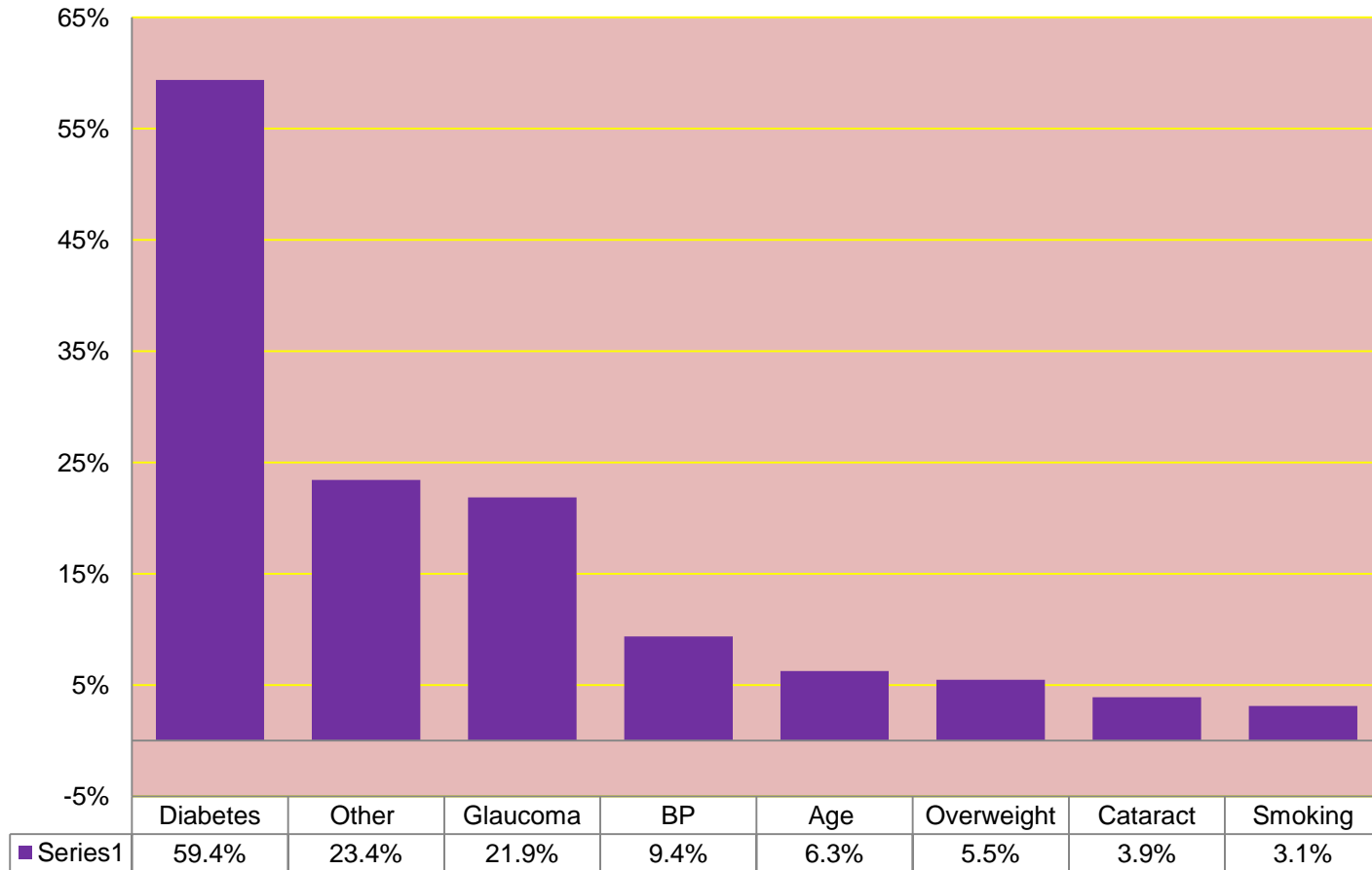
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*Other category mainly includes: People working with computer and student (in full time education).*

Response: 163 People

# What conditions do you think affect eyes?



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*Other category mainly includes: Eye problem (N=5), Stroke (N=3), MSK (N=3) and Brain problem (N=3)*

Response: 128 People

### **Barking & Dagenham Local Optical Committee Submissions**

The Five Year Forward View starts the move towards a different NHS, recognising the challenges and outlining potential solutions to the big questions facing health and care services in England. It defines the framework for further detailed planning about how the NHS needs to evolve over the next five years.

The NHS may be the proudest achievement of our modern society.

It was founded in 1948 in place of fear – the fear that many people had of being unable to afford medical treatment for themselves and their families. And it was founded in a spirit of optimism – at a time of great uncertainty, coming shortly after the sacrifices of war.

Our nation remains unwavering in that commitment to universal healthcare, irrespective of age, health, race, social status or ability to pay and to high quality care for all.

Our values haven't changed, but our world has. So the NHS needs to adapt to take advantage of the opportunities that science and technology offer patients, carers and those who serve them. But it also needs to evolve to meet new challenges: we live longer, with complex health issues, sometimes of our own making. One in five adults still smoke. A third of us drink too much alcohol. Just under two thirds of us are overweight or obese.

These changes mean that we need to take a longer view – a Five Year Forward View to consider the possible futures on offer, and the choices that we face. So this Forward View sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health.

It represents the shared view of the NHS' national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders. It sets out a vision of a better NHS, the steps we should now take to get us there, and the actions we need from others.

#### ***Changes in treatments, technologies and care delivery***

Technology is transforming our ability to predict, diagnose and treat disease. New treatments are coming on stream. And we know, both from examples within the NHS and internationally, that there are better ways of organising care, breaking out of the artificial boundaries between hospitals and primary care, between health and social care, between generalists and specialists - all of which get in the way of care that is genuinely coordinated around what people need and want.



Some of the improvements we need over the next five years are more specific to England in mental health and learning disability services.

People with learning disabilities are ten times more likely to have eye problems, but are less likely to receive timely and appropriate care, than the rest of the population.

The aims of this Community Eye Care Pathway therefore are:

- to provide an additional community service, information and support, where appropriate, to enable people with more complex learning disabilities to access NHS eye health services care (e.g. a sight test and any necessary visual correction) in a community setting like everyone else
  - to improve access to front-line eye health services for all people with learning disabilities
  - to minimise stress and distress for all people with learning disabilities when accessing eye care services
  - to provide reporting of the results of the sight test in an agreed format to the patients and their carers where appropriate
- The UK Vision Strategy seeks a major transformation in the UK's eye health, eye care and sight loss services. A determined and united cross-sector approach will make that change a reality. Three strategic outcome areas are identified:
1. Improving the eye health of the people of the UK
  2. Eliminating avoidable sight loss and delivering excellent support for people with sight loss
  3. Inclusion, participation and independence for people with sight loss

Recent studies have shown that the estimated prevalence of visual impairment or significant refractive error in people with learning disabilities is 52.43% in children, 62.3% in the 20-49 age group and 70.1% in the over 50s<sup>12</sup> - far higher than for the population as a whole. Most of this impairment is refractive<sup>12</sup> and can be corrected with spectacles; however people with learning disabilities are less likely to access sight tests and are also less likely to receive visual aids<sup>13</sup>. "Health Checks for People with Learning Disabilities: A Systematic review of Evidence" by Robertson, Roberts and Emerson, sponsored by the Department of Health<sup>14</sup>, also highlights many of the other health inequalities experienced by people with learning disabilities. This Pathway for adults and young people with learning disabilities is designed to enable access to local NHS eye health services for all patients aged 16 years and older with learning disabilities in the most cost-effective way.

### ***The Health and Wellbeing Gap:***

If the nation fails to get serious about prevention, then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.

For eyes this means: If people are not advised about eye health and risks and if eye conditions are not detected and diagnosed and treated early enough this will lead to blindness or partial loss of vision.

Local services should be directed towards opticians being used to help pick up these diseases and give advice or refer for treatment. Then opticians should be being utilised as health care professionals in the long-term monitoring of these diseases in conjunction with other specialists avoiding the need to visit the hospital which is inconvenient for the person and often more expensive to provide.

This could include:

### **Detection of Glaucoma & Referral Refinement**

To ensure that only people who are failing glaucoma detection tests on two separate occasions are sent to the hospital. Not everyone should be sent for a double check to the hospital. This is expensive and often a waste of money as they pass the test when repeated at the hospital. Many persons may fail the test once but pass it when repeated as they may be tired, lacking concentration etc and results vary from day to day. Ideally the test should be repeated at different day and time to see whether hospital referral is actually necessary. The benefit of repeating the test at their local optician is that they can chose to do so at a time and date of their convenience.\

The aim of this pathway is to:

- reduce unnecessary referrals to the hospital eye service
- reduce patient anxiety and increase capacity within the overburdened hospital glaucoma clinics
- provide a more cost effective service with a greater number of patients being managed within the primary care setting (closer to home and at more convenient times)

### **Cataract Direct Referral**

Currently if a person is thought to have cataract then a letter is issued for the GP. The patient will then either make an appointment with the GP who will then refer them to the hospital or clinic. On attending the hospital the cataract procedure will then be discussed and some further examination will take place to determine whether the person is suitable or even willing to go ahead with surgery.

A much better idea is to allow opticians to carry out a further assessment and to discuss the procedure and details of the operation with the person. If all is acceptable then a referral is made directly to the hospital or clinic. This would mean that the person was not inconvenienced by an unnecessary visit to the GP (which costs the NHS money and also frees up an appointment which can be offered to someone who needs only the GPs expertise.

It is a needless waste of person's time and NHS money sending people to hospital or clinic (such as Upney or Loxford for such a basic service which is more expensive and where they have to travel far from home at appointment times which are inconvenient.

What about the elderly and frail who find it easier to attend a local accessible opticians' practice?

### **Minor Eye Conditions (MECS)**

The aim of the Minor Eye Conditions Service pathway is to:

- provide a timely assessment of the needs of a patient presenting with an eye condition
- reduce unnecessary referrals to the hospital eye services
- reduce patient anxiety and increase capacity within the overburdened hospital eye health services
- provide a more cost effective service with a greater number of patients being managed within the community setting.

A MECS examination will provide a rapid assessment of the needs of a patient presenting with an eye condition.

The examination will be undertaken by an accredited optometrist within suitably equipped premises who will manage the patient appropriately and safely.

Management will be maintained within the community setting for as many patients as possible, thus avoiding unnecessary referrals to hospital services and providing care closer to home.

Where referral to secondary care is required it will be to a suitable specialist with appropriate urgency.

Patients can self-refer or be referred by GPs, pharmacists, NHS 111 or other optometrists.

- Age-related Macular Degeneration (AMD)
- Flashes and Floaters
- Red Eye

**AT PRESENT ALL OF THESE MINOR EYE CONDITIONS ARE ENDING UP AT THE HOSPITAL WHICH IS UNNECESSARY AND EXPENSIVE.**

### Adult Low Vision

There are currently 1.8 million people living with sight loss in the UK (Future Sight Loss, RNIB 2008).

One pathway offers adults with sight loss, quicker access to a low vision assessment and support closer to home. In particular, community optical pathway for an Adult Low Vision enhanced service is designed to:

- reduce unnecessary referrals to the hospital low vision service
- reduce patient anxiety and increase capacity within the overburdened hospital clinic
- provide a more cost effective service with a greater number of patients being managed within the primary care setting
- high quality low vision assessment, information and clinical support, and
- where appropriate, low vision aids (LVAs), daily living aids and follow-up in a community setting in a convenient location for them
- provide accredited theoretical training which supports the pathway (jointly designed by the WOPEC and LOCSU to ensure successful delivery of the pathway).

### Children's Vision

There ought to be a school/ children's' vision screening programme in place for ALL 4-5 year olds in the borough. IN B&D there was a programme a few years ago provided by orthoptists from Queen's Hospital. Of late there is supposed to be a programme running, however we doubt that this is actually being carried out by the NELFT school nurses team. If it is then there is definitely no onward referral to opticians (which ought to happen in an ideal service and was previously the case).

This means that either children who suffer poor vision are not being picked up and treated (very poor for their learning ability and final outcomes for health & wellbeing) OR in children might be screened and then there are unnecessary referrals directly to the hospital when they could be easily seen and treated at their local opticians (more cost effective and less anxiety for the child and easier convenience for the parents so more likely to actually attend the appointments).

The aim of a Children's Vision community service pathway is to reduce unnecessary referrals to secondary care ophthalmology departments. This is achieved by allowing community optometrists to provide management and treatment to children who are found to have suspected amblyopia (lazy eye) following school screening.

Benefits of the pathway include:

- early intervention for patients who have a suspected eye defect which has been identified at school screening, with a maximum waiting time of two weeks

- increased access and choice for patients
- increased capacity and reduced waiting times in secondary care to treat more complex patients
- development of the role of community optometrists
- improved communications between secondary and primary care
- reduction in costs compared with the acute mode/

Under current arrangements, reception age children who are identified as having a suspected eye defect at school vision screening are referred to secondary care. The percentage of children who fail school vision screening at reception age is found to be between 10 and 20% nationally. Screening coverage is approximately 95% in those areas with a screening programme.

### **HOW WE GET THERE VIA FIVE YEAR FORWARD PLAN:**

Risk that NHS will lock itself into outdated models of delivery unless we radically alter the way in which we train and plan our workforce.

Working patterns evolve to support service redesign.

On demand, this Forward View makes the case for a more activist prevention and public health agenda: greater support for patients, carers and community organisations; and new models of primary and out-of-hospital care. While the positive effects of these will take some years to show themselves in moderating the rising demands on hospitals, over the medium term the results could be substantial. Their net impact will however also partly depend on the availability of social care services over the next five years.

There are currently 1.8 million people living with sight loss in the UK (Future Sight Loss, RNIB 2008).

Our pathway offers adults with sight loss, quicker access to a low vision assessment and support closer to home. In particular, community optical pathway for an Adult Low Vision enhanced service is designed to:

- reduce unnecessary referrals to the hospital low vision service
- reduce patient anxiety and increase capacity within the overburdened hospital clinic
- provide a more cost effective service with a greater number of patients being managed within the primary care setting
- high quality low vision assessment, information and clinical support, and
- where appropriate, low vision aids (LVAs), daily living aids and follow-up in a community setting in a convenient location for them

- provide accredited theoretical training which supports the pathway (jointly designed by the WOPEC and LOCSU to ensure successful delivery of the pathway).

### Eye Clinic Liaison Officer (ECLO)

The Barking and Dagenham ECLO is based in Queen's Hospital in Romford. The role of an ECLO is to support people at the point of diagnosis and enable them to access other services and support.

ECLOs :

- Liaise between the hospital eye department and local sensory Impairment and low vision services
- Provide emotional support and signpost to counseling services
- Provide information about a person's eye condition
- Explain life changes and what difficulties a person may expect to experience
- Explain what help and benefits a person can receive because of their visual impairment
- Explain where a person may receive this help, both nationally and locally
- Explain and provide information on the visual impairment registration process

### GAPS & OBSTACLES IN CURRENT PATHWAYS:

- Not integrated with other professionals ie GP, ophthalmologist, local optometrist (opticians) very little information transfer or working together.
- Very poor communication between Moorfields and local opticians.
- Also between health and social care gaps in communication.
- Not Patient focussed.
- Not utilising or developing skills of local workforce
- Current services in hospital and clinics such as Moorfields Upney Lane and Loxford can be less convenient (so more appointments may be missed)
- Current services cannot be accessed at multiple locations throughout borough ie care closer to home
- Not innovative or looking at new models of care to provide better outcomes
- Current services are probably not the most efficient use of budget or existing skills

### **ACTIONS:**

We need to follow suggestions outlined in the five year forward review to ensure new models of care which are patient focussed and also deliver good outcomes on a budget are encouraged during commissioning activity.

### **KEY AREAS:**

- Glaucoma
- Cataract
- Learning Disabilities
- Low Vision
- Minor Eye Conditions
- Macular Degeneration
- Diabetes, Obesity, Stroke, Frailty...
- Childrens Vision

***Jig Joshi, Chair of Local Optical Committee***

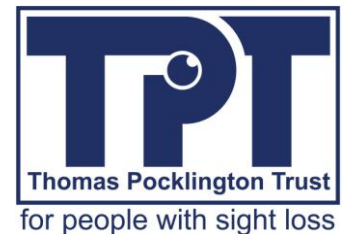
### **References:**

*The Barking & Dagenham Vision Strategy*

<https://www.lbbd.gov.uk/wp-content/uploads/2014/12/Vision-strategy>

*LOCSU Community Services Pathways*

<http://www.locsu.co.uk/>



### Submissions from Thomas Pocklington Trust and ELVis

Further to discussions with the Vision Strategy Group, and in the light of service provision in other London boroughs, please see below the key recommendations for consideration under the LBBB HASSC Local Eye Care Services Scrutiny Review.

- **Low Vision Service:** Establish a holistic community Low Vision service across the borough; to include rehab and emotional support, plus a follow up service to ensure people know how to use the equipment they are issued with (cf. Camden & Islington's service, run out of RNIB, Judd St, or, alternatively, a service run by accredited opticians cross the borough).
- **Eye Clinic Liaison Officer (ECLO):** Ensure an ECLO is in place at Queen's Hospital, Romford, King George Hospital, and Ilford & Barking Community Hospital (BHR Hospitals) eye clinics, to provide emotional support at the point of diagnosis, smooth CVI registration and onward referral to Social Services. The ECLO provides the vital link between health, social care and voluntary services. Latest research shows that 'An investment of £1 can net a return of £10.57 to health and social care budgets'  
(RNIB: *Economic Impact of Eye Clinic Liaison Officers: A Case Study*: <http://www.rnib.org.uk/economic-impact-eclo> cf. Moorfields and Whipps Cross Hospitals)
- **Child screening programme:** Ensure screening is in place for all Reception aged children (rising 5 yr olds), (cf. Bromley, Bexley, Croydon, Tower Hamlets, Newham, Greenwich)
- **Community Eye Care Service:** Fully use the training and skills of opticians to provide local, accessible and timely primary eye care community service, at various opticians' practices across the borough.

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**Chief Executive** Peter Corbett



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## Appendix 4



At present people are having to visit the hospital and wait for appointments when services (e.g. direct referral for cataract, glaucoma/IOP referral refinement & minor eye conditions services) could easily be provided at their local, high street opticians, who are already fully trained to deal with such conditions (cf. Croydon Community Ophthalmology Service and the Bridge to Vision Scheme; enhanced eye examination service for people with Learning Disabilities, already operating very successfully in B&D).

***Submitted by Sharon Schaffer, Vision Strategy Manager, Thomas Pocklington Trust/ East London Vision, Feb 2015***

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INVESTOR IN PEOPLE



Registered Charity No. 1113729  
Company Registered No. 5359336

***Published September 2015***



## HEALTH AND WELLBEING BOARD

20 October 2015

<b>Title:</b>	<b>An Accountable Care Organisation for Barking &amp; Dagenham, Havering, and Redbridge</b>		
<b>Report of the Cabinet Member for Adult Social Care and Health</b>			
<b>Open Report</b>		<b>For Information</b>	
<b>Wards Affected: ALL</b>		<b>Key Decision: NO</b>	
<b>Report Author:</b> Mark Tyson, Group Manager, Integration & Commissioning		<b>Contact Details:</b> Tel: 020 8227 2875 E-mail: mark.tyson@lbbd.gov.uk	
<b>Sponsor:</b> Anne Bristow, Corporate Director of Adult & Community Services & Deputy Chief Executive			
<b>Summary:</b>			
<p>Across local health and social care partners, the next few years will bring a combination of financial challenge and rising demand which is without precedent. Managing this situation will require more than the incremental cutting of elements of service. It will require partners to accelerate the work that is currently underway to strengthen prevention and to shift activity into the community and away from expensive hospital and residential care settings.</p>			
<p>One potential vehicle for achieving this shift in activity is called an 'Accountable Care Organisation'. It is one of the organisational forms which is referred to in the NHS Five-Year Forward View, and would form a vehicle for devolution of responsibility from some central government functions to local areas, in this case the commissioning and management of some NHS services. The principle behind an Accountable Care Organisation is to realign financial incentives so that the system is built around prevention and community support. Potentially, the new organisation would manage urgent and emergency care, other elements of hospital care, primary and community health services, social care and preventive services. All stakeholders in the organisation would be jointly responsible for ensuring that it delivered better outcomes for residents, at reduced cost, removing the incentives in the health and social care system which are currently thought to drive more expensive activity.</p>			
<p>Barking &amp; Dagenham, Havering and Redbridge are seen as a good candidate for piloting this form of devolution, and have submitted an initial expression of interest in doing the more detailed assessment of whether it forms a viable approach to the managing the demands that lie ahead. This report summarises the current position with respect to the development of a business case for piloting an Accountable Care Organisation for Barking &amp; Dagenham, Havering and Redbridge, including the outline timetable for future</p>			

developments, and some of the background on Accountable Care Organisations generally.

No decision is required of the Board at this stage: the expression of interest commits partners to no more than the development of a business case, upon which a future decision by the Board will be required should it adequately evidence the benefits to be gained through the formation of an Accountable Care Organisation.

### **Recommendation(s)**

Members of the Health and Wellbeing Board are recommended to:

- (i) Note that a proposal has been submitted to NHS England's London regional team to develop a business case for the formation of an Accountable Care Organisation across the Barking & Dagenham, Havering and Redbridge health economy;
- (ii) Note that this will be accompanied by a substantial process of consultation to determine how the Accountable Care Organisation will operate, its governance, the services that will be in scope, and the financial parameters within which it will work

### **Reason(s):**

The development of an Accountable Care Organisation potentially offers an approach to the management of the health and social care system for Barking & Dagenham, Havering and Redbridge over the coming years. It will be a major transformation of how services are planned and delivered. At this stage, this is an expression of interest to undertake the detailed work on whether it could deliver the savings and improved services that are initially promised.

Through the business case development, we would seek to demonstrate the extent to which the Accountable Care Organisation could support the Council to achieve, in particular, the part of its vision relating to the enabling of social responsibility: a shift to greater preventive, community-based and self care would be a critical element of the new approach.

## **1. Background, and work to date**

- 1.1 In the Chair's Report to the last Board, it was noted that the Integrated Care Coalition (a partnership of health and care organisations across Barking & Dagenham, Havering and Redbridge) was considering making a case to NHS England to pilot an 'Accountable Care Organisation'.
- 1.2 On 24 September 2015, a high-level proposal was submitted to NHS England to begin the development of a full business case which aims to demonstrate whether an Accountable Care Organisation could deliver both efficiencies and improved care locally over the coming 3-5 years. This followed an intensive piece of work across the three local authorities, CCGs and health trusts, supported by UCL Partners (our academic health sciences partner), to set an initial scope and vision for the potential Accountable Care Organisation.

## 2. An Accountable Care Organisation

- 2.1 Fundamentally, Accountable Care Organisations (ACOs) are about improving health outcomes and care quality whilst containing costs and improving efficiency. They devolve responsibility for care outcomes from a range of different commissioners and providers into a single organisation which takes end-to-end responsibility for supporting prevention of health problems, intervening early, ensuring high quality managed care is in place, and managing acute hospital care.
- 2.2 The NHS 5-Year Forward View identified three critical system ‘gaps’ that had to be addressed for the NHS and its partners. These were about improving the health and wellbeing of our population; addressing challenges in the quality and consistency of care delivered; and managing the challenging funding and efficiency issues in health and social care. ACOs were referred to in this context as one of the ways in which accountability for health and social care could be better devolved to local areas – and nearer to the ‘front line’ – with the intention of improving efficiency, and ensuring that local areas had better control over health interventions in order to address what mattered locally.
- 2.3 As part of the Government’s approach to devolving power and control to local areas, and ahead of the Comprehensive Spending Review due in the Autumn, bids have been sought from areas with the capacity, history of sound joint working, and the appetite to pilot such new arrangements. Barking & Dagenham, Havering and Redbridge have been identified as one such area and early discussions with NHS England and UCL Partners encouraged the submission of the proposal. In essence, the potential of our bid rests on a number of factors particular to our local area:
- A strong history, through the Integrated Care Coalition in particular, of joint working to address significant health and social care ‘system challenges’;
  - As part of that, a strong sense that the work that we are currently doing within the current framework of health and social care organisations will take us as far as it is possible to go without a more radical change to the relationships between organisations responsible for health and social care locally; and
  - Particularly significant health and care challenges that could be impacted upon by the approach taken by an ACO, particularly the shift in emphasis to greater preventive and community-based care.

### How an Accountable Care Organisation would operate

- 2.4 In essence, the ACO would have a *per capita* budget for the delivery of health and social care for a defined population, in this case the 750,000 people that live in Barking & Dagenham, Havering and Redbridge. The ACO is not a commissioning organisation: it is fundamental to its potential success that it has control over how care is actually delivered for a whole population, and can evaluate the potential of preventive interventions and, in turn, reap the benefits of good community-based care through reducing hospital activity.
- 2.5 The shift in governance, accountability and funding flows is complex and would require considerable detailed work to establish. As with other devolution proposals

across the country, there is also the opportunity to set out at the outset the conditions under which the Integrated Care Coalition considers the ACO to be viable, and this is likely to include a number of 'asks' of the national bodies involved, including up-front investment, freedoms and flexibilities, and the opportunity to work with regulators on new approaches to regulating health and social care services.

- 2.6 No decisions have been made about the services that would be in or out of the ACO. The current working hypothesis is that the core of any approach to an ACO locally would be the urgent and emergency care Vanguard programme, which has recently been given the go-ahead for a transformation of urgent care and which includes health services provided by both BHRUT and NELFT. It is anticipated that Primary care would also be part of any ACO, as the principal healthcare providers outside the hospital setting. From a local authority perspective, adult social care and the bulk of the preventive work undertaken through the Public Health Grant have been considered as a likely starting point for inclusion. It is possible, however, that when the needs of our local population are considered more fully, as part of the development of the business case, then other services such as elements of children's services or housing support may be considered a good fit with the ACO's aims and vision.

### **3. Status of the bid and timelines**

- 3.1 It is important to emphasise that the bid is not, at this stage, looking to develop an Accountable Care Organisation. It is a bid to undertake a 6-9 month piece of work, at the end of which, the case to pilot an Accountable Care Organisation will have been rigorously assessed. During the course of this period, there will be a substantial programme of engagement with health and social care partners, service users/patients, and the general public, to refine the proposal and to ensure that we have a full understanding of the risks as well as the potential benefits for the ACO proposal.
- 3.2 The submission to NHS England is expected to form part of their discussions with the Treasury ahead of the Comprehensive Spending Review. It is expected that resources will be secured to support the business case development, to be matched with 'in kind' staff time contributions from local partners.
- 3.3 Whilst discussions continue with NHS England through October, the formal timelines for the next stages of the bid development are:
- 25 November: announcement of the Comprehensive Spending Review, indicating approval of the development of a business case;
  - Through to Summer 2016: development of the business case and preparation of a series of important decisions on governance arrangements, services to be included, 'asks' from central Government, and the risk/benefit analysis;
  - If agreed, then staged development of the pilot ACO over the course of the three years to 2018/19.
- 3.4 It is also important to emphasise that the ACO development is not the sole mechanism by which the budget challenge can be met in the coming years, and nor can partners wait for it to be introduced before implementing further efficiencies in

the delivery of health and social care. Transformation programmes in adult social care and across health services (the urgent and emergency care Vanguard being a prime example) will need to continue at pace in order to ensure that the efficiencies needed over the coming years are delivered.

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

None

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## HEALTH AND WELLBEING BOARD

20 October 2015

<b>Title: Health and Wellbeing Outcomes Framework Performance Report – Quarter 1 (2015/16)</b>	
<b>Report of the Director of Public Health</b>	
<b>Open Report</b>	<b>For Decision</b>
<b>Wards Affected: ALL</b>	<b>Key Decision: NO</b>
<b>Report Author:</b> Susan Lloyd, Consultant in Public Health Danielle Lawrence, Public Health Analyst	<b>Contact Details:</b> Tel: 020 8227 5943 Email: danielle.lawrence@lbbd.gov.uk
<b>Sponsor:</b> Matthew Cole, Director of Public Health	
<b>Summary</b>	
<p>The quarter 1 performance report provides an update on health and wellbeing in Barking and Dagenham. It reviews performance for the quarter, highlighting areas that have improved, and areas that require improvement. The report is broken down into 6 sub-headings:</p> <ul style="list-style-type: none"> <li>• Primary Care</li> <li>• Secondary Care</li> <li>• Mental Health</li> <li>• Adult Social Care</li> <li>• Children's Services</li> <li>• Public Health</li> </ul>	
<b>Recommendation(s)</b>	
<p>(I) The Health and Wellbeing Board is recommended to:</p> <p>(I) Review the overarching dashboard, and raise any questions with lead officers, lead agencies or the chairs of subgroups as Board members see fit.</p> <p>(II) Note the further detail provided on specific indicators, and to raise any further questions on remedial actions or actions being taken to sustain good performance.</p> <p>(III) Note the areas where new data is available and the implications of this data, specifically the immunisation uptake, children and young people accessing Child and Adolescent Mental Health Services (CAMHS), health checks of looked after children, Chlamydia screening, smoking quitters, NHS Health Check, permanent admissions of older people to residential and nursing care homes, delayed transfers of care, A&amp;E attendance and CQC inspections.</p>	

## **Reason(s)**

The dashboard indicators were chosen to represent the wide remit of the Board, and to remain manageable. It is important, therefore, that Board members use this opportunity to review key areas of Board business and confirm that effective delivery of services and programmes is taking place. Subgroups are undertaking further monitoring across the wider range of indicators in the Health and Wellbeing Outcomes Framework and, when areas of concern arise outside of the indicators ordinarily reported to the Board, these will be escalated as necessary.

## **1. Performance Summary**

**Section 1 is a summary. Further information and detail on the actions implemented to improve performance can be found in the main report.**

### **Primary Care**

Please see **section 4** for detailed information.

- 1.1. The development of the Primary Care Transformation Strategy is currently underway. This will outline how NHS Barking and Dagenham Clinical Commissioning Group (CCG) intend to address the complex context of primary care delivery in the borough.
- 1.2. The Care Quality Commission inspected Dr P and S Poologanathan's practice, which was rated good.

### **Secondary Care**

Please see **section 5** for detailed information.

- 1.3. A&E performance for patients waiting less than four hours from arrival to admission, transfer or discharge improved between April and June, but remained below the 95% national standard. In contrast, A&E attendances at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) increased between April and June 2015.
- 1.4. NHS Barking and Dagenham CCG non-elective admissions decreased between April and June. However, delayed transfers of care increased during the same period.
- 1.5. The Care Quality Commission (CQC) conducted a re-inspection of BHRUT in March 2015. The outcome recommended that the trust should remain in special measures.
- 1.6. BHRUT has been selected to participate in a new initiative to receive mentorship from the Virginia Mason Institute to help deliver improvements to the services it provides.

### **Mental Health**

Please see **section 6** for detailed information.

- 1.7. The number of children and young people accessing Child and Adolescent Mental Health Services (CAMHS) increased between Q4 2014/15 and Q1 2015/16.
- 1.8. The proportion of adults on Care Programme Approach in employment increased this quarter. However, we are unable to report IAPT performance as we are awaiting validation.

### **Adult Social Care**

Please see **section 7** for detailed information.

- 1.9. The number of permanent admissions to residential and nursing care homes decreased compared to Q1 2014/15. However, if admissions continue at this high rate, we are likely to overshoot the Better Care Fund annual target.
- 1.10. This ASCOF indicator is a snapshot taken on the last Thursday of the month. This indicator feeds into Domain 2 of the ASCOF (Adult Social Care Outcomes Framework). This is a two-part measure that reflects both the overall number of delayed transfers of care (part 1) and the number of these delays which are attributable to social care services (part 2). In Q1 there was an increase in both delayed transfers of care from hospital and delayed transfers of care due to social care. However, this increase in delays is not significant and we are still below the England average and only slightly above the London average. Early indications are that this is likely to level out over the next two quarters.
- 1.11. During the first quarter of 2015/16, six CQC inspection reports were published. Four were rated good, and the remaining two were rated requires improvement and inadequate. The appropriate action has been taken as a result of the inspections. Please see section 7.5 and appendix C for detailed information.

### **Children's Care**

Please see **section 8** for detailed information.

- 1.12. Most recent data for the uptake of childhood immunisations for MMR2 and DTaP/IPV in children aged up to 5 years shows that coverage increased in Q4 2014/15, but performance remains below the national target (MMR2 by nine percentage points, and DTaP by twelve percentage points). An action plan, with NHS England input, has been put in place to improve performance.
- 1.13. The percentage of looked after children with an up to date health check decreased in Q1. However, this level of performance is comparable to Q1 2014/15. A drop in performance, of around ten percentage points, between Q4 and Q1 has been observed for the last two years as performance on LAC health checks fluctuates throughout the year as new children come into care. By the end of the financial year performance usually exceeds 90%, above national and London averages.

Regular meetings to review progress and address any issues have been implemented to improve performance. An action plan is in place to improve performance, monitored at monthly meetings between the Local Authority and Designated LAC Nurse to review progress and address any issues. There has also been a recent change of process, resulting in an improvement in the return of paperwork. Performance on health has also been included in performance dashboards for each team across social care. Performance is on track to exceed 90% at the end of March 2015/16.

### **Public Health**

Please see **section 9** for detailed information.

- 1.14. The number of positive Chlamydia screening results decreased in Q1. In contrast, the annual Chlamydia detection rate increased in 2014. However, this still remains below the national target. A robust payment process and increased offer and uptake in primary care are being implemented to improve performance.
- 1.15. The number of four week smoking quitters in the borough this quarter was less than half of the number reported in Q4 2015/16, and fell short of the quarterly target. An action plan focusing on increasing promotion and activity in acute, primary care and community-based settings is being implemented.
- 1.16. The provisional figure for NHS Health Check uptake shows a decrease in performance in Q1. However, this is comparable with the performance reported in Q1 2014/15, and this trend has been observed in previous years.

### **Indices of Deprivation**

Please see **section 10** for detailed information.

- 1.17. Barking and Dagenham is now ranked as the 12<sup>th</sup> most deprived borough in England, and the 3<sup>rd</sup> most deprived borough in London for overall deprivation. Both rankings have worsened since 2010, which means that there has been slower improvement in the borough compared to other boroughs.

## **2. Background / Introduction**

- 2.1. The Health & Wellbeing Board has a wide remit, and it is therefore important to ensure that the Board has an overview across this breadth of activity.
- 2.2. The indicators chosen include those which show performance of the whole health and social care system, and include selected indicators from the Urgent Care Board's dashboard.
- 2.3. The indicators contained within the report have been rated according to their performance; red indicates poor performance, green indicates good performance and amber shows that performance is similar to expected levels. The indicators are measured against targets, and national and regional averages.

## 2. Main Report

### Overview of Health and Wellbeing performance in Quarter 1

- 2.4. **A dashboard summary of performance in Q1 (April – July 15) against the indicators selected for the Board can be found in Appendix A.** There continues to be substantial gaps in monitoring information due to indicators being on annual cycles or having significant delays in the data becoming available.

**We have not reported on childhood obesity, under 18 conception rate, cervical screening, breast screening and injuries due to falls in persons aged 65 and over because there is no new data available on these indicators.** At the last report Barking and Dagenham was performing below national average on these indicators.

## 3. Primary Care

### Primary Care Transformation Strategy

- 3.1. **Development of the Primary Care Transformation Strategy is currently underway.** This strategy will outline how NHS Barking and Dagenham CCG intend to address the complex and changing context of primary care delivery in the borough, including the increased demand for healthcare services, more people suffering from long term conditions and the emergence of GP federations. The Primary Care Transformation dashboard will be approved by the Primary Care Transformation Board in autumn 2015.

### CQC Inspections

- 3.2. **The CQC carried out an inspection of Dr P and S Poologanathan's practice** on 18 March 2015, the outcome of which was published in July 2015. The practice was rated **good** for providing well-led, effective, caring and responsive services. However, the provision of safe services was highlighted as an area requiring further improvement. Further details on the areas that were judged by the CQC to be good, and those areas where improvements must be made can be found in the [full report](#).

## 4. Secondary Care

### Urgent Care

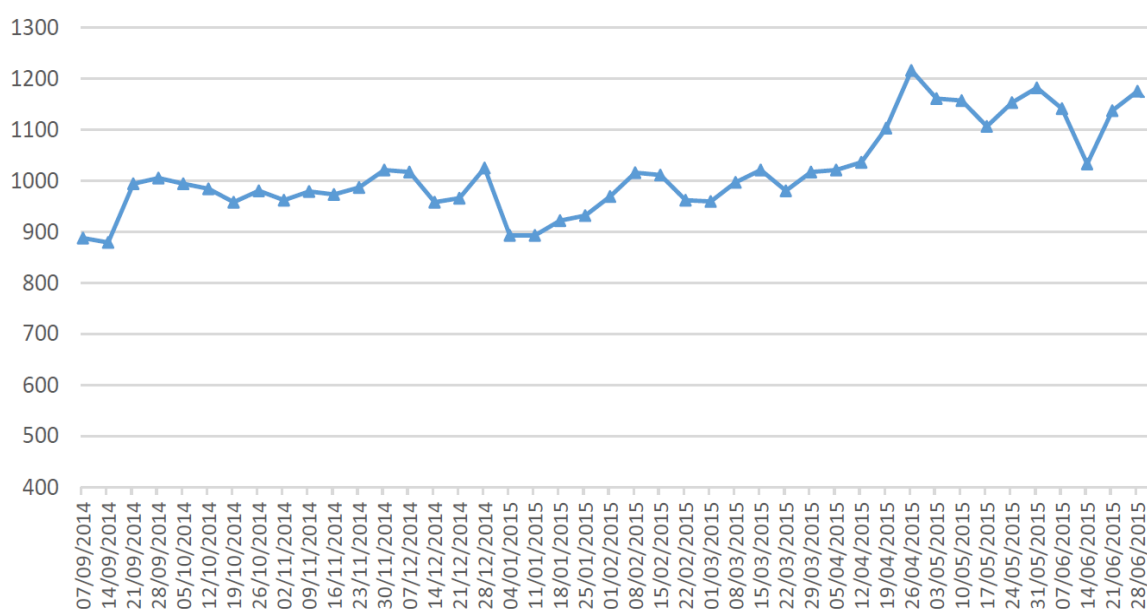
- 4.1. **A&E performance for patients waiting less than four hours from arrival to admission, transfer or discharge improved this quarter.** The Trust's overall performance began the quarter at 93.3% in April, before decreasing slightly to 93.1% in May, then increasing again to 94.6% in June. Therefore, in Q1 performance was below the national standard of 95%. Overall, Queens Hospital

performance increased from 91.2% in April to 93.3% in June, and King George Hospital performance began and ended the quarter on 96.6%.

4.2. **Overall, A&E attendances at BHRUT increased; attendances rose from 21,571 in April to 22,444 in June.**

4.3. **The total Barking and Dagenham, Havering and Redbridge CCGs non-elective admissions at BHRUT decreased by 134 (3.4%) from 3,967 in April to 3,833 in June.** NHS Barking and Dagenham CCG had a decrease of 14 (0.1%) from 1,129 in April to 1,115 in June. In comparison with June 2014, June 2015 non-elective admissions increased by 11.4% (1,001 non-elective admissions in June 2014).

**Figure 1: BHRUT Non-Elective Admissions**



4.4. **Overall, delayed transfers of care performance deteriorated between April and June, but remained within target.** At the start of the quarter the weekly average was 9.8. This increased to 12.3 in May, before falling again to 10.8 in June. In response to the performance concerns around delayed transfers of care, the Joint Executive Management Group for the Better Care Fund requested a deeper analysis of the causes. Three key areas were identified as affecting performance, and action is being taken to address these:

- Patients awaiting Specialist Rehabilitation placements. NHS England is responsible for this area and they are currently carrying out a review of the pathway to ensure delays are reduced.
- There is currently a freeze on further social care placements for people with mental health problems whilst a budget overspend is contained for this service. Urgent placements are being made by exceptional agreement with the statutory Director of Adult Services.

- The Joint Assessment & Discharge Service reviews all cases which BHRUT propose to report as a delayed transfer to confirm that they meet the requirements for reporting. This was not in place with other hospitals, but it has now been agreed that the JAD will review reporting so that causes can be understood.

## **CQC Inspections**

- 4.5. **Both Trusts that serve Barking and Dagenham are still in special measures.** The population of Barking and Dagenham is mainly served by BHRUT. However, services are also provided by Barts NHS Trust, Whipps Hospital. Both of these NHS Trusts have been placed into special measures and have performance improvement plans in place. As a result, improvements have been made, but further work is required.
- 4.6. **The CQC conducted a re-inspection of BHRUT in March 2015**, the outcome of which was published in July 2015. The CQC report stated that the trust had made significant progress over the past year. However, further improvement in quality and safety was required across multiple services before they could be rated good; the trust received a rating of **requires improvement** for **4 out of 5** of the standards required by CQC, and received a rating of **inadequate** for its **responsiveness**. Therefore, the recommendation was made that the trust should remain in special measures. The trust is now working with its partners to update their improvement plan on how they can continue to develop and improve services for patients.
- 4.7. **BHRUT is one of five NHS Trusts to be selected to participate in a new initiative to receive mentorship from the Virginia Mason Institute in the USA** – a hospital renowned for its healthcare expertise.
- 4.8. **Improvements to maternity services are required at Homerton Hospital.** The CQC inspected the maternity unit at the Homerton Hospital in March and published their report in August. The report found that maternity and gynaecology services required improvement and that services were rated **inadequate** for safety. Further details can be found in the [full report](#). Assurances are being sought from City and Hackney CCG on the immediate steps that have been taken to ensure the safety of services.

## **5. Mental Health**

### **Child and Adolescent Mental Health Services (CAMHS)**

- 5.1. **The number of children and young people accessing CAMHS tiers 3 and 4 increased from 563 in Q4 2014/15 to 585 in Q1 2015/16.** This performance is also an improvement on Q1 2014/15, when 528 children and young people accessed CAMHS. This indicator has not been given a RAG rating as there is no target associated with this indicator.
- 5.2. **100% of inpatients discharged from hospital received follow ups within 7**

**days in Q1.** Performance in this indicator has remained constant since Q1 of 2014/15, with the exception of Q4 2014/15.

### **Improving Access to Psychological Therapies (IAPT)**

- 5.3. IAPT data is being validated, so we are unable to report on performance this quarter.
- 5.4. **In Q1, 258 people completed treatment and moved towards recovery, which is higher than the Q4 2014/15 figure of 225.** Therefore, performance in this service area has improved.

### **Care Programme Approach (CPA)**

- 5.5. **The proportion of adults on CPA in settled accommodation has decreased slightly from 89.3% in Q4 2014/15 to 88.2% in Q1 2015/16.** Therefore performance in this indicator has slightly decreased.
- 5.6. **The proportion of adults on CPA in employment has increased from 5.0% in Q4 2014/15 to 5.4% in Q1 2015/16, indicating improved performance.** The Richmond Fellowship continues to support access to employment for individuals on CPA.

## **6. Adult Social Care**

### **Delayed Transfers of Care**

- 6.1. This is a measure that reflects both the overall number of delayed transfers of care, and the number of these delays attributable to social care services.
- 6.2. **There was a significant increase in delayed transfers of care from hospital, from 5.4 (per 100,000 population) in Q4 2014/15 to 7.2 in Q1 2015/16.** There was also a significant increase in the delayed transfers of care due to social care, which increased from 2.2 (per 100,000) in Q4 2014/15 to 2.63 in Q1 2015/16. However, this figure continues to be lower than the national average, which for Q1 2015/16 was 4.39.

### **Social Care Admissions**

- 6.3. The number of permanent admissions to residential and nursing care homes is a good measure of the effectiveness of care and support in delaying dependency on care and support services.
- 6.4. **In Q1 2015/16 there were 40 admissions into residential and nursing care homes, which equates to 183.03 admissions per 100,000 population. This is an improvement on the Q1 2014/15 figure of 240.80 admissions per 100,000 population.** However, the annual target set by the Better Care Fund is 125 admissions (635.93 per 100,000 population), where good performance would not



be higher than this figure. Therefore, if admissions continue at this high rate, we are unlikely to meet the target.

## **CQC Inspections**

- 6.5. **An overview of CQC inspection reports published during the first quarter of 2015/16 on providers in the Borough, or those who provide services to our residents and actions taken as a result of the inspection, can be found in Appendix C.**
- 6.6. **During this period 6 reports were published on local organisations using the new CQC ratings introduced in October 2014.** Of the 6 providers inspected, 4 met the requirement for an overall rating of good. The 2 remaining providers were rated requires improvement and inadequate.
- 6.7. **Cherry Orchard Care Home (CareUK) rated requires improvement.** Cherry Orchard is registered for adults aged 18 years onwards with dementia, mental health conditions and learning disabilities who also have challenging behaviour. Residents are all health funded.
- 6.8. The CQC identified during their inspection several areas of concern including staff training, administration of medication, level of staffing and inefficient Deprivation of Liberty training and processes.

Care UK took the decision to suspend placements to address the concerns raised by the CQC and to comply with the CQC action plan. Please see Appendix C for further information.

- 6.9. **George Brooker House (Abbeyfield East London) rated inadequate.** George Brooker House is registered for people over 65 with dementia and physical disabilities.
- 6.10. During their inspection, the CQC found poor administration of medicine, inadequate staff training and record keeping, lack of effective infection control, ineffective management structure and poor reporting of incidents to CQC.

**As a result of the poor rating, risk assessments on residents in the home have been carried out. Residents were found to be safe, well cared for and happy with the service being provided to them.** We have increased quality assurance monitoring to support the provider to meet the requirements of the action plan. The Deputy Manager has now taken over all managerial responsibilities and is making the necessary changes to comply with the CQC action plan. Please see Appendix C for further information.

## **7. Children's Care**

### **Immunisation**

- 7.1. **The percentage uptake of Diphtheria, Tetanus and Pertussis and Polio booster immunisation (DTaP/IPV) by the age of 5 remains above the London**

**rate of 77.0%, but below the England rate of 88.4%.** Performance in this indicator increased by 5.3 percentage points, from 80.9% in Q3 2014/15 to 86.2% in Q4. This is the most recent data for this indicator.

- 7.2. **The percentage uptake of Measles, Mumps and Rubella immunisation (MMR2) by the age of 5 also increased in Q4, from 78.8% in Q3 2014/15 to 83.4% in Q4.** Therefore performance in this indicator is also above the London rate of 80.1%, but below the England rate of 88.6%. **Performance for both immunisation indicators is below the national target of 95%, which has resulted in a red RAG rating.**
- 7.3. **An action plan, with NHS England input, has been put in place to address areas of poor performance.** Actions are also being undertaken to ensure Barking and Dagenham GP practices have access to I.T. support for generating immunisation reports. Furthermore, children who persistently miss immunisation appointments are to be followed up to ensure they are up to date with immunisations. Identifying the best performing practices for immunisation uptake and sharing their best practice will help improve immunisation uptake in poorer performing practices. GP practices are also to be encouraged to remove ghost patients from their register, as a significantly higher than expected number of eligible children was highlighted as a data quality issue for NHS Barking and Dagenham CCG.

#### **Annual Health Checks of Looked After Children (LAC)**

- 7.4. **Performance is currently 82% (Q1 2015/16), which is below the London (88.1%) and just below the England (84.3%) average rates.** The percentage of looked after children with an up to date health check decreased from 93% in Q4 2014/15 to 82% in Q1 2015/16. However, this level of performance is comparable with Q1 2014/15, when 84.2% of looked after children had an up to date health check. A drop in performance of around 10% between Q4 and Q1 has been observed in the last two years; prior to this data was reported annually. This indicator has been rated amber. Performance, however, is on track to exceed 90% at the end of March 2015/16.
- 7.5. **An action plan is in place to improve performance.** This includes monthly meetings between the Local Authority and Designated LAC Nurse to review progress and address any issues. There has also been a recent change of process which has resulted in an improvement in the return of paperwork.
- 7.6. **The LAC Nurse attended the Children's Social Care management meeting in July to outline performance requirements and issues to all responsible managers, and will continue to attend this meeting quarterly.** Performance on health has also been included in performance dashboards for each team.

## **8. Public Health**

### **Four week smoking quitters**

The four week quitter figure measures the number of individuals who have successfully quit for four weeks.

**Table 1: Barking and Dagenham four week quitters**

	April	May	June	TOTAL	Annual Target
<b>GP</b>	6	12	12	<b>30</b>	2,000
<b>Pharmacy</b>	28	20	22	<b>70</b>	
<b>Tier 3</b>	5	5	8	<b>18</b>	1,000
<b>TOTAL</b>	<b>39</b>	<b>37</b>	<b>42</b>	<b>118</b>	3,000

- 8.1. **There were 98 quitters in Q1 2015/16, which is less than half of the number of quitters in Q4 2014/15 (200 quitters).** This figure is also significantly lower than the Q1 2014/15 figure of 142 quitters. To achieve this year's annual target of 3,000, an average of 750 quitters would be required each quarter. This quarter's figure falls significantly short of this target, and as a result this indicator has been rated red.
- 8.2. **Women smoking during pregnancy are being targeted via the babyClear scheme. In Q1 2015/16, there were 3 pregnant quitters, compared to 1 pregnant quitter in Q1 2014/15.** However, the scheme was introduced recently, and it is expected that there will be more pregnant quitters in subsequent quarters, following completion of stop smoking advice training for midwives in Queen's and King Georges Hospital in September 2015.
- 8.3. **Public Health has implemented a project plan to improve smoking cessation performance in the borough by focusing on increasing stop smoking services promotion and activity in acute, primary care and community-based settings.** The project plan intends to improve awareness of stop smoking services and accessibility, targeting priority groups including pregnant women, routine and manual workers and those with chronic obstructive pulmonary disease and mental health diagnoses.
- 8.4. **Care pathways are to be improved to allow better referral and navigation of the stop smoking pathway.** Those wishing to quit smoking will be signposted to a comprehensive range of support including access to healthy lifestyle support, nicotine replacement therapy, or intensive specialist advice as appropriate. Local implementation of national quit smoking campaigns such as Stoptober is underway.

### **NHS Health Check**

- 8.5. This indicator measures the percentage uptake of NHS Health Check among the eligible population of persons aged 40-74 years.
- 8.6. **Provisional figures for this indicator show that the uptake of health checks**

**decreased from 4.8% (1,628) in Q4 2014/15 to 2.5% (1,079) in Q1 2015/16.** However, this performance is comparable with Q1 2014/15, when 2.6% of the eligible population had received an NHS Health Check. Performance in this indicator has therefore been rated amber.

- 8.7. **To meet the national annual target of 15%, the uptake of health checks needs to maintain an average of 3.75% each quarter.** This quarter's performance does not meet this target. However, if this year's performance follows the trend observed last year, and performance improves over the remaining quarters, Barking and Dagenham could meet the annual target.
- 8.8. **An action plan is in place to facilitate performance improvement in this indicator.** This includes making improvements to the NHS Health Check invitation letter to increase uptake, developing a local marketing campaign to raise awareness of the benefits of the NHS Health Check, and working with external stakeholders, such as the CCG and the GP Federation and Local Medical Committee. The worst performing practices for NHS Health Check offer and uptake will be identified and targeted.

#### **Number of positive chlamydia screening tests**

- 8.9. The chlamydia screening indicator is a measure of the number of positive tests from the screening process in young adults aged 16-24 years, compared with the expected numbers of positive tests.
- 8.10. **The number of positive chlamydia screening results decreased from 132 in Q4 2014/15 to 118 in Q1 2015/16.** This is also lower than the number of positive results reported in Q1 2014/15 (141 positive results). To achieve this year's annual target of 593 positive tests, an average of 149 positives would be required each quarter. This quarter's result falls short of this target by 31. As a result, this indicator has been rated red.
- 8.11. **In 2014, the chlamydia detection rate in Barking and Dagenham was 2,174 per 100,000 population aged 15-24. This is an improvement on the 2013 figure of 2,087, and is higher than the 2014 England average of 2,012.** However, this rate remains below the national target of 2,300. To achieve the national target the positive detection rate would need to increase by 126 per 100,000 population aged 15-24 years.
- 8.12. **To improve performance in this indicator a robust payment process has been implemented,** as payment delays for reported activity impacted on GP activity in 2014/15. The number of GPs and pharmacies providing chlamydia screening will be increased in Q2 to provide wider primary care screening capacity, as well as GUM clinics at BHRUT. In addition, enhanced integrated approaches to delivering chlamydia screening and psychosexual support will be developed, as will a local promotional campaign to support the normalisation of regular chlamydia screening amongst young people.

## 10. Indices of Deprivation

- 10.1. The English Indices of Deprivation measure relative levels of deprivation across small areas (neighbourhoods) in England. The 7 areas which make up the English Indices of Deprivation are: income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, crime, barriers to housing and services, and living environment deprivation. Figures for 2015 were recently released.
- 10.2. **Barking and Dagenham is now ranked as the 12<sup>th</sup> most deprived borough in England for overall deprivation; the borough is now ranked as more deprived relative to other boroughs in England.** In 2010, the borough was ranked as the 22<sup>nd</sup> most deprived borough in England, so there has been a change of 10 positions.
- 10.3. **The borough is now the 3<sup>rd</sup> most deprived borough in London,** below Tower Hamlets and Hackney. In 2010, the borough was ranked as the 7<sup>th</sup> most deprived borough in London, so there has been a change of 4 positions.
- 10.4. **It is essential to note that the worsening in rank does not mean that deprivation has worsened in the borough,** but that **there has been a slower relative improvement in Barking and Dagenham compared to some other London and England boroughs** and local authorities.

## 11. Mandatory implications

### 11.1. Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment provides an overview of the health and care needs of the local population, against which the Health and Wellbeing Board sets its priority actions for the coming years. By ensuring regular performance monitoring, the Health and Wellbeing Board can track progress against the health priorities of the JSNA, the impact of which should be visible in the annual refreshes of the JSNA.

### 11.2. Health and Wellbeing Strategy

The Outcomes Framework, of which this report presents a subset, sets out how the Health and Wellbeing Board intends to address the health and social care priorities for the local population. The indicators chosen are grouped by the 'life course' themes of the Strategy, and reflect core priorities.

### 11.3. Integration

The indicators chosen include those which identify performance of the whole health and social care system, including in particular indicators selected from the Urgent Care Board's dashboard.

#### 11.4. Legal

Implications completed by: Dawn Pelle, Adult Care Lawyer, Legal and Democratic Services

There are no legal implications for the following reasons:

The report highlights how the various bodies have met specific targets such as the performance indicators: whether they have or have not been met in relation to the indicators for London and England. How the authority is measuring up against the National average.

#### 11.5. Financial

Implications completed by: Roger Hampson Group Manager, Finance

There are no financial implications directly arising from this report.

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

None

#### **List of Appendices**

**Appendix A:** Performance Dashboard

**Appendix B:** NELFT Mental Health Services Quarter 1 2015/16 Dashboard

**Appendix C:** CQC Inspections Quarter 1 2015/16

**Key**

**Appendix A: Indicators for HWBB - 2015/16 Q1**

..	Data unavailable due to reporting frequency or the performance indicator being new for the period
..	Data unavailable as not yet due to be released
	Data missing and requires updating
	Provisional figure
<b>DoT</b>	The direction of travel, which has been colour coded to show whether performance has improved or worsened
<b>NC</b>	No colour applicable
PHOF	Public Health Outcomes Framework
ASCOF	Adult Social Care Outcomes Framework
HWBB OF	Health and Wellbeing Board Outcomes Framework
BCF	Better Care Fund

Title	2013/14	2014/15				2014/15	2015/16				2015/16	DoT	RAG Rating	BENCHMARKING		HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4				England Average	London Average		
<b>1 - Children</b>																	
Percentage of Uptake of Diphtheria, Tetanus and Pertussis (DTaP) Immunisation at 5 years old	83.4%	82.8%	83.3%	80.9%	86.2%	..	..					↗	R	88.4%	77.0%	1	PHOF
Year end figures not yet published. Data is published each quarter but when the full year figures are published they adjust for errors in the quarterly data and comprise all the children immunised by the relevant birthday in the whole year. 2014/15 Q4 data is not yet published																	
Percentage of Uptake of Measles, Mumps and Rubella (MMR2) Immunisation at 5 years old	82.3%	82.2%	82.2%	78.8%	83.4%	..	..					↗	R	88.6%	80.1%	2	PHOF
Year end figures not yet published. 2014/15 Q4 data not yet published.																	
Prevalence of children in reception year that are obese or overweight	26.6%					27.6%						↗	R	22.5%	23.1%	3	PHOF
Prevalence of children in year 6 that are obese or overweight	42.4%					40.5%						↘	R	33.5%	37.6%	4	PHOF
Number of children and young people accessing Tier 3/4 CAMHS services	1,053	528	546	635	563	1,217	585					↗	NC			5	HWBB OF
Year end figure is the number of unique people accessing CAMHS over the course of the year.																	
Annual health check Looked After Children	93.4%	84.2%	78.4%	74.8%	93.0%	93.0%	82.0%					↘	A	84.3%	88.1%	6	HWBB OF
<b>2 - Adolescence</b>																	
Under 18 conception rate (per 1000) and percentage change against 1998 baseline.	42.4	..	..	..	..	..						↗	R	24.3	21.8	7	PHOF
Number of positive Chlamydia screening results (data)	511	141	141	127	132	541	118					↘	R			8	HWBB OF

\* Data from 2011/12

**Key**

**Appendix A: Indicators for HWBB - 2015/16 Q1**

	Data unavailable due to reporting frequency or the performance indicator being new for the period
..	Data unavailable as not yet due to be released
	Data missing and requires updating
	Provisional figure
DoT	The direction of travel, which has been colour coded to show whether performance has improved or worsened
NC	No colour applicable
PHOF	Public Health Outcomes Framework
ASCOF	Adult Social Care Outcomes Framework
HWBB OF	Health and Wellbeing Board Outcomes Framework
BCF	Better Care Fund

Title	2013/14	2014/15				2014/15	2015/16				2015/16	DoT	RAG Rating	BENCHMARKING		HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4				England Average	London Average		
<b>3 - Adults</b>																	
Number of four week smoking quitters	1,174	142	162	139	200	643	98					↘	R			9	HWBB OF
Please note that the most recent quarter is an incomplete figure and will be revised in the next HWBB report.																	
Cervical Screening - Coverage of women aged 25 -64 years	72.4%					..						↗	A	74.2%	70.3%	10	PHOF
Percentage of eligible women screened adequately within the previous 3.5 (25-49 year olds) or 5.5 (50-64 year olds) years on 31st March																	
Percentage of eligible population that received a health check in last five years	11.4%	2.6%	4.2%	4.4%	4.8%	16.3%	2.5%					↘	A	9.6%	11.6%	11	PHOF
Please note that annual figures are a cumulative figure accounting for all four previous quarters.																	
<b>4 - Older Adults</b>																	
Breast Screening - Coverage of women aged 53-70 years	71.2%					..						→	A	75.9%	68.9%	12	PHOF
Percentage of women whose last test was less than three years ago.																	
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	696.8	240.8	425.3	614.9	936.58	936.58	183.03					↘	A	668.4	463.9	13	BCF/ASCOF
Q4 figure is not finalised yet and will be updated for next meeting.																	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	88.3%					..						↘	A	81.9%	87.8%	14	BCF/ASCOF
2014/15 figures due to be released November 2015																	
Injuries due to falls for people aged 65 and over	2027.0					..						↘	A	2064.0	2197.0	15	BCF/PHOF
Directly age-sex standardised rate per 100,000 population over 65 years. Unable to calculate more recent figures due to lack of access to HES data.																	

\* Data from 2011/12



Key

Appendix A: Indicators for HWBB - 2015/16 Q1

	Data unavailable due to reporting frequency or the performance indicator being new for the period
..	Data unavailable as not yet due to be released
	Data missing and requires updating
	Provisional figure
DoT	The direction of travel, which has been colour coded to show whether performance has improved or worsened
NC	No colour applicable
PHOF	Public Health Outcomes Framework
ASCOF	Adult Social Care Outcomes Framework
HWBB OF	Health and Wellbeing Board Outcomes Framework
BCF	Better Care Fund

Title	2013/14	2014/15				2014/15	2015/16				2015/16	DoT	RAG Rating	BENCHMARKING		HWBB No.	Reported to
		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4				England Average	London Average		
<b>5 - Across the Lifecourse</b>																	
The percentage of people receiving care and support in the home via a direct payment	73.4%	74.7%	75.2%	76.2%	76.7%	75.7%	76.6%					↗	G	62.1%	67.4%	16	ASCOF
Delayed transfers of care from hospital	5.5	4.2	4.7	5.4	5.4	4.9	7.2					↗	A	9.7	6.9	17	ASCOF
Delayed transfers due to social care	1.1	2.22	1.73	2.91	2.2	2.25	2.63					↗	A	3.1	2.3	18	ASCOF
Emergency readmissions within 30 days of discharge from hospital	13.3%	..	..	..	..	..						→	A	11.8%	11.8%	19	PHOF
Percentage of emergency admissions occurring within 30 days of the last, previous discharge after admission, Indirectly standardised rate - 2011/12 is most recent data and was published in March 2014.																	
A&E attendances < 4 hours from arrival to admission, transfer or discharge (type all)	88.8%	85.6%	86.4%	80.5%	88.8%	..	93.4%					↗	A	93.6%		20	HWBB OF
BHRUT Figure. 2014/15 annual figure not available.																	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions	1,072.7	..	..	..	..	..						↘	R	799.6	776.9	21	HWBB OF
Update due in November 2015.																	

\* Data from 2011/12

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## 2015-16 NELFT Mental Health Services

### Barking & Dagenham CCG Information Requirements

#### Monthly Targets

No	Requirement	Threshold		Apr	May	Jun	YTD
MHS 1	4 Hour A&E waiting times	95%		100%	96.8%	97.5%	
MHS 2	Average length of stay for Inpatients (trimmed)	< 25 days	Adults	23.2	22.8	17.1	
			Older Adults	65.0	27	56.5	
MHS 3	Number of readmissions within 28 days of discharge since start of financial year		Adults	0	3	3	
			Older Adults	0	0	1	
MHS 4	Cumulative % of readmissions within 28 days of discharge since start of financial year		Adults	0.0%	7.0%	5.3%	
			Older Adults	0.0%	0.0%	33.3%	
MHS 5	Delayed Transfer of Care	< 7.5%	Adults	0.3%	1.9%	5.3%	
			Older Adults	5.2%	11.5%	30.9%	
MHS 6	% occupancy adult acute wards	90%	Male	90.1%	87.2%	95.8%	
			Female	96.6%	93.5%	98.9%	
MHS 7	% occupancy older adult acute wards	90%	Male	85.0%	82.3%	75.0%	
			Female	87.3%	84.4%	89.6%	
MHS 8	Number of Patients on Memory services Caseload			308	318	341	
MHS 9	Number of new patients allocated in Memory Services			119	60	91	
MHS 10	Number of people with a new diagnosis of Dementia			16	24	15	
MHS 11	Number of referrals received by memory service			110	52	79	
MHS 12	Referrals by source for memory services			See "memory referrals" tab			
MHS 13	Memory services - Time from referral to assessment (days)			51.02	39.71	51.89	
MHS 14	Re-referral rate for Tariff in scope services (re referred within 30 days)			10.4%	11.2%	14.7%	
MHS 15	Proportion of CPA reviews with a corresponding Clustering review			19.2%	26.3%	15.8%	
MHS 16	Indicator of Accommodation problems			249	243	244	

Requirement		Threshold		Q1			YTD
MHS 17	Number of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team		Adults			53	
			Older Adults			7	
MHS 18	Percentage of inpatient admissions that have been gate-kept by crisis resolution/ home treatment team	95%	Adults			100%	
			Older Adults			100%	
MHS 19	Number of patients on CPA discharged from inpatient care who are followed up within 7 days		Adults			26	
			Older Adults			1	
MHS 20	% of patients on CPA discharged from inpatient care who are followed up within 7 days	95%	Adults			100%	
			Older Adults			100%	
MHS 21	Proportion of service users on CPA with a recording of: 1. Employment Status. 2. Accommodation status. 3. Having a HoNoS assessment in the last 12 months. 4. Having a diagnosis for patients discharged from inpatient care. 5. Having a formal CPA HoNoS review in the past 12 months. 6. Having a Crisis Plan. 7. Having a copy of their care plan	97% minimum of patients should have this information recorded	<b>ADULTS</b>				
			Employment status			99.4%	
			Accommodation Status			99.5%	
			Having a HoNoS Assessments in the last 12 months			95.2%	
			Having a diagnosis for patients discharged from inpatient care			51.7%	
			Having a formal CPA Review in the past 12 months			97.8%	
			Having a crisis plan			97.5%	
			A copy of their care plan			99.2%	
			<b>OLDER ADULTS</b>				
			Employment status			91.0%	
			Accommodation Status			92.1%	
			Having a HoNoS Assessments in the last 12 months			96%	
			Having a diagnosis for patients discharged from inpatient care			67%	
			Having a formal CPA Review in the past 12 months			97.8%	
			Having a crisis plan			100%	
			A copy of their care plan			100%	
MHS 22	Proportion of adults (18-69) on CPA in settled accommodation		Settled accommodation			88.2%	
MHS 23	Proportion of adults (18-69) on CPA in employment		In employment			5.44%	
MHS 24	The number of episodes of AWOL for the number of patients detained under the MHA 1983		AWoL of Detained Patients			0 / 53	
MHS 25	Number of people managed by the memory service with an individual care plan						
MHS 26	NELFT to survey carers of all patients in the care of the memory service. Qualitative measure – patient satisfaction survey (from 2014/15) using F&F methodology.						
MHS 27	Percentage reduction in self harm and suicide attempts comparing first month of treatment with last month of treatment for clients discharged from Impart in the quarter		Impart reduction in self harm				

## Former CQUINS Information

No	Requirement	Threshold		Q1			YTD
MHS 28	HTT Carers survey						
MHS 29	Inpatient Carers Survey						
MHS 30	Complete physical and mental health diagnostic coding (ICD 10)		Improving physical healthcare: 95% of all hospital inpatients & people on CPA to have set of MH & physical health high mortality ICD 10 codes (for COPD, diabetes, obesity, CHD & Hep C) recorded for 1) their most recent completed inpatient episode or 2) their current episode of community based care				
MHS 31	Reduction of medication errors through medicines reconciliation on admission to hospital		Mental health trusts must demonstrate medicine reconciliation within care plans within 72hours of admission. Achievement of this indicator will be measured through an audit of care plans using the POMH UK definition and audit tool. This indicator applies to all inpatient services including Adult and Older People as well as admissions to Forensic and learning disability				
MHS 32	Adequate and timely communication between primary and secondary care to ensure high quality care and patients safety - community mental health teams and primary care		Trust to send letter/care plan to GP within two weeks of CPA review for all community patients on CPA. Letter to include information on physical health conditions and medicines. <b>Target: 95% of CPA patients.</b>				
MHS 33	Mental Health Trusts to implement a comprehensive programme of training in smoking cessation for staff so that at least a third of professional staff have been trained in a recognised brief intervention protocol						
MHS 34	Smoking status of service users recorded in electronic patient records						

## IAPT Information

No	Requirement	Threshold	Borough	Q1		YTD
MHS 35	Number of people who have been referred to IAPT for psychological therapies during reporting period				886	886
MHS 36	The number of IAPT active referrals who have waited more than 28 days from referral/first contact to first treatment/first therapeutic session at the end of the quarter				40	
MHS 37	The number of people who have entered psychological therapies (i.e. had first therapeutic session during the reporting quarter)				700	
MHS 38	The number of people who have completed treatment and are moving to recovery				258	
MHS 39	The number of people who have completed treatment who did not achieve clinical caseness at initial assessment				0	
MHS 40	IAPT - The number of people moving off sick pay and benefits during the reporting quarter				67	
MHS 41	The proportion of those referred to IAPT services that enter treatment				79%	
MHS 42	Access to psychological therapies services by people from black and minority ethnic groups				32.6%	

## CAMHS Information

No	Requirement	Threshold		Apr	May	Jun	YTD
MHS 43	% DNA rate - First appointments	15% (possibly 12%)		6.1%	16.3%	25.0%	
MHS 44	% DNA rate - Follow up appointments	15% (possibly 12%)		12.2%	11.2%	14.7%	
MHS 45	Quarterly 5x5 Survey report						
MHS 46	CAMHS waiting times to emergency assessment		% CYP requiring emergency assessment seen by the end of the following working day (Serious immediate incident of self - harm, including overdose)	100%	100%	100%	
MHS 47	Number of referrals Received			101	97	105	
MHS 48	% of referrals accepted			93.2%	94.5%	95.7%	
MHS 49	% of referrals not accepted			6.8%	5.5%	4%	
MHS 50	Number of referrals not accepted			7	11	5	
MHS 51	Number of LAC referrals received						
MHS 52	% of BHR LAC referrals accepted						
MHS 53	Number of repeat referrals (within the last 12 months)			18	9	15%	
MHS 54	Number of Appointments cancelled by provider			30	20	11%	
MHS 55	Number of inpatients discharged from hospital receiving follow up within 7 days: Split by F2F and telephone contact			1 Tel	no discharges	no discharges	
MHS 56	% of inpatients discharged from hospital receiving follow up within 7 days: Split by F2F and telephone contact	95%		100%	no discharges	no discharges	
MHS 57	Total Caseload			636	683	705	
MHS 58	Number of CYP whose cases were closed by team			81	76	99	
MHS 59	% of Cases closed by Team			12.7%	11.1%	14.0%	
MHS 60	Breakdown of destination on case closure by Team by available RIO reporting category			See CAMHS Discharge Dest tab			
MHS 61	Number on caseload with EHC Plan						
MHS 62	Number of known cases of Child Sexual Exploitation (disclosure does not need to be physically evidenced.)						
MHS 63	Number of known cases of Child Sexual Abuse (disclosure does not need to be physically evidenced.)						
MHS 64	Number (client total) of initial measures completed. By team			17	21	22	
MHS 65	%age (client total) of initial measures completed. By team			20.2%	27.6%	26.5%	
MHS 66	Number of follow up mental health measures completed by Team			4	6	6	
MHS 67	%age of follow up mental health measures completed by Team			4.8%	7.9%	7.2%	

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## Appendix C

Provider Name	Location	Weblinks	Location Org Type	Report Date	Inspection Date	Rating	Comments / Summary
R Hart Care	Hart Lodge	<a href="http://www.cqc.org.uk/directory/1-127130055">http://www.cqc.org.uk/directory/1-127130055</a>	Social Care Org	21/04/15	26/11/14	Good	
Care UK Community Partnerships	Cherry Orchard	<a href="http://www.cqc.org.uk/directory/1-469602584">http://www.cqc.org.uk/directory/1-469602584</a>	Social Care Org	28/04/15	14, 17 & 24/11/14	Requires Improvement	<p>Nursing Home – Dementia</p> <p><b>Safe</b> – Inadequate</p> <p>Risk assessment unclear and medicines not always administered or monitored safely. Staff training not up to date, some staff had not completed safeguarding training. Overall staffing inadequate for size of the home.</p> <p><b>Effective</b> – Inadequate</p> <p>Again staff not received adequate training. Care planning and monitoring of dietary requirements inadequate.</p> <p><b>Caring</b> – Good</p> <p>People were treated with dignity, respect and kindness</p> <p><b>Responsive</b> – Requires Improvement</p> <p>People were not protected from unsafe and inappropriate care as adequate training and monitoring not in place. Complaints</p>

							<p>procedures insufficient.</p> <p><b>Well led</b> – Requires Improvement</p> <p>Notifications not sent to CQC regarding DoLs applications. Staff levels and training not sufficient or monitoring of care plans and administration of medicines.</p> <p>9 Breaches of the Health &amp; Social Care Act 2008</p> <p>Warning Notice Issued</p> <p>Actions:</p> <ul style="list-style-type: none"> <li>• CQC action plan in place.</li> <li>• Care UK suspended accepting placements at Cherry Orchard whilst working towards meeting the requirements of the action plan.</li> <li>• New management personnel and structure is now in place.</li> <li>• QA monitoring increased to support provider</li> <li>• NELFT safeguarding investigation to be concluded</li> </ul> <p>If progress of improvements is satisfactory to all involved partners and stakeholders (CCG, NELFT, LA) the lifting of the</p>
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							providers imposed suspension will be considered. The provider is awaiting a follow up visit from CQC to review the action plan.
<b>Lodge Group Care Ltd</b>	Strathfield Gardens	<a href="http://www.cqc.org.uk/directory/1-811281854">http://www.cqc.org.uk/directory/1-811281854</a>	Social Care Org (0-18 years)	08/05/15		<b>Good</b>	
<b>Triangle Community Services Ltd</b>	Fred Tibble Court	<a href="http://www.cqc.org.uk/directory/1-189037049">http://www.cqc.org.uk/directory/1-189037049</a>	Social Care Org	02/06/15	09/04/15	<b>Good</b>	
<b>Dr Simon Haskell</b>		<a href="http://www.cqc.org.uk/directory/1-517744260">http://www.cqc.org.uk/directory/1-517744260</a>	GP	04/06/15		<b>Good</b>	
<b>Abbeyfield East London Extra Care Society Limited</b>	George Brooker House	<a href="http://www.cqc.org.uk/directory/1-112951275">http://www.cqc.org.uk/directory/1-112951275</a>	Social Care Org	11/06/15	26 & 30/01/15	<b>Inadequate</b>	Residential home with extra care services for people over 65 <b>Safe</b> – Inadequate Poor administration of medicines and inadequate infection control. Risk assessments not completed. <b>Effective</b> – Requires Improvement Staff training not up to date. No regular supervision or appraisals carried out with staff. Lack of line management structure. <b>Caring</b> – Good People are treated with dignity, respect and are listened to. <b>Responsive</b> – Requires

							<p>improvement</p> <p>No adequate protection in place against unsafe inappropriate care or monitoring of medical conditions and administering of medicines.</p> <p><b>Well led</b> – Inadequate</p> <p>Notifications not sent to CQC. Views were not observed regarding the services being delivered. Records not easily accessible. Lack of appropriate line management or structure.</p> <p>10 breaches of the Health &amp; Social Care Act 2008</p> <p>Warning notice issued</p> <p>Actions:</p> <ul style="list-style-type: none"><li>• Risk assessments carried out by social work staff on service users. All service users safe and happy with the care being provided</li><li>• QA monitoring increased to support provider</li><li>• Deputy Manager now taken over management responsibilities and implementing improvements</li><li>• CQC review visit due in September</li></ul>
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## HEALTH AND WELLBEING BOARD

20 October 2015

<b>Title:</b> CONTRACT - Procurement Strategy and Waiver for Public Health Primary Care Services Contracts 2016/17	
<b>Report of the Cabinet Member for Adult Social Care and Health</b>	
<b>Open Report</b>	<b>For Decision</b>
<b>Wards Affected:</b> All	<b>Key Decision:</b> Yes
<b>Report Author:</b> Matthew Cole Director of Public Health	<b>Contact Details:</b> Tel: 020 8227 3657 E-mail: <a href="mailto:matthew.cole@lbbd.gov.uk">matthew.cole@lbbd.gov.uk</a>
<b>Accountable Divisional Director:</b> Matthew Cole, Director of Public Health	
<b>Accountable Director:</b> Anne Bristow, Strategic Director for Service Development and Integration	
<p><b>Summary:</b></p> <p>A number of public health services transferred to the Council in April 2013 including Local Enhanced Services (LEs); now known as Public Health Primary Care Services are delivered by primary care providers namely General Practices (GPs) and Community Pharmacies (CPs) across the borough.</p> <p>Public Health Primary Care Services are commissioned for the prevention of poor health and improved wellbeing outcomes. These services are demand led and are a combination of mandatory essential services that specifically respond to local population health needs.</p> <p>They include;</p> <ul style="list-style-type: none"> <li>• Health Checks- (General Practices and Community Pharmacies)</li> <li>• Smoking Cessation -Tier 2 (General Practices and Community Pharmacies)</li> <li>• Long Acting Reversible Contraception (General Practices)</li> <li>• Chlamydia Screening (General Practices and Community Pharmacies)</li> <li>• Emergency Hormonal Contraception (Community Pharmacies)</li> <li>• Supervised Consumption (Community Pharmacies)</li> <li>• Shared Care (General Practices)</li> <li>• HIV Rapid Testing (General Practices)</li> </ul> <p>Nationally, these services have historically only been commissioned with GPs and CPs and as such these are the main service providers within the market. The current service delivery model is based on delivery through primary care, largely GPs and CPs; this has ensured the required comprehensive and even geographical coverage for access to these services to date. Service providers require specific qualifications and registration with the appropriate governing bodies in order to deliver these services.</p>	

In December 2014, a waiver report was submitted to and approved by the Health and Wellbeing Board to waive the requirement to tender the contracts for these services and to continue commissioning services with the current providers for another 12 months starting from 1 April 2015. The report highlighted plans to undertake a review of the procurement strategy for these services in order to establish the best procurement options beyond March 2016; for example sub-contracting through larger specialist providers, competitive tender, private-public blend etc.

From the review of the market in considering the re-procurement of these services, there is no representation of other service providers outside of GPs and CPs, with the combination of means, reach, and clinical expertise in best delivering these services and ensuring the accessibility of services to the local population.

The current Public Health Primary Care contracts will expire on 31 March 2016 with no provisions as part of the contracts for the Council to extend these arrangements.

### **Recommendations**

The Health and Wellbeing Board is recommended to:

- (i) Approve the strategy set out in this report for the procurement of the public health primary care contracts identified in Section 3.1
- (ii) Waive the requirement to conduct a competitive procurement exercise for the said contracts in accordance with Contract Rule 6.6.8.
- (iii) Delegate Authority to the Lead Divisional Director of Adult and Community Services, in consultation with the Director of Public Health, Head of Legal Services and the Strategic Director of Finance to award the Public Health Service Contracts as set out in section 3.1 to the 40 GPs and 38 CPs for a period of 2 years from 1 April 2016 to 31 March 2018 with the option to extend for a further 1 year period in accordance with the strategy set out in this report.

### **Reason(s)**

The direct award of contracts will allow the Council to fulfil its legal obligations and continue to engage with GPs and CPs who continue to be best placed in delivering the services, with minimal resources required to facilitate this.

This option offers best value and local coverage for the Council in supporting the health needs of the local population.

## 1. Introduction and Background

- 1.1. From April 2013, local authorities became responsible for taking the lead in improving the health of local communities with the transfer of Public Health functions to them. These include most of the health promotion and public health services commissioned as Local Enhanced Services (LESs); now known as Public Health Primary Care services.
- 1.2. LESs were introduced in 2004 to enable GPs and other core healthcare service providers such as community pharmacies to provide extra services to meet local need, improve convenience and extend choice. They were commissioned by Primary Care Trusts (PCTs) and designed to fill the gap in essential services provided by GPs, or to deliver higher than specified standards, with the aim of reducing demand on secondary care and prevent poor health outcomes.
- 1.3. Nationally, these services have historically only been commissioned with General Practices (GPs) and Community Pharmacists (CPs) and as such they are the main service providers within the market. The current service delivery model based on delivery through primary care has ensured the achievement of the required comprehensive and geographical coverage for access to these services to date.
- 1.4. The services are demand led and are a combination of mandatory services and essential services that specifically respond to local population health needs.

### 1.5. Sexual Health – Mandatory Service

Local authorities are mandated to commission comprehensive, open-access sexual health services. Embedding sexual health services into core healthcare services such as primary care will help to improve access within the borough, increase cost-effectiveness and support normalisation and de-stigmatisation.

*Intrauterine Device (IUD) and Nexplanon contraceptive implant* – These are known as long-acting reversible contraception (LARC), which are much more effective at preventing pregnancy than traditional contraception and also more cost-effective. Anyone delivering the service must either hold a Letter of Competence for the method being fitted/removed or hold the Diploma of the Faculty of Sexual and Reproductive Healthcare and must have fitted at least 12 devices in the preceding year (unless newly qualified). Over 500 patients accessed the service in GP practices during 2014/15. This service will be opened to all GPs for delivery.

*Emergency Hormonal Contraception (EHC)* – This is the ‘morning-after pill’ and is provided for free in pharmacies to girls and young women aged 13 - 24 years of age to help increase access to local services. Women aged 25 years and over will pay to receive this service. Completion of specialist sexual health training is required for the provision of this service. Over 1500 young women received this service from CPs during 2014/15. This service will be opened to all CPs for delivery.

*Chlamydia Screening* – Chlamydia often has no symptoms and young people 15-24 year olds are at highest risk. The programme aims to increase the number of 15-24 year olds screened for Chlamydia in primary care to promote early identification and treatment. Training in Chlamydia screening process is required for the provision of this service. Around 600 young people were screened by GPs and CPs during 2014/15. This service will be opened to all GPs and CPs for delivery.

#### 1.6. **Health Checks – Mandatory Service**

This is a mandatory service for local authorities to commission. Health Checks are offered to all adults aged 40-74 to help lower their risk of heart disease, stroke, diabetes and kidney disease. Individuals identified as very high risk are referred to appropriate lifestyle intervention programmes and managed through primary care. Staff delivering the service are trained in vascular risk assessment and adhere to the requirements of the NHS Health Check programme standards 2015. Over 6000 people received a Health Check in Barking and Dagenham during 2014/15. This service will be opened to all GPs and CPs for delivery.

#### 1.7. **Substance Misuse**

Investing in substance misuse (Drug and Alcohol) prevention, treatment and recovery support helps to save long-term health costs as well as substantial costs relating to crime and community safety, housing, employment support, welfare benefits and road traffic accidents. There are an estimated 1079 drug users in Barking and Dagenham.

*Supervised Consumption* – Pharmacy providers play a key and unique role in the care of substance misusers through the supervised administration of Methadone or Buprenorphine. The provider is instrumental in supporting drug users in complying with their prescribed regime, therefore reducing incidents of accidental deaths through overdose. Also through supervision, pharmacy providers are able to keep to a minimum the misdirection of controlled drugs, which may help to reduce drug related deaths in the community. Around 90 people accessed the supervised consumption service during 2014/15. This service will be opened to all CPs for delivery.

*Shared Care* - Treatment and management of opiate dependent patients in the primary healthcare setting, supported by and in partnership with the local specialist treatment service. 45 people were in shared care service during 2014/15. Up to a total number of 100 shared care places are planned over the next year to utilise current shared care capacity and to reflect targets set in the new specialist drug services contracts. More patients in shared care releases capacity within specialist drug services enabling them to focus on more complex cases. This service will be opened to all GPs for delivery.



### 1.8. **Smoking Cessation (*Primary care level 2 smoking cessation service*)**

Smoking is the single most preventable cause of ill health and early deaths. Reducing the prevalence of tobacco usage is a key public health priority. An estimated 38,895 people in Barking and Dagenham smoke (approximately 28% of the adult population) and 384 deaths in the borough during 2014/15 were attributed to smoking. Around 645 people gave up smoking through support from local services during 2014/15 mostly through GPs and CPs.

General Practices and Pharmacies have been delivering the level 2 smoking cessation service in Barking and Dagenham for over 10 years; this is in addition to the Council run specialist smoking service. The service involves face-to-face consultations with patients or services users that express a wish to quit smoking along with the provision of Nicotine Replacement Therapy (NRT) such that they are supported to quit smoking within 4 weeks. This service will be opened to all GPs and CPs for delivery.

### 1.9. **Human Immunodeficiency Virus (HIV) Rapid Testing (*for New Patients*)**

The aim of this new service is to establish HIV testing as a routine element of the new-patient registration process in general practices. This will improve early detection rates and reduce late presentation of the infection. The wider benefits of the scheme include improved prognosis, life expectancy and quality for life and quicker access to treatment and support. It is estimated that about 5,000 new patients per year will be tested for HIV as part of this service and will involve commissioning of training programme to primary care, all of which has been budgeted for. This service will be opened to all GPs for delivery.

## 2. **The Local Market**

- 2.1. In December 2014, a waiver report was submitted to and approved by the Health and Wellbeing Board to waive the requirement to tender the contracts for these services and to continue commissioning services with the current providers for another 12 months starting from 1 April 2015. This current contract will expire on 31 March 2016 with no provisions as part of the contracts for the Council to extend these arrangements.
- 2.2. The report highlighted plans to undertake a review of the procurement strategy for these services in order to establish the best procurement options beyond March 2016 for example, sub-contracting through larger specialist providers, competitive tender, private-public blend etc.
- 2.3. From analysis of the market in considering the re-procurement of the primary care services, there are minimal or no other service providers outside of GPs and CPs, with the combination of means, reach, and clinical expertise in best delivering these services and ensuring the accessibility of services to the local population.
- 2.4. The smoking cessation service which can be provided by other organisations apart from GPs and CPs is being provided in the community by the Council run specialist smoking service. All the other services require specialist training and access to patient records in order to be delivered. GPs and CPs have the specific

qualifications and registration with the appropriate governing bodies to deliver these services in primary care.

- 2.5. A notable local development which has also been dully considered as part of the re-procurement of these services is the establishment of the GP Federation named *Together First Ltd*; a formal alliance of local GPs working together as a single legal body to consider best practice and select preferred delivery options.
- 2.6. The Federation aim to forge closer working partnership between the practices, provide a borough-wide extended primary care service and work together to reduce the variability in performance between GP practices. 27 out of the 40 practices in the borough are currently part of the alliance.
- 2.7. An option for consideration may be the award of the contracts to the Federation; whereby they will subcontract and manage performance on behalf of the Council. However, discussions with the Federation revealed that the alliance is still in development and is not yet in a position where it can bid for, subcontract and manage services such as the public health primary care services.
- 2.8. Another notable development to be mindful of is the Barking and Dagenham, Havering and Redbridge (BHR) Councils proposal to set up an Accountable Care Organisation (ACO); partnership working and collaboration across health and social care for the benefit of the population they serve. The proposal if successful, will remove commissioner-provider distinctions by taking ownership of the combined health and social care budgets of the three boroughs including public health to deliver improved outcomes for the population.
- 2.9. It is also likely in the future that provision of some of the services may no longer be limited to GPs and CPs. In this case, alternative delivery models will be considered and adequately tested for potential efficiencies without compromising the clinical quality, safety and population coverage.

### **3. Proposed Procurement Strategy**

#### **3.1. Outline specification of the works, goods or services being procured.**

A direct award of the Public Health Service contracts to the 40 GPs and 38 CPs for a period of 2 years from 1 April 2016 to 31 March 2018 with the option to extend for a further 1 year for the provision of the following;

	<u>Yearly Budget</u>
• Health Checks (GP and CP)-	£400,000
• Smoking Cessation -Tier 2 (GP and CP)-	£300,000
• Long Acting Reversible Contraception (GP)-	£60,000
• Chlamydia Screening (GP and CP)-	£100,000
• Emergency Hormonal Contraception (CP)-	£200,000
• Supervised Consumption (CP)-	£65,000
• Shared Care (GP)-	£35,000
• HIV Rapid Testing (GP)-	£60,000

**3.2. Estimated Contract Value, including the value of any uplift or extension period.**

The overall Public Health Primary Care Services estimated budget for 15/16 is circa £1,220,000. Therefore the estimated service cost is circa **£ 3,660,000 for 3 years.**

It is not possible to accurately state the exact value per provider (GPs or CPs) since the services within the contract are optional and their choice of preferred services is not known until after expression of interest stage. This is in addition to the fact that some of the services within the contract are demand led. All of the services are paid for on a cost and volume basis and actual spend is therefore dependent on need, demand and provider performance.

**General Practices**

As General Practices vary in the size of registered population they cater for, estimated contract values vary from as little as £6,500 for a smaller general practice, that delivers all services on offer, and achieves 100% of their targets, to as much as £44,000 for the larger practices also delivering all services on offer and achieving 100% of their targets/expected delivery. This estimate is based on activities information from 2014/15.

**Community Pharmacists**

Depending on the services delivered, individual contracts with each community pharmacy could be worth up to an estimated value of £18,000. This estimate is based on a combination of information from previous activity for the demand led services and assuming providers are able to achieve 100% of their annual targets for the other services.

The full cost of the services will be met from the Public Health Grant. All spend will be monitored during the year through monthly and quarterly spend reports.

**3.3. Duration of the contract, including any options for extension.**

**Three (3) years** - 2 years from 1 April 2016 to 31 March 2018 with the option to extend for a further 1 year period.

**3.4. Is the contract subject to the (EU) Public Contracts Regulations 2015? If yes and the contract is for services, is it subject to the light touch regime?**

Yes, the service is subject to the Light Touch Regime (LTR) of the Public Contract Regulations 2015. This means that a higher threshold, currently set at approximately £625,050, applies before a contract needs to be advertised in the Official Journal of the European Union. The maximum estimated Contract Value for each GP contract would be in the region of £44,000 and £18,000 for a community pharmacy respectively. These values therefore fall below the threshold requiring a formal competitive tender exercise.

### 3.5. **Recommended procurement procedure and reasons for the recommendation.**

The recommended procurement procedure is to waive the requirement for a tender and award these contracts to primary care providers (General Practices and Community Pharmacies).

Upon the approval of this procurement strategy and waiver, Expressions of Interests (EOI) to deliver the relevant Public Health Primary Care Services would be invited from all local GPs and CPs respectively. Contracts will then be awarded to individual GPs and CPs based on their EOIs and ability to meet the requirements of individual service specifications and national guidance in order to deliver the services.

#### **Reasons**

There is a justified rationale as to why these particular services continue to be best delivered and provided by GPs and CPs and these are set out below:

#### ***Accessibility***

- The 40 GPs and 38 CPs provide core healthcare services to local residents in the borough in a variety of locations, ensuring good access to the whole population.
- CPs often operate in high street settings which may encourage people (e.g. young people) to access the services and may also help to reduce stigma.
- GPs have access to patient lists covering the entire population, ensuring that services are universally available. This also ensures that targeted groups (e.g. age range for NHS Health Checks) or newly-registered patients can be invited to use certain services.
- Both GPs and CPs have ability to offer a public health service opportunistically when a person visits the GP practice or CP for another reason (e.g. stop smoking support may be discussed if visiting GP about a long-term condition or picking up a prescription from a CP).
- People may be more willing to visit their GP practice or their local CP as they feel comfortable that the service is delivered from an identifiable health setting and/or they already know the staff, venue and quality of care.
- GPs and CPs have the most suitable and universal geographical coverage of the borough in terms of accessible venues for patients and service users.

#### ***Resources and Clinical Expertise***

- Both GPs and CPs have access to a range of clinical equipment with resources at their disposal, such as blood testing equipment and private consultation rooms.
- GPs and practice nurses are clinically trained; this is required for certain services (e.g. fitting of contraceptive implants and coils).
- CPs are also clinically trained; this is required for certain services e.g. the provision of EHC (morning-after pill).
- GPs and CPs have the specific qualifications and registration with the appropriate governing bodies to deliver these services

- The availability of clinical expertise within general practice and pharmacy setting in the event of an emergency or any associated health concerns.
- GPs and CPs are gatekeepers for accessing healthcare and are first point of contact for patients, this gives them greater influencing factor to encourage patients to take up services

### ***Other Providers***

- There is limited representation within the market place of other providers outside of GPs and CPs to match the existing coverage of provision across the borough and to support the accessibility of services to the local population
- In order to deliver these services, service providers require specific qualifications and registration with the appropriate governing bodies; these are held by GPs and CPs.
- Other providers require access to patient records which are held by and cannot be shared by healthcare providers

### **3.6. The contract delivery methodology and documentation to be adopted.**

- These contracts will be based on the standard Public Health Services Contract. It is anticipated there will be circa 40 GP and 38 CP contracts.
- The services will be provided from premises or service delivery points that are within the borough of Barking and Dagenham and meet appropriate and necessary clinical standards for whichever service they are intended.
- General Practices will be paid quarterly, as per activity recorded on the clinical systems and queried through a commissioner database. Community Pharmacies will be paid monthly, based on invoices and activity data submitted to the Public Health Team.
- GPs and CPs will be set annual targets and performance monitored through quarterly meetings, and monthly data monitoring. Visits to and meetings will be held with poor performers in order to agree and implement service improvement actions plans.
- Services are to be provided to Barking and Dagenham residents only and individual service specifications will highlight respective service eligibility criteria

### **3.7. Outcomes, savings and efficiencies expected as a consequence of awarding the proposed contract.**

The health topics addressed by these services; cardiovascular disease/ diabetes detection, smoking, sexual health and substance misuse are all outlined in the Joint Strategic Needs Assessment (JSNA) as areas where improvements need to be made in Barking and Dagenham in terms of early detection and reducing prevalence.

Although no direct savings relating to service provision are proposed, the services will play a significant role in improving outcomes and reducing health inequalities across these key population health topics.

In considering the re-procurement options for these services, it was agreed that the Council would continue with a fixed price approach for each of these services in

order to maintain the current providers' coverage of the borough. A benchmarking exercise was therefore undertaken with 6 neighbouring/ similar population authorities as being the most appropriate means of determining the fixed prices that would apply for these services.

As a result of this benchmarking the Public Health team has satisfied that current prices for the services:

- are in line with/comparable to the prices paid by neighboring authorities
- continue to offer the Council good value for money
- support the sustainability and growth of service provision within the borough

Indirect savings will also be made through improved efficiency in contract management. Opportunities for further savings will be considered alongside reviews and developments of other public health service areas, of which primary care services are a component part. In addition, funding levels will be reviewed once the comprehensive spending review and the public health grant for 16/17 is announced in November 2015.

### **3.8. Criteria against which the tenderers are to be selected and contract is to be awarded**

Providers (GPs and CPs) will be awarded the contract if they meet core criteria that are relevant to all the services. These are likely to include the following indicative high-level criteria, all of which would be pass/fail criteria; however, the criteria may be amended once service specifications have been finalised:

- Provider premises or service delivery points are within the borough of Barking and Dagenham, meet appropriate and necessary clinical standards for whichever service they are intended for
- Services are provided in an environment that is appropriate for the provision of public health services
- Registration with the Care Quality Commission (CQC) or General Pharmaceutical Council (GPC) where required
- Adequate insurance/professional indemnity provision
- Evidence of staff training and competency in safeguarding children and vulnerable adults
- Evidence of relevant continuing professional development of staff providing the service(s)
- The provider has a nominated service lead for communication between the Council and the provider
- An electronic patient record system is in place that meets information governance standards
- An electronic data monitoring system is/will be in place that is suitable for providing performance data to the commissioner
- A system is in place to ensure the service user's NHS record is updated where appropriate
- Policies and processes are in place for dealing with serious untoward incidents, infection control, maintenance and proper storage of equipment, health and safety, information governance and equality and diversity
- All staff delivering services have had an enhanced DBS check satisfactorily completed

The respective services will have their individual specification and criteria against which providers who express an interest to provide them will be assessed. Examples of likely criteria for each service are detailed below; however, these may be amended once service specifications have been finalised:

### ***Smoking Cessation Services:***

- All interventions must be delivered by a stop smoking advisor who has received stop smoking service training that meets the standards published by the National Centre for Smoking Cessation Training (NCSCT) for one-to-one and/or group support;
- Providers will deliver services that meet or exceed the minimum quality standards for service providers e.g. success rates, validation of quitters etc. as outlined in the Department of Health's Stop Smoking Service and Monitoring Guidance update 2012/13<sup>1</sup> as well as any locally agreed standards e.g. targeting of priority populations, delivery of minimum levels of activity in order to retain provider status, annual attendance at training update events etc.

### ***NHS Health Checks***

- Access to GP patient lists and history through which the eligible population can be identified.
- Use of point of care testing equipment for cholesterol and blood glucose;
- Availability of private consultation area;
- Member(s) of staff delivering the service are trained in vascular risk assessment and adhere to the requirements of the NHS Health Check programme standards 2015.

### ***Long Acting Reversible Contraception:***

- Member of staff delivering the service must either hold a Letter of Competence for the method being fitted/removed or hold the Diploma of the Faculty of Sexual and Reproductive Healthcare and must have fitted at least 12 devices in the preceding year (unless newly qualified)
- Availability of a private consultation area.

### ***Chlamydia screening:***

- Competent in Fraser guidelines
- You're Welcome compliant
- Staff delivering the service are trained in the Chlamydia screening process
- At least one person is available to deliver the service during opening hours.

### ***Specialist sexual health service for young people:***

- Completion of all specialist sexual health training as detailed in the service specification in order to achieve accreditation under the appropriate PGDs
- Availability of private consultation area

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<sup>1</sup> [http://www.ncsct.co.uk/pub\\_dh-Guidance.php](http://www.ncsct.co.uk/pub_dh-Guidance.php).

- Competent in Fraser guidelines
- You're Welcome compliant
- Availability of a private consultation area and a toilet for patient use
- Accredited pharmacists available to deliver the service at least 5 days per week
- Staff delivering the service demonstrates regular updates in line with CPD and specification requirements.

***GP shared care:***

- A registered GP practice within the London Borough of Barking and Dagenham
- Able to demonstrate knowledge and interest in the field of substance misuse including ability to attend shared care forums and local training sessions
- Compliance with all relevant NICE guidance and the local recovery treatment model for substance misuse.

***Supervised consumption***

- Registered pharmacy premises within the London Borough of Barking and Dagenham
- Able to demonstrate interest in the field of substance misuse including ability to attend local training sessions with specialist treatment providers.

***HIV Rapid Testing for New patients***

- A registered GP practice within the London Borough of Barking and Dagenham
- Able to demonstrate that all staff involved in HIV testing are appropriately trained.

**3.9. How the procurement will address and implement the Council's Social Value policies.**

The procurement of these services from General Practices and Community Pharmacies will enable the council to fulfil its duties around improving the health of the local population. Collectively the programmes aim to;

- Reduce the incidence of sexual health infections which can have long lasting adverse health impacts for residents.
- Prevent unplanned pregnancies, reduce the number of avoidable terminations of pregnancies and avoid any possible associated adverse health and social impacts.
- Increase the uptake of healthier lifestyle such as quitting smoking and increased physical activity and weight management to achieve greater healthier life expectancy, and reducing the prevalence of residents/patients living with long term conditions such as COPD or developing Lung Cancer.
- Establish residents'/patients' risk of developing long term and acute cardiovascular conditions such as diabetes and/or stroke therefore enabling residents'/patients' to make healthier choices to prevent adverse health event and positively impacting health inequalities within the borough.



## **4. Options Appraisal**

### **4.1 Option 1: Services contracts are competitively tendered**

The option to go out to tender for the provision of these services will ensure that the procurement exercise is in line with the Councils Contract Standing Orders and the Public Contract Regulations 2015. However, this option was rejected because:

- There is limited representation within the market place of other providers outside of GPs and CPs to match the existing coverage of provision across the borough and to support the accessibility of services to the local population. The procurement is likely to result in the same service providers (GPs and CPs) who are currently contracted to provide these services.
- A procurement exercise is likely to be protracted and resource intensive, with minimal interest likely from other suppliers outside of GP and CPs within the local providers' landscape.
- There would be a necessity to equip the main suppliers within market (GPs and CPs) to participate within a competitive tendering exercise. This would include support and guidance required in assisting them to register and use the Council's e-tendering portal.

### **Option 2: The direct award of Contracts to GPs and CP (Preferred Option)**

#### **Advantages**

- The main suppliers in the market who have historically delivered these services are GPs and CPs. This option would allow the Council to continue to have in place contracts with service providers with the proven track record, resources, reach, clinical expertise and established local presence to deliver the services.
- The GPs and CPs already hold contracts with NHS England, Barking & Dagenham Clinical Commissioning Group (CCG) and the Council. Due diligence has already been undertaken in assessing the risks in commissioning services and awarding contracts to these service providers.
- Limited resources and time would be necessary to facilitate the direct award of contracts to GPs and CPs, with no foreseeable disruptions to the provision of services and to working to achieve national indicators and local targets.
- These services fit around the core business functions of GPs and CPs and as a result offer value for money for the Council, alongside providing the accessibility and reach of services to the local population.

#### **Disadvantages**

- Seeking to waive the Councils' Contract Standing Orders.

### **Option 3: Framework**

A framework approach was considered; however this was rejected as it does not provide the flexibility for new providers to be admitted during its term. In the case of the NHS Health Checks programme, where access to GP lists is essential in order to identify the eligible population, precluding a newly opened practice would unnecessarily disadvantage the patients of that new practice.

## **5. Waiver**

Approval is being sought to waive the requirements of the Contract Rules, specifically Clause 6.6.8 which relates to genuinely exceptional circumstances. It is believed to be in the Council's best interest to issue the waiver due to no alternative satisfactory procurement option being available to commissioners at this stage apart from primary care providers (General Practice and Community Pharmacies) for the reasons identified in 2.5 above

## **6. Equalities and other Customer Impact**

Quality Public Health Services delivered through Primary Care are aimed at reducing health inequalities by decreasing health related disabilities and morbidity in the borough. They are aimed at all gender classifications, sexual orientations, religious and ethnic groups alike. Some of the programmes are targeted at younger age groups due to high disease prevalence and with the aim of making the programmes more cost and clinically effective however; this does not prevent other age groups from accessing similar services. A high number of service users are expected to be from high risk and vulnerable groups.

## **7. Other Considerations and Implications**

### **7.1 Risk and Risk Management**

The assessment is attached as **Appendix A**.

### **7.2 TUPE, other staffing and trade union implications.**

N/A

### **7.3 Safeguarding Children**

The provider has in place the necessary safeguarding protocols, in line with Council Policy and applies the Frazier Guidelines and Gillick Competency where a young person is under 16.

### **7.4 Health Issues**

The direct award of these services from General Practices and Pharmacies will enable the council to fulfil its duties around improving the health of the local population.

Collectively the programmes aim to:

- Reduce the incidence of sexual health infections which can have long lasting adverse health impacts for residents.
- Prevent unplanned pregnancies, reduce the number of avoidable terminations of pregnancies and avoid any possible associated adverse health and social impacts.

- Increase the uptake of healthier lifestyle such as quit smoking and increased physical activity and weight management to achieve greater healthier life expectancy, and reducing the prevalence of residents/patients living with long term conditions such as COPD or developing Lung Cancer.
- Establish residents'/patients' risk of developing long term and acute cardiovascular conditions such as diabetes and/or stroke therefore enabling residents'/patients' to make healthier choices to prevent adverse health event and positively impacting health inequalities within the borough.

The proposal is in line with the outcomes and priorities of the joint Health and Wellbeing Strategy. The direct awards of an interim contract should further enhance the quality and access of services as well as user and patient experiences. The proposal will have a positive effect on our local community

#### **7.5 Crime and Disorder Issues**

N/A

#### **7.6 Property / Asset Issues**

N/A

### **8. Consultation**

- Statutory Proper Officer – Director of Public Health
- Corporate Director for Adult and Community Services
- Group Manager Finance- Adults and Community Services
- Legal Services
- Councillor Maureen Worby- Portfolio holder for Adult Social Care and Health
- Barking and Dagenham Clinical Commissioning Group (CCG)
- Local Medical Committee (LMC)
- Local Pharmaceutical Committee (LPC)
- Procurement Board

### **9. Corporate Procurement**

Implications completed by: Adebimpe Winjobi, Category Manager

- 9.1. This report seeks authority to waive the requirement to conduct a competitive procurement exercise for the public health primary care services in accordance with Contract Rule 6.6.8 which relates to genuinely exceptional circumstances and sets out the strategy for the procurement of the services.
- 9.2. There are a number of mandated public health services which the Council has a legal obligation to provide and are covered in this paper; these include the NHS Health Checks Programme and Sexual health services. From analysis of the market, there are minimal or no other service providers outside of GPs and CPs who are the current providers, with the combination of means, reach, and clinical expertise in best delivering these services and ensuring the accessibility of services to the local population.

- 9.3. The services are subject to the Light Touch Regime (LTR) of the Public Contract Regulations 2015. This means that a higher threshold, currently set at approximately £625,050, applies before a contract needs to be advertised in the Official Journal of the European Union. The maximum estimated Contract Value for each GP contract would be in the region of £44,000 and £18,000 for a community pharmacy. These values therefore fall below the threshold requiring a formal competitive tender exercise.
- 9.4. In order to ensure service continuation and for the Council to fulfil its legal obligation, I support the methodologies detailed in this paper as being the ones that offer value for money and continue to ensure the Council keeps to its corporate and social responsibilities.
- 9.5. Corporate procurement will continue to support the public health team throughout the process to contract award

## **10. Financial Implications**

Implications completed by: Carl Tomlinson, Group Manager, Finance.

- 10.1 The 2016/17 grant allocation is expected to be circa £15.5 million (subject to confirmation in the comprehensive spending review in November 2015) and will have sufficient budget allocation for the commissioning of primary care services outlined above.
- 10.2 The 2015/16 primary care services budget value is £1,220,000, with final payments being based on the actual demand of the service. There is a contingency for any over subscription of the service by local residents, hence preventing a cost pressure to the Council.
- 10.3 There are currently no other suppliers on the market that can provide these services as outlined in the summary section above. Awarding the contract directly to GPs and Pharmacies in the borough will offer the Council the best value for money.
- 10.4 There are no direct savings from these contracts, but it is expected with performance management from the Council we should be able to see in year efficiency savings that can help support other pressures in the Council

## **11. Legal Implications**

Implications completed by: Kayleigh Eaton, Contracts and Procurement Solicitor, Legal and Democratic Services

- 11.1 This report is seeking approval from the Health and Wellbeing Board (HWB) that a waiver is granted, of the requirement to tender contracts under the Council's Contract Rules.
- 11.2 The report proposes that the contracts being procured should be awarded directly to GP's and Community Pharmacies. The ground being replied upon for a waiver is under rule 6.6.8 which states that 'there are other circumstances which are genuinely exceptional'. The reasons for this are stated in paragraph 2.4 of this report.

- 11.3 The services referred to fall within the Light Touch Regime (LTR) of the Public Contract Regulations 2015. This means that a higher threshold, currently set at approximately £625,050, applies before a contract needs to be advertised in the Official Journal of the European Union. It is noted that the maximum estimated Contract Value for each GP contract would be in the region of £44,000 and £18,000 for a pharmacy. These values therefore fall below the threshold requiring a formal competitive tender exercise. However, the Council still has a legal obligation to comply with the relevant provisions of the Council's Contract Rules, specifically rule 28.4 requiring three quotes to be obtained, and with the EU Treaty principles of equal treatment of bidders, non-discrimination and transparency in conducting the procurement exercise.
- 11.4 The Contract Rules do provide for Cabinet/HWB or Chief Officers (as may be appropriate) to waive the requirement to tender or obtain quotes for contracts on any one of several grounds set out in Contract Rule 6.6, including the ground that there are "genuinely exceptional circumstances" why a competitive procurement exercise should not be conducted. Each ground is however subject to the proviso that the appropriate decision-maker considers that no satisfactory alternative is available and it is in the Council's overall interests.
- 11.5 In considering whether to agree the recommendations set out above in this report, the Health and Wellbeing Board needs to satisfy itself that the reasons provided and grounds stated by officers are satisfactory.
- 11.6 Legal Services will be on hand to assist throughout the process and also to answer any queries that may arise

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

Procurement Strategy and Waiver for Public Health Services Contracts in Primary Care 2015/16 – 9<sup>th</sup> December 2014

### **List of appendices:**

**Appendix A** – Risk Assessment

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Risk	Likelihood	Impact	Risk Category	Mitigation
Low expression of interest and service uptake by individual GPs and CPs	Low	High	Medium	Ongoing engagement with LMC/ LPC/ CCGs to use their influence to increase service uptake of local GPs and CPs especially in areas with high population health needs
Change in future funding allocation	Medium	High	Medium	Ensure service provision in evidence based and underpinned by needs; ensure mandatory services are still commissioned
Cross boundary patient flow and impact on programme costs	Low	Medium	Low	Services will be commissioned for borough residents. Each service specification will state the eligibility criteria for individual services. There will be on regular service monitoring including cost
Contract award decision is challenged.	Low	Low	Low	Procure contract in line with Council's contract rules. Liaise with legal departments at all stages and ensure documentation is kept
Provider failing to meet contractual obligations	Low	High	Medium	Robust and regular performance monitoring procedures, performance indicators and consequences of failure to meet them set out in service specification

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## HEALTH AND WELLBEING BOARD

20 October 2015

<b>Title:</b> Contract - Advocacy Services Re-tender	
<b>Report of the Strategic Director for Service Development and Integration</b>	
<b>Open Report</b>	<b>For Decision</b>
<b>Wards Affected:</b> All	<b>Key Decision:</b> Yes
<b>Report Author:</b> Adrian Marshall, Integrated Commissioning Manager  Louise Hider, Principal Commissioning Manager	<b>Contact Details:</b> Tel: 020 8227 3259 E-mail: <a href="mailto:adrian.marshall@lbbd.gov.uk">adrian.marshall@lbbd.gov.uk</a>  Tel: 020 8227 2861 E-mail: <a href="mailto:louise.hider@lbbd.gov.uk">louise.hider@lbbd.gov.uk</a>
<b>Sponsor:</b> Anne Bristow, Strategic Director for Service Development and Integration	
<b>Summary:</b>  The local authority currently commissions two different advocacy services to fulfil its statutory advocacy duties: <ul style="list-style-type: none"> <li>• <b>Independent advocacy</b> - The Care Act 2014 requires the local authority to arrange independent advocacy to ensure a service user or carer's involvement in the care and support process. This is required where an individual has substantial difficulty in understanding the care and support process and may not have anyone appropriate to support them.</li> <li>• <b>Mental health advocacy</b> - The Mental Health Act and Mental Capacity Act require local authorities to commission Independent Mental Health Advocacy (IMHA), Independent Mental Capacity Advocacy (IMCA) and advocacy for those undergoing the Deprivation of Liberty Safeguards (DoLS) process.</li> </ul> <p>Feedback received from stakeholders has suggested that these services are too fragmented and confusing to access for service users and professionals. As a result, Commissioners have reviewed current service provision and the advocacy pathway. As the current range of advocacy contracts are all due to expire on 31 March 2016, it is proposed that advocacy services are remodelled to address all statutory advocacy requirements. This would mean a single contract for advocates under the Care Act, Mental Capacity Act and Mental Health Act. By bringing the services into one contract, access to statutory advocacy will be improved and simplified and the Borough will be able to make cost reductions on the current budget allocation.</p>	
<b>Recommendations</b>  The Health and Wellbeing Board is recommended to: <ul style="list-style-type: none"> <li>(i) Approve the procurement of an integrated statutory advocacy service for a term of two years, with the option to extend for one further year, in accordance with the</li> </ul>	

strategy outlined in this report.

- (ii) Delegate authority to the Corporate Director for Adult and Community Services, in consultation with the Chief Finance Officer and the Head of Legal and Democratic Services to award the contract to the winning bidder and execute related contracts for an integrated statutory advocacy service.

### **Reason(s)**

The Council is required to fulfil its legal obligation to provide statutory advocacy services under the Mental Capacity Act (2005), Mental Health Act (2007) and Care Act (2014).

The Council has committed to the vision of 'One borough; one community; London's growth opportunity' and advocacy services deliver this vision and in particular, the priority of 'enabling social responsibility'. Advocacy supports individuals who require it, to be meaningfully involved throughout the care and support process for social care and mental health, enabling individuals to direct their care and support and have choice and control.

## **1. Introduction and Background**

1.1 Advocacy means supporting a person to understand information, express their needs and wishes, secure their rights, represent their interests and obtain the care and support they need.

1.2 There are a number of different statutory duties on local authorities. Statutory advocacy is based on the principle of enabling those who require it to be fully involved in the key decisions that shape their lives by providing extra help to those who need it most. It is different and distinct from general advocacy or campaign activity as it is focussed on the individual within the agreed criteria.

1.3 Our statutory advocacy duties can be summarised as the following:

### **Mental Health Advocacy**

1.4 The Mental Capacity Act 2005 (MCA) and the Mental Health Act 2007 (MHA) introduced statutory obligations in England and Wales to provide advocacy services in certain circumstances. These can be summarised as:

1.5 **Independent Mental Health Advocacy (IMHA)** - IMHAs are specialist advocates who are trained to work within the framework of the Mental Health Act to provide an additional safeguard for patients who are subject to the Act (who have been detained). IMHA support also includes providing information and exploring options for individuals. IMHA work will take place in the community or in hospital. IMHAs are available for anyone over the age of 18.

1.6 **Independent Mental Capacity Advocacy (IMCA)** - IMCAs provide specialist independent advocacy to people (aged over 16) covered by the Mental Capacity Act 2005 who have no one able to support or represent them, and who lack the capacity to make a decision and/or have problems communicating, possibly because of dementia, a brain injury, a learning disability or mental health needs.

- 1.7 **Deprivation of Liberty Safeguards (DoLS)** - DoLS is one element of a wider IMCA Service and is intended to protect individuals who have been deprived of their liberty to serve their best interest. The Council may request advocacy support on receipt of a DoLS application. The purpose of a DoLS is to ensure that a person's liberty is only restricted correctly and safely. The Law Commission are currently consulting on proposals to revise the DoLS regime, and proposals in this paper would be adaptable to their recommendations as they currently stand.

### **Individual Advocacy under the Care Act**

- 1.8 Local authorities must involve people in decisions made about them and their care and support. No matter how complex a person's needs, local authorities are required to help people express their wishes and feelings, support them in weighing up their options, and assist them in making their own decisions. An independent advocate can help someone to do this.
- 1.9 Individual advocacy must be considered from the very first point of contact with the local authority and at any subsequent stage of the assessment, planning, care review, safeguarding enquiry or safeguarding adult review.
- 1.10 The criteria for the provision of independent advocacy is set out in the Care Act. It is required if the individual has substantial difficulty in:
- Understanding relevant information
  - Retaining information
  - Using or weighing the information as part of engaging
  - Communicating their views, wishes and feelings.
- 1.11 An individual advocate will need to be provided if there is no other appropriate individual available to support and represent the person's wishes and their involvement in the care and support process. It should be noted that an individual advocate cannot be paid or professionally engaged in providing care or treatment to the person or their carer.
- 1.12 The Care Act is clear that all local authorities must ensure that there is sufficient provision of independent advocacy to meet their obligations under the Act. There should be sufficient independent advocates available for all people who qualify, and it will be unlawful not to provide someone who qualifies with an advocate.

### **Independent NHS Complaints Advocacy**

- 1.13 Independent NHS Complaints Advocacy supports patients, service users, residents, their family, carer or representative with a complaint or grievance related to any aspect of healthcare as described in the Health and Social Care Act 2012. This includes that which falls under the remit of the Health Service Ombudsman, such as complaints about poor treatment or service provided through health services in England. **This is out of scope for this tender – please see para 2.3 below.**

## **2. Current advocacy services**

- 2.1 The Council currently commissions three separate contracts for the provision of statutory advocacy:

Contract	Statutory Advocacy	Provider(s)	Advocacy Hours	End date	Annual contract value	Notes
Mental Health Advocacy	IMCA IMHA DoLS	Voiceability	2,962 hours approx	31 March 2016	£79,646	
Specialist Advocacy Framework providing Independent Care Act Advocacy (ICA) and 'specialist', non-statutory advocacy	Individual advocacy under the Care Act	Advocacy providers: <ul style="list-style-type: none"> <li>• Voiceability</li> <li>• Royal Mencap</li> <li>• DABD</li> </ul> Gateway provider: Independent Living Agency (ILA)	3,800 hours approx	31 March 2016	£95,000* split between the three advocacy providers  £11,700* for the Gateway provider	This contract currently provides 'general', non-statutory advocacy. This is advocacy support that is outside of Care Act requirements. This has been a reducing proportion of the activity since the Care Act was introduced and it is anticipated that this reduction will continue.
<b>Total</b>					<b>£186,346</b>	
						<b>* Please note that £61,700 of the specialist advocacy framework has been funded from the Care Act Burdens Grant to enable the contract to deal with additional demand from the Care Act</b>
NHS Complaints Advocacy Service (NCAS)  <b>Out of scope</b>	Independent NHS Complaints Advocacy	Voiceability	1,925 hours approx	31 March 2016 (option to extend for one year)	£52,000 (currently being negotiated down)	This is a pan-London contract with 26 London Boroughs. The London Borough of Hounslow is the Lead Commissioner.

- 2.2 Each of the current advocacy services have different routes into the service. For Mental Health Advocacy or NHS Complaints Advocacy, Voiceability are directly contacted. For independent advocacy under the Care Act and non-statutory advocacy, the Independent Living Agency (ILA) are contacted as the 'gateway'. The ILA screen referrals, and monitor the contract. Social workers determine if an individual is eligible or not for individual advocacy.
- 2.3 For the purposes of this tender, the NHS Complaints Advocacy Service (NCAS) is out of scope. This service is provided on a Pan-London arrangement and the Commissioning Manager for this contract is negotiating a reduction in the Barking and Dagenham spend to maximise efficiencies (it operates as a fixed amount independent of activity). There is also an option in extending this contract to March 2017 which the lead Council are encouraging participant boroughs to take up, and which is supported by Barking & Dagenham's commissioners. It is proposed that the existing pan-London agreement would therefore continue but referrals would also be able to be signposted through the 'Advocacy Centre' proposed below – see Section 4.

### **Feedback on current service provision**

- 2.4 As part of the consultation process for the re-tender of advocacy services, consultation has been undertaken with social workers, providers, service users and other professionals to gain feedback on the current advocacy service. Feedback can be summarised as the following:
- Advocacy services are **confusing to access** because there are two different contact telephone numbers and two different sets of referral forms (one for Mental Health advocacy and one for the specialist advocacy contract, which includes the Care Act).
  - Stakeholders have suggested that **one referral pathway would be beneficial**. Stakeholders also suggested that a **web-based**, digital platform would be welcome in order that advocates can be selected and booked.
  - Social workers have stated that they **do not always get feedback** on which provider has been given their referral for individual advocacy and the timescales involved.
  - Service users have also commented that they have had to **repeat their stories a number of times**, particularly where they have made self-referrals to an advocacy provider. They can be passed from an advocacy provider, to the gateway (for the referral to be logged and allocated), and then to a different advocacy provider, or to a signposted service where the referral is not eligible for the advocacy service. This has created some anxiety and confusion for service users. This is not to do with the performance of the gateway contract.
  - Social workers have also commented that the current advocacy providers **do not always have specialist advocates available**, particularly enough advocates who are trained in working with adults with learning disabilities or who communicate non-verbally.
- 2.5 The majority of service users who access these advocacy services are people with learning disabilities, older people with dementia, people who have acquired a brain injury or people with mental health problems, as well as people with a temporarily reduced mental capacity due to alcohol or drug abuse, illness or trauma.

- 2.6 It is useful to note therefore that some individuals have need for advocacy under both of the current services that are commissioned, for example IMCA and individual advocacy under the Care Act.
- 2.7 Currently, these individuals would need to be referred separately to the two different services. However, the Care Act explicitly states that where someone already requires an Independent Mental Capacity Advocate (IMCA) or an Independent Mental Health Advocate (IMHA) **the same advocate may be used** in the context of providing individual advocacy.

### **Utilisation and demand**

- 2.8 The IMCA/IMHA/DoLS contract is paid on a quarterly basis at a fixed value, independent of the usage of the service. Last year the service received 218 referrals. In estimating utilisation, using the average hours spent on each case and a typical market rate for advocacy services, it is suggested that the current contract was under-utilised by approximately £15,000 last year. Although efforts are currently being made to gauge the full impact of recent Supreme Court judgements on IMCA workloads, we expect that we will see a similar number of referrals for IMCA, IMHA and DoLS this year.
- 2.9 Although activity is being seen to increase in recent months for individual advocacy under the Care Act, by the end of Quarter 1 of 2015/16 there was an underspend on the budget for these services. The Department of Health and national advocacy organisations such as Voiceability have predicted an increase in the number of Care Act referrals, and there are early indications that this is now coming through. 30 Care Act referrals were made in Q1 and for Q2, 50 referrals have been made – a significant increase already on the first quarter. It is expected that demand for Care Act advocacy will be progressive as the Act becomes embedded, and it is estimated that the Borough may see 200 referrals for individual advocacy under the Care Act this year.

## **3. Looking forward: one advocacy service**

- 3.1 There is substantial duplication and overlap between the two existing advocacy services that are commissioned (excluding NCAS) and substantial under-utilisation of the current budget.
- 3.2 This combined with the feedback at paragraph 2.4 above strongly suggests that both of the advocacy services should be integrated into one contract. This will minimise duplication of referrals for an individual and simplify the different access routes for service users and stakeholders. One advocacy service will lead to a more outcome-focused service, enabling one advocate to support an individual throughout their care and support journey, whether this is subject to the Care Act, Mental Capacity Act or Mental Health Act without any reduction in specialisms. A single advocacy service (proposed to be called the 'Advocacy Centre') will:
- Receive all referrals for advocacy as per the requirements outlined in the Mental Health Act, Mental Capacity Act, Deprivation of Liberty Safeguards and the Care Act. It should be noted that the Care Act requires independent advocacy to be available for those who require it for assessments for young carers, as well as assessments for young people and their carers

approaching transition. It is anticipated that this will be included in the Advocacy Centre.

- Provide a seamless advocacy service for the Borough's diverse population, with one advocate (where possible) supporting the needs of an individual who requires statutory advocacy.
- Provide an easy-to-access, flexible referral process with one system to allocate and monitor referrals effectively. Providers should actively promote digital, self-service technology options for service users and professionals, which put them in control, improve their customer experience and reduce the need for costly one to one contact where possible. A web-based system with functions enabling professionals to book an advocate would be desirable.
- Ensure that referrals are allocated appropriately and efficiently to trained advocates that have a range of specialisms (including learning disabilities, mental health, dementia, autism and older people). The lead provider would need to have capacity to mobilise or supply-in specialist and targeted advocates as needed.
- Communicate effectively with professionals in order that they are aware of the progress of advocacy referrals.
- Signpost to other services in the Borough and encourage informal and self-advocacy – see 3.4 below.
- Participate in prevention and capacity building activity to sustain the local advocacy market – see 3.8 below.
- Promote advocacy services to service users, carers, professionals and providers.

### **Non-statutory advocacy**

3.3 At present, services provide advocacy which is not directed by a social worker in response to a capacity assessment or an assessment of 'substantial difficulty' that the service user experiences during the assessment process. This is outside the Care Act requirement for advocacy and therefore could be termed 'non-statutory'. In line with the need to consider the essential nature of any expenditure, it is proposed that non-statutory advocacy ceases as part of the new contracting arrangements.

3.4 Although the new service would not be commissioned for 'non-statutory advocacy', there would be a requirement for the new service to efficiently signpost to other services in the Borough. The provider would also respond to self referrals by encouraging informal and self advocacy. These measures would help sustain localised advocacy interventions for people whilst reducing the need for formal advocacy providing:

- Information regarding wider sources of advice and support, signposting to other services e.g. Citizens Advice Bureau
- Support tools and templates for those who wish to self advocate
- Information, training and capacity building for appropriate persons advocating as an informal advocate for a friend or relative
- Support to wider Voluntary and Community Sector (VCS) organisations that provide local citizen or peer advocacy such as Sycamore Trust
- Dissemination of generic information materials such as navigating the care system, know your rights, how to complain etc

3.5 This would ensure that the advocacy services contribute to the borough's overall approach to prevention (preventing, reducing or delaying social care need) without substantial investment.

3.6 We would retain the option to commission additional advocacy in regard to service changes and other operational or specialist demands.

### **Prevention and Capacity Building**

3.7 As well as an integrated advocacy service, the remodelled advocacy contract will also include elements around prevention and capacity building to build, shape and develop the local advocacy market in the Borough. The successful Provider will be asked to:

- **Develop and support 'appropriate persons'** (family member, interpreter, friend, carer etc) to provide advocacy support. The Advocacy Centre would support and "train" these appropriate persons in order that service users only require individual advocacy where no appropriate person is available, or professionals determine that an appropriate person would not be acting in the best interests of the individual seeking advocacy.
- **Work with local organisations**, such as our colleges and Care City, to establish advocacy training centres in the Borough and ensure, where possible, that **advocates are recruited from Barking and Dagenham** and the local area.

3.8 Prevention and capacity building activity will support the Council's stated aims of 'enabling social responsibility' and 'growing the Borough', empowering those best placed to support individual's needs, helping to reduce future demand for formal advocacy, and encouraging local employment.

## **4. Proposed Procurement Strategy**

### **4.1 Outline specification of the works, goods or services being procured**

As stated in Section 3 above, a contract award to address all statutory independent advocacy through a contract to procure a service to be known as the Advocacy Centre. This will provide a single gateway for the appointment of advocates under the Care Act, the Mental Capacity Act and the Mental Health Act.

### **4.2 Estimated Contract Value, including the value of any uplift or extension period.**

The budget allocation for the service should allow comfortably for the delivery of current statutory advocacy service demand and be able to accommodate a significant increase in demand due to the introduction of Independent Advocacy under the Care Act and any changes resulting from the Law Commission review of DoLS (see paragraph 1.7).

The budget has been put together using demand data for the IMCA, IMHA, DoLS and Care Act advocacy. Calculations are based on a generous assessment of the hours required for each case and the hourly rates (usually £25 - £30). This allows for any new legal judgements, high use of hours and poor market competitiveness amongst providers.



It is proposed that an investment of £30k will be made in the first year of the contract for prevention and capacity building activity to develop the local advocacy market and reduce the need for formal advocates in later years of the contract. For subsequent years the prevention and capacity building investment will be removed. It is expected that the activity from this initial investment will impact upon the amount of formal advocacy required in year two onwards of the contract.

The proposed budget for the contract can therefore be summarised as the following:

<b>Element of the contract</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3 (one year extension)</b>
The Advocacy Centre (provision of statutory advocacy)	£130,000	£115,000	£115,000
Prevention and capacity building	£30,000	£0	£0
<b>Total</b>	<b>£160,000</b>	<b>£115,000</b>	<b>£115,000</b>

The estimated contract value is therefore **£390,000** for 2 years with an additional one year extension.

A reduction in cost of **£26,346** will be made from the first year of the contract on the current advocacy allocation. As this is an activity-based contract, further cost reductions may also be seen in the first year, although we cannot predict actual activity. From the second year onwards, a further reduction of **£45,000** will be made on the revised advocacy allocation.

#### 4.3 **Duration of the contract, including any options for extension.**

A two year contract from 1 April 2016 to 31 March 2018, with the option to extend for a further year.

#### 4.4 **Recommended procurement procedure and reasons for the recommendation.**

The recommended procurement procedure routes for these services are:

- (i) An open award of a 2 year contract from 1 April 2016 to 31 March 2018 with the option to extend for a further year.

The contract will contain specific service requirements, and expected outcomes. Key performance indicators will be outlined in the service specification and agreed with the providers. Performance management of both services will be undertaken by commissioners.

Market engagement indicates a maximum of up to 15 potential national and local bidders thus an open procurement procedure would be the recommended option.

#### 4.5 **Selection and Award**

Selection and award will be based upon the offer, which is most economically advantageous to the council. It is proposed that a 70(price):30(quality) selection and award criteria is implemented.

A higher quality component has been proposed because of a number of factors, including:

- Duties within the Care Act, Mental Capacity Act and Mental Health Act.
- The particularly sensitive nature of the service and vulnerable nature of service users involved.
- The need to secure suitably qualified advocates to act in the statutory advocacy roles and the more limited amount of current supply in this respect.

Efficiencies have already been made through the integration of advocacy services under one contract.

#### 4.6 **The contract delivery methodology and documentation to be adopted.**

The standard Council contract 2015 is the form of contract to be used for the contract, with the addition of the terms and conditions agreed for social care contracts. The contract will have a break clause allowing notice to be given by either party for termination. This allows increased flexibility should a significant change in service provision be required. Terms and conditions will also take account of changes in the law, which may be relevant for the work currently being undertaken by the Law Commission.

It is proposed to opt for a full service commissioning model. Bids will be welcomed from a single provider or by a partnership (working on a consortium or lead/sub basis).

The contract will be an activity-based, call-off contract for the provision of statutory advocacy. However, an investment of £30k will be made in the first year of the contract for prevention and capacity building activity to develop the local advocacy market and reduce the need for formal advocates in later years of the contract.

#### 4.7 **Outcomes, savings and efficiencies expected as a consequence of awarding the proposed contract.**

See cost reductions as detailed in paragraph 4.2 above.

As stated above, bringing the services together into one contract will create efficiencies, enabling the Borough to maximise contract utilisation and make the budget saving suggested. One advocacy service will also negate the need for a 'gateway' provider to manage the referrals. One service will also lower overheads and back office costs for the provider, enabling them to invest in the promotion of their service and recruiting and developing specialist advocates. The prevention and capacity building additional £30,000 in the first year will help to develop the local advocacy market and reduce the need for formal advocacy in future years.

#### 4.8 **Criteria against which the tenderers are to be selected and contract is to be awarded**

Tenderers will be required to submit a method statement stating how they will meet the criteria detailed in paragraph 3.3. In addition, tenderers will also be marked against the following:

- Providers meeting the National Advocacy Quality Performance Mark as an independent measure of quality.
- Providers with local knowledge of the Borough able to appropriately signpost to alternative local services in Community, Faith and voluntary sector organisations.

#### 4.9 **Tender timetable**

An indicative timetable for tender is outlined below:

<b>Milestone</b>	<b>Date</b>
Procurement Board	29 September 2015
Health and Wellbeing Board	20 October 2015
Advert	November 2015
Evaluation	January 2016
Award decision	January 2016
Implementation	1 February 2016 – 30 March 2016
Contract start date	1 April 2016

#### 4.10 **How the procurement will address and implement the Council's Social Value policies.**

Through the award of the contract the Prevention and Capacity Building support will:

- Develop a sustained localised market for appropriate individuals and representatives wishing to informally advocate for individuals, supporting a more resilient and engaged community, building social value and reducing future demand for formal advocacy.
- Work with local providers, colleges and Care City to develop training centres in the Borough in order that local people could be trained as independent advocates.

We intend to invite providers to bid who have a track record in attracting external investment and building social value through the development of services, jobs, skills and volunteering opportunities.

### **5. Options Appraisal**

5.1 Other options considered as an alternative option to the above are as follows:

## 5.2 **Do Nothing**

This option is not viable because the Council is mandated to provide advocacy provision for people under the Care Act, Mental Health Act and Mental Capacity Act and the Mental Health Advocacy contract does not permit an option to extend, which would necessitate a need to tender, unless the relating contract rules were waived.

## 5.3 **Extend and maintain existing contract arrangements.**

Extensive stakeholder feedback and service reviews have highlighted problems with satisfaction around the current contractual arrangements.

There would also be a loss of opportunity to integrate the advocacy service and achieve better outcomes for service users who require independent advocacy. The Care Act explicitly states that where someone already requires an Independent Mental Capacity Advocate (IMCA) or an Independent Mental Health Advocate (IMHA) the same advocate should be used where possible to ensure a seamless service for the individual.

## 5.4 **Waiver**

Not applicable.

# 6. **Equalities and other Customer Impact**

6.1 Advocacy means supporting a person to understand information, express their needs and wishes, secure their rights, represent their interests and obtain the care and support they need.

6.2 This proposal for the remodelling and integration of statutory advocacy services under one single contract will provide a seamless advocacy service for the Borough's diverse population. The service will focus on ensuring that all individuals requiring statutory advocacy can easily access the service at any suitable point of their care and support journey, depending on their condition or setting.

6.3 It will also go some way to addressing some of the feedback concerns raised with the current service delivery, particularly around being confusing and difficult to access.

6.4 An Equalities Impact Assessment is currently being produced and will be analysed before going to tender.

# 7. **Mandatory Implications**

## 7.1 **Joint Strategic Needs Assessment**

The priorities for consideration in this report align well with the strategic recommendations of the Joint Strategic Needs Assessment. It should be noted, however, that there are areas where further investigation and analysis have been recommended as a result of this year's JSNA. The purpose of the ongoing JSNA process is to continually improve our understanding of local need, and identify areas to be addressed in future strategies for the borough.

## 7.2 Health and Wellbeing Strategy

If agreed and taken forward, the recommendations from the report will contribute to a number of the Health and Wellbeing Strategy outcomes:

- Residents are supported to make informed choices about their health and wellbeing to take up opportunities for self help in changing lifestyles such as giving up smoking and maintaining a healthy weight. This also involves fostering a sense of independence rather than dependence.
- Every resident experiences a seamless service.
- Service providers have and use person centred skills across their services that makes every contact with a health professional count to improve health.
- More older people feel healthy, active and included.
- Early diagnosis and increased awareness of signs and symptoms of disease will enable residents to live their lives confidently, in better health for longer.

## 7.3 Integration

Proposals for the Advocacy Centre have been developed in response to feedback from colleagues from the local authority and North East London NHS Foundation Trust.

An integrated advocacy service will minimise duplication of referrals for an individual and simplify the different access routes for service users and stakeholders. One advocacy service will lead to a more outcome-focused service, enabling one advocate to support an individual throughout their care and support journey, whether this is subject to the Care Act, Mental Capacity Act or Mental Health Act without any reduction in specialisms.

## 7.4 Financial Implications

Implications completed by: Carl Tomlinson, Group Finance Manager

The independent advocacy service is a call-off contract dependent on usage and the rate of advocacy charged by the provider. In previous years the actual costs of the advocacy service has been lower than the allocated budget. The introduction of the Care Act 2014 is seeing an increase in the numbers accessing independent advocacy. The financial envelope of £79,646 set aside for meeting Mental Health advocacy in 2015/16 is projected to spend to the contract value whilst the independent advocacy is projected to under spend by £35,000 against the allocated financial envelope of £95,000.

The cost of the new advocacy service has been determined by using demand data for the IMCA, IMHA, DoLS and Care Act advocacy with some contingency for further demand under the Care Act 2014. The contract value assumes an allocation of hours per case and at the market rate for advocacy to allow for any new legal judgements, high use of hours and poor market competitiveness amongst providers.

All local authorities were awarded a New Burdens Grant in April 2015 to meet its statutory duties under the Care Act 2014. The 2015/16 current advocacy contract of £186,346 (excluding the NHS Complaints Advocacy Service) is met through base budget of £126,346 and £60,000 of New Burdens Grant. The autumn announcement in 2015 will confirm the amount of New Burdens Grant to be paid to

local authorities from April 2016 to support the increased in activity associated with the implementation of the Care Act 2014.

It is intended that £33,654 of the 2016/17 New Burdens grant continues to be made available to support the statutory independent contract of £160,000. In 2017/18 the contract will reduce to £115,000 which will result in savings of £ £11,346 against the base budget of £126,346 with no further call against New Burdens Grant. The trend to date indicates that the proposed advocacy contract can be contained within the allocated financial envelope. However if the level of demand for independent advocacy is greater than anticipated it is expected the additional costs are met within Adult Social Care existing resources.

## **7.5 Legal Implications**

Implications completed by: Bimpe Onafuwa, Contracts and Procurement Solicitor

This report is for the procurement of an integrated statutory advocacy service. This procurement is not subject to the full rigor of the Public Contracts Regulations, but rather to the Light Touch Regime due to the nature of the service.

This procurement is however subject to the EU procurement principles of transparency, non-discrimination and equal treatment of bidders. Clauses 4.5 to 4.9 of this report indicate that there will be a call for competition by way of an advertisement. The clauses also state the timetable, and the evaluation and award criteria for this process – all of which show evidence of a fair tender exercise.

Provided the procurement strategy in this report is adhered to, and the Health and Wellbeing Board is satisfied that the procurement represents value for money, Legal Services do not see a reason why the recommendations of this report should not be approved.

## **8. Other Implications**

### **8.1 Corporate Procurement**

Implications completed by: Euan Beales – Head of Procurement and Accounts Payable

An evaluation model of 70% Cost and 30% Quality will allow an effective approach by the Council to obtain best value services. This will be supported through a 2 +1 year term to a value of £390k, which under the Councils Contract Rules requires approval from Procurement Board and the Health and Well Being Board. Under the 2015 Regulations the Council will be required to conduct the tender process under the Light Touch regime.

The amalgamation of the Advocacy services should allow the Council to realise benefit in terms of economies of scale and/or service delivery enhancements.

I support the recommendations as set out in this report.

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

**List of appendices:** None

## HEALTH AND WELLBEING BOARD

20 October 2015

<b>Title:</b> Contract extension for the provision of extra care accommodation services	
<b>Report of the Strategic Director for Service Development and Integration</b>	
<b>Open Report</b>	<b>For Decision</b>
<b>Wards Affected:</b> All	<b>Key Decision:</b> Yes
<b>Report Author:</b>  Michael Fenn, Integrated Commissioning Manager  Louise Hider, Principal Commissioning Manager	<b>Contact Details:</b>  Tel: 020 8227 2619 Email: <a href="mailto:Michael.fenn@lbbd.gov.uk">Michael.fenn@lbbd.gov.uk</a>  020 8227 2861 Louise.hider@lbbd.gov.uk
<b>Sponsor:</b> Anne Bristow, Strategic Director for Service Development and Integration	
<b>Summary:</b>  The local authority currently commissions four extra care schemes for older people in Barking and Dagenham. The contract for the care and support delivered in these schemes is with Triangle Care Services, formerly TLC Care Services.  The contract for the four extra care schemes has an annual contract value of £1,333,980. The contracts for the provision of extra care accommodation at the four commissioned schemes commenced on 1 May 2012. The contracts were agreed by Cabinet for a period of 3 ½ years with the ability to extend for an additional two years, one year at a time.  Due to the value of the contract exceeding £500,000, the Health and Wellbeing Board is recommended to agree to invoke the extension provision contained within the contract for extra care accommodation with Triangle Care Services for one year, from 1 November 2015 – 31 October 2016. An agreement of an extension will enable the continuation of extra care services at the four commissioned schemes to meet the care and support needs of the residents who live there.  Additionally, the local authority will use the next 12 months to review older people's accommodation across the Borough, including extra care housing. Reviewing the way in which extra care services are delivered in the borough will enable the Council to take stock of our extra care provision and make recommendations for the future size and type of extra care provision that we will need to cater for our older population.  It should be noted that negotiations with the provider on the extension has resulted in an increase in the hourly rate for providing the care element of the contract. Within the extension we will also vary the contract and reduce the maximum care hours available to ensure that the total contract value is not exceeded. This will not reduce the hours of	

<p>care that is currently being provided in the schemes, as the contract is under spent and we do not anticipate an increase in the number of care hours required.</p>
<p><b>Recommendations</b></p> <p>The Health and Wellbeing Board is recommended to:</p> <ul style="list-style-type: none"> <li>(i) Approve the extension and variation of the contract for the provision of extra care accommodation services with Triangle Care in accordance with the strategy set out in this report.</li> <li>(ii) Delegate authority to the Strategic Director for Service Development and Integration, in consultation with the Strategic Director, Finance &amp; Investment and the Head of Legal and Democratic Services to extend and vary the contract and execute related documentation.</li> </ul>
<p><b>Reason(s)</b></p> <p>The extension of this contract will allow the local authority the time to thoroughly review older people's accommodation in the Borough. Reviewing the way in which extra care services are delivered will enable the Council to ensure that the right amount and type of older people's accommodation and extra care provision is available, as well as ensure that services are provided in a personalised way. The Council will also be able to consider how this significant area of service provision can make a greater contribution to meeting the prevention duty set out in the Care Act, and the need to delay escalating social care need.</p> <p>The service also promotes the Council's vision of 'One Borough; One Community; London's Growth Opportunity' and particularly the priorities of :</p> <ul style="list-style-type: none"> <li>• Encouraging civic pride by 'promoting a welcoming, safe and resilient community' and 'building civic responsibility and helping residents shape their quality of life'.</li> <li>• Encouraging social responsibility by 'protecting the most vulnerable, keeping adults healthy and safe' and 'supporting residents to take responsibility for themselves, their homes and their community'.</li> </ul>

## 1. Introduction and Background

### What is Extra Care?

- 1.1 The term 'extra care' is used to describe self-contained housing that has design features and services attached to it which enable residents to self-care and remain independent for as long as possible. It comes in a wide variety of forms and may be described in different ways, for example 'very sheltered housing', 'housing with care', 'retirement communities' or 'villages'.
- 1.2 Most residents in 'extra care' are older people, who often find it attractive because it offers them independent living in a home of their own with other services on hand if they need or want them.



- 1.3 Extra care is often seen as a good alternative to early entry into residential care because it enables people to live in their own home for longer.
- 1.4 Extra care housing is expanding and is now offered by local authorities, housing associations and private providers. There are now approximately 60,000 units of extra care housing in England.<sup>1</sup>

### **Extra Care provision in Barking and Dagenham**

- 1.5 There are eight extra care schemes in Barking and Dagenham for older people aged 55 and over. These schemes are geographically spread across the Borough, with 294 units available. Four of these are provided 'in-house' by the local authority, with staff providing personal care and housing-related support to residents. These schemes include:
- George Crouch Centre
  - Millicent Preston House
  - Ted Hennem House
  - Fewes Lodge – this is an extra care scheme specifically for people with dementia
- 1.6 Additionally, the local authority commissions four extra care schemes. Triangle Community Services (previously TLC Care Services) provide the personal care and housing-related support at each scheme. These schemes have a total of 176 units and include:
- Colin Pond Court
  - Darcy House
  - Fred Tibble Court – this is an extra care scheme specifically designated for people with dementia
  - Harp House
- 1.7 Extra care schemes are at capacity, with a small waiting list of Borough residents. All of the extra care schemes are for rent only, with no shared ownership options in the Borough.

## **2. Current commissioned provision – Triangle Community Services**

- 2.1 The contracts for the provision of extra care accommodation at the four commissioned schemes commenced on 1 May 2012. The contracts were agreed by Cabinet for a period of 3 ½ years with the ability to extend for an additional two years, one year at a time. The contract was subject to and procured in accordance with the (EU) Contracts Regulations 2006 and are Part B services.
- 2.2 The main elements of the support provided by Triangle Community Services at the schemes, include:
- Providing domiciliary (personal) care to residents.

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<sup>1</sup> Source: Elderly Accommodation Counsel, June 2015

- Providing housing-related support to help residents to manage their tenancies and facilitating communications between residents and the landlord of the schemes.
- Developing and sustaining residents' capacity to live independently within the community through a person centred approach
- Empowering residents to make choices, and contribute and participate in their care and support
- Reducing the number of emergencies.
- Providing support to informal carers.
- Maximising the number of residents participating in community activities.

- 2.3 The overarching goal of the schemes are to provide conditions which enable older people to live in the community with the opportunity to maintain maximum independence, choice and control over their own lives.
- 2.4 The contract for the four schemes are split into two separate physical contracts, one which covers Harp House, Darcy House and Colin Pond Court and the other separate contract for Fred Tibble Court. Fred Tibble has a separate contract in place as this was initially designed as a dementia specialist scheme. In light of this, greater rates are paid at this scheme for care and support and housing related support in comparison to the other three schemes.
- 2.5 The contract has provision for a minimum and maximum number of hours to be delivered at each scheme, with more hours per week contracted at Fred Tibble due to the dementia-specialist nature of the scheme. All four schemes have on-site care available 24 hours per day, seven days per week. Fred Tibble also currently has two waking staff members throughout the night to ensure the safety and care of residents at the scheme. The other three schemes have one waking staff member and one sleeping night staff member.
- 2.6 The extra care schemes are subject to regular monitoring and quality assurance visits. Performance at the schemes is satisfactory with residents reporting good levels of satisfaction.
- 2.7 As stated above, the contract contains provisions to extend the contract for two additional years. It is proposed to invoke a contract extension for all four of the commissioned extra care schemes for one year from 1 November 2015 – 31 October 2016. This is recommended for the following reasons:
- The option is contained within the contract
  - A one year extension will allow for the current service to be re –designed following the review of the older people's housing pathway which is currently being undertaken. Please see Section 3 below.

### **Contract value and negotiations**

- 2.8 The current annual contract value is £1,333,980. This encompasses all personal care and housing-related support delivered by Triangle Community Services at the schemes.
- 2.9 In March 2015, Triangle Community Services wrote to the local authority to request an uplift in the hourly rate paid for personal care in all four of the extra care

schemes. They stated that due to market changes and staff costs, the contract in its current form was not financially viable.

- 2.10 Following protracted negotiations, it has been agreed to increase the hourly rate paid at Harp House, Colin Pond and Darcy House. We have agreed to this uplift to ensure that we are fully compliant with our duties under the Care Act, especially those duties in relation to ensuring a sustainable marketplace.
- 2.11 To counteract this increase we have also agreed to a reduction in the amount paid for housing-related support across all four sites. Triangle have agreed that they will make efficiencies in the way that housing-related support is delivered whilst maintaining a level of support which adequately assists residents to help manage their tenancy.
- 2.12 Financial modelling has shown that the increase in the hourly rate will cost the local authority a maximum of £78,000 per year. However, due to the fact that three of the four schemes are not delivering the maximum number of hours allocated in the contract, the contract is currently underspent by over £120,000. This means that even with the agreed increase, the contract will remain in budget over the next year as long as the care hours remain consistent. An increase in care hours is not anticipated over the coming year and to ensure that the provider does not exceed the contract value, the contract will be varied to reduce the maximum care hours available in the contract in line with the existing care hours required by residents in the schemes.

### **3. Reviewing extra care and sheltered housing**

- 3.1 Adult Social Care commissioners are working with Housing Strategy to undertake a review of the housing pathway for older people, starting this month. This review will include extra care provision. The review will look at existing older people's accommodation and will make recommendations for the way in which older people's housing in Barking and Dagenham could be delivered in the future. The review will take demographic changes, Social Care demand, budget pressures and the impact of the Care Act into consideration.
- 3.2 Reviewing the way in which extra care services are delivered in the borough will enable the Council to ensure that the right amount and type of extra care provision is available in Barking and Dagenham, as well as ensure that extra care services are provided in a personalised way in which residents have meaningful choice over the care and support that they receive in extra care accommodation.

### **4. Recommendations**

- 4.1 This report requests an extension in accordance with the Council's contract rules clause 54.6 that requires that every decision to extend a contract must be in writing by a Cabinet/HWBB minute for all contracts over £500,000.
- 4.2 The Health and Wellbeing Board is recommended to:
  - Approve the extension and variation of the contract for the provision of extra care accommodation services with Triangle Care in accordance with the strategy set out in this report.

- Delegate authority to the Strategic Director for Service Development and Integration, in consultation with the Strategic Director, Finance and Investment and the Head of Legal and Democratic Services to extend and vary the contract and execute related documentation.

**Alternative options considered and rejected:**

- 4.3 Cease the contract: This option is not practical as the local authority has a statutory duty to provide support and services to the residents of the scheme.
- 4.4 Retender the contract for October 2015: This option was considered and rejected due to the fact that the older people's housing pathway review being undertaken will influence the service design moving forward.

**5. Mandatory Implications**

**5.1 Joint Strategic Needs Assessment**

The priority for consideration in this report aligns well with the strategic recommendations of the Joint Strategic Needs Assessment (JSNA). It should be noted, however, that there are areas where further investigation and analysis have been recommended as a result of this year's JSNA. The purpose of the ongoing JSNA process is to continually improve our understanding of local need, and identify areas to be addressed in future strategies for the Borough.

**5.2 Health and Wellbeing Strategy**

The report's recommendations are consistent with outcomes and priorities outlined in our joint Health and Wellbeing Strategy.

**5.3 Integration**

Over the next 12 months, the local authority will review older people's accommodation in the Borough, including extra care. This review will be informed by discussions with a range of health and social care services.

**5.4 Financial Implications**

Implications completed by: Carl Tomlinson, Group Finance Manager

This report seeks to extend the current contract for the provision of extra care accommodation services for one year. This will enable the Council to review the provision of older person's accommodation in the borough going forward.

The current contract is valued at £1.334m assuming maximum hours are utilised and is funded from existing revenue budgets. Extra care schemes have typically not fully utilised the maximum hours allowable in the contract, therefore resulting in under spend.

A request from providers for hourly rate price uplifts, to reflect changes in the market and the Local Authority's requirement to be Care Act compliant in ensuring market sustainability, would lead to additional cost of £78k on the contract. In order

to manage this pressure within existing budgets, the service will need to reduce the maximum number of hours available within the contract.

## 5.5 **Legal Implications**

Implications completed by: Bimpe Onafuwa, Contracts and Procurement Solicitor

This report is seeking approval to exercise the option to extend the existing contract with Triangle Care for the provision of Extra Care Services.

This report also states that an extension provision in respect of an additional period of 2 years was reserved in the initial contract.

Contract Rule 54 permits the approval of a contract extension by a Chief Officer if there is provision in the original contract for such extension.

As an extension period has been provided for in the original Extra Care Services contract, Legal Services do not see a reason why this extension may not be granted.

## 6. **Other Implications**

### 6.1 **Corporate Procurement**

Implications completed by: Euan Beales – Head of Procurement and Accounts Payable

As outlined in the report the Council requires extension of contracts to be viewed as new procurements in terms of process. The 1 year extension period will allow for a review to be conducted to enable the modelling of the service going forward to include personalization elements.

There would be no financial or operational benefit to compete this service as the requirements are unknown and any implementation would increase risks to the residents and the cost of the procurement again outweighs any potential benefit.

I therefore support the recommendations as set out in this report.

### 6.2 **Equalities and other Customer Impact**

The extension of this contract will allow us to achieve outcomes in the service provision for older people living in wards in the borough with levels of social isolation, low income deprivation and poorer health outcomes.

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

None

### **List of appendices:**

None

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## HEALTH AND WELLBEING BOARD

20 OCTOBER 2015

<b>Title:</b>	<b>Systems Resilience Group Update</b>		
<b>Report of the Systems Resilience Group</b>			
<b>Open Report</b>		<b>For Information</b>	
<b>Wards Affected: ALL</b>		<b>Key Decision: NO</b>	
<b>Report Author:</b> Andrew Hagger, Health and Social Care Integration Manager, LBBD		<b>Contact Details:</b> Tel: 020 8227 5071 E-mail: <a href="mailto:Andrew.Hagger@lbbd.gov.uk">Andrew.Hagger@lbbd.gov.uk</a>	
<b>Sponsor:</b> Conor Burke, Accountable Officer, Barking and Dagenham Clinical Commissioning Group			
<b>Summary:</b> This purpose of this report is to update the Health and Wellbeing Board on the work of the Systems Resilience Group. This report provides an update on the Systems Resilience Group meetings held on 23 September 2015.			
<b>Recommendation(s)</b> The Health and Wellbeing Board is recommended consider the updates and their impact on Barking and Dagenham and provide comments or feedback to Conor Burke, Accountable Officer to be passed on to the Systems Resilience Group.			
<b>Reason(s):</b> There was an identified need to bring together senior leaders in health and social care to drive improvement in urgent care at a pace across the system.			

## **1 Mandatory Implications**

### **1.1 Joint Strategic Needs Assessment**

The priorities of the Group are consistent with the Joint Strategic Needs Assessment.

### **1.2 Health and Wellbeing Strategy**

The priorities of the Group are consistent with the Health and Wellbeing Strategy.

### **1.3 Integration**

The priorities of the Group are consistent with the integration agenda.

### **1.4 Financial Implications**

The Systems Resilience Group will make recommendations for the use of the A&E threshold and winter pressures monies.

### **1.5 Legal Implications**

There are no legal implications arising directly from the Systems Resilience Group.

### **1.6 Risk Management**

Urgent and emergency care risks are already reported in the risk register and group assurance framework.

## **2 Non-mandatory Implications**

### **2.1 Customer Impact**

There are no equalities implications arising from this report.

### **2.2 Contractual Issues**

The Terms of Reference have been written to ensure that the work of the Group does not impact on the integrity of the formal contracted arrangements in place for urgent care services.

### **2.3 Staffing issues**

Any staffing implications arising will be taken back through the statutory organisations own processes for decision.

## **3 List of Appendices**

System Resilience Group Briefings:

**Appendix 1:** 23 September 2015



<b>System Resilience Group (SRG) Briefing</b>	Meeting dated – 23 September 2015
	Venue – Becketts House
<b>Summary of paper</b>	This paper provides a summary of the key issues discussed at the System Resilience Group meeting. The meeting was chaired by Conor Burke (Chief Officer, BHR CCGs) and attended by members as per the Terms of Reference.

<b>Agenda</b>	<b>Areas/issues discussed</b>
<b>Matters arising</b>	Members received a report on non-elective admissions/attendances. Further work be done and reported back at the October meeting. An update on workforce resilience was provided.
<b>Performance reporting</b>	Key areas from the dashboard were highlighted.
<b>Trust Improvement Plan</b>	Members received an update on BHRUT A&E.
<b>Plan for 2015/16</b>	Members received an update on progress of key areas of the 2015/16 plan.
<b>Strategic Development</b>	Members noted the latest position of the Urgent and Emergency Care Vanguard bid and the NEL Urgent and Emergency Care Network.
<b>Planned Care</b>	Members were updated on the RTT and Cancer improvement plans.
<b>Next meeting:</b>	Thursday 22 October 2015 2pm – 4pm Committee room 3b, Havering Town Hall, Main Road, Romford, RM1 3BD

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## HEALTH AND WELLBEING BOARD

**8 SEPTEMBER 2015**

<b>Title:</b>	<b>Sub-Group Reports</b>		
<b>Report of the Chair of the Health and Wellbeing Board</b>			
<b>Open Report</b>		<b>For Information</b>	
<b>Wards Affected: NONE</b>		<b>Key Decision: NO</b>	
<b>Report Authors:</b> Andrew Hagger, Health and Social Care Integration Manager, LBBD		<b>Contact Details:</b> Telephone: 020 8227 5071 E-mail: <a href="mailto:Andrew.Hagger@lbbd.gov.uk">Andrew.Hagger@lbbd.gov.uk</a>	
<b>Sponsor:</b> Councillor Maureen Worby, Chair of the Health and Wellbeing Board			
<b>Summary:</b> At each meeting of the Health and Wellbeing Board each sub-group, excluding the Executive Planning Group, report on their progress and performance since the last meeting of the Board.  Please note that there is no report for the Mental Health and Children and Maternity sub-groups as they have not held a meeting since the last Health and Wellbeing Board.			
<b>Recommendations:</b> The Health and Wellbeing Board is asked to note the contents of sub-group reports set out in the appendices and comment on the items that have been escalated to the Board by the sub-groups.			

### List of Appendices

**Appendix 1:** Integrated Care Sub group

**Appendix 2:** Public Health Programmes Board

**Appendix 3:** Learning Disabilities Partnership Board

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## Integrated Care Sub group

Chair: Sharon Morrow, Chief Operating Officer, Barking and Dagenham CCG

<p><b>Items to be escalated to the Health &amp; Wellbeing Board</b></p> <ul style="list-style-type: none"> <li>The Health and Wellbeing Board is asked to note progress of the Integrated Care Sub Group</li> </ul>
<p><b>Meeting Attendance</b></p> <p>12 August 2015: 37% ( 7 out of 19)</p> <p>16 September 2015: 37% (7 out of 19)</p>
<p><b>Performance</b></p> <p>Reported through performance dashboard which updates on the work streams that impact on the BCF metrics. The BCF Q4 and Q1 performance has been above plan. The Joint Executive Mgt team has been presented with a report on the performance and a workshop is set for 21<sup>st</sup> of October to agree with all local partners actions to bring performance back on trajectory.</p>
<p><b>Action(s) since last report to the Board</b></p> <ol style="list-style-type: none"> <li>The group received a briefing on work being commissioned by Public Health to develop the dementia needs assessment and discussed the criteria that needed to be met in order to become a Dementia Friendly Community. It was noted that a part time project co-ordinator was requested for 1 year to set up the Dementia Action Alliance. Members were of the view that many organisations are already signed up to the key principles and a lot of the work that the project co-ordinator would do is already being done. It was suggested that a resource could be identified through the Dementia Task and Finish Group. Members agreed in principle to support the plan to become a Dementia Friendly Community.</li> <li>Members to review the JSNA key recommendations and feedback to Public Health.</li> <li>Emergency Admissions. A planning meeting took place to progress the Stakeholder Workshop to address unplanned admissions. The Workshop is arranged for 21 October 2015</li> <li>The group reviewed and commented on CCG draft commissioning intentions related to integrated care</li> </ol>
<p><b>Action and Priorities for the coming period</b></p> <ol style="list-style-type: none"> <li>Commissioning Intentions paper to be drafted for the HWBB.</li> <li>The Group to receive a presentation of LBBD's Ambition 2020 programme.</li> </ol>

**Contact:** Eileen Williams

Tel: number / E-mail: [eileen.williams@barkingdagenhamccg.nhs.uk](mailto:eileen.williams@barkingdagenhamccg.nhs.uk)

*Contact person should be someone who is able to respond to queries about the subgroup's work, and may be a PA or Business Support Officer rather than the Chair where this is more appropriate.*

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## Learning Disability Partnership Board

Chair: Glynis Rogers, Divisional Director Commissioning and Partnerships, London Borough of Barking and Dagenham

<p><b>Items to be escalated to the Health &amp; Wellbeing Board</b></p> <p>None.</p>
<p><b>Attendance:</b></p> <p>15<sup>th</sup> September – 80% (12 out of 15) member attended.</p>
<p><b>Performance issues.</b></p> <p>There are no issues at this time.</p>
<p><b>Action(s) since last report to the Board</b></p> <p>(a) The partnership board meets regularly and has active membership representing a range of stakeholders inclusive of service users, Carers, Providers, Children services, Care management, Housing, Healthwatch and Hospitals. The meetings offer members an opportunity to comment on consultations both national and local policies directly affecting people with a learning disability. Examples of this are the DoH green paper “ No voice unheard, No right untold” and the implementation of the boroughs’ carers strategy.</p> <p>(b) The authority and the CCG continue to deliver on the agreements set out in the Winterbourne concordat. London is under a great deal of focus from both NHS England and Association of Directors of Adult Social Services (ADASS) following poor performance in the past year. There is strong emphasis on discharging patients who have spent over a year in an Assessment and Treatment Unit. (ATU). The Borough has achieved the target the national target of meeting a 10% reduction in its cohort of patients. However this report wishes the board to note Barking &amp; Dagenham have on occasion implemented a lengthy discharge transition plan when discharging patients that have spent several years in an ATU. This has at times resulted in discharge dates being extended, which receives a negative report to NHS England and ADASS. The London average of re-admissions back into an ATU is 28% Barking &amp; Dagenham to date have a zero % readmission performance.</p> <p>(c) A Coroner’s report detailing the circumstances which led to the death of a woman with Learning disability in a neighbouring borough was used as a lesson learnt document to ensure Barking &amp; Dagenham have in place the appropriate support to people with a learning disability access medical attention. The report was presented to the learning disability partnership board. Reassurance was given on the support</p>

the hospitals offer to people with a learning disability; however it highlighted a need for GPs across the borough to be more consistent and robust in providing health checks. The Clinical Commissioning Group and the Community Learning Disability Team will develop an improvement plan to refresh the training that GPs may need on completing health checks and developing health action plans.

- (d) Feedback from the Sub groups is proving valuable. Attendance from the Carers forum has been very low over the past 3 months. Attempts to encourage participation have been to rotate the meetings between morning and evening sessions. Further ideas will need to be developed to stimulate attendance. The Carers Forum is keen to ensure the councils Carers strategy meets the needs of carers who support people with a learning disability and that the strategy distinguishes between the different needs of older and younger carers of people with a learning disability.
- (e) The sub-groups have active members that are contributing to the development of the Learning Disability Independent Housing strategy.
- (f) The Council is planning to carry out a consultation to service users and carers on changes to the charging policy.

#### **Action and Priorities for the coming period**

- (a) An update of the implementation of the Learning Disability Self Assessment Framework Action Plan.
- (b) An update of the implementation of the Learning Disability Autism Monitoring Action Plan.
- (c) Overview update of all the implementation programmes where Learning Disability services are a stakeholder.

**Contact:** Karel Stevens-lee, Integrated Commissioning Manager – Learning Disabilities

**Tel:** 020 8227 2476 **Email:** karel.stevens-lee-lee@lbbd.gov.uk



# Public Health Programmes Board

Chair: Matthew Cole Director of Public Health

## Items to be escalated to the Health and Wellbeing Board

None

## Performance

### 2015/16 Budget and Performance of Programmes

The public health programme performance and expenditure was reviewed. Most services/projects meet targets, however those that are red include:

#### Child Weight Management Programme Q1 target not met

The child and young people weight management service is a programme for children and young people (aged 5 to 17 years) who are overweight or obese. The service aims to improve participants' skills, knowledge and confidence in healthy eating and physical activity to prevent further weight gain/achieve a healthy weight. Table 1 shows that the service was not on target at the end of Q1.

**Table 1: Leisure Services Child Weight Management Programme Performance, Q1 2015/16**

	Q1 Actual	Q1 Target	Annual Target
Tier 1	20	36	144
Tier 2 (starters)	56	120	480
Tier 3	0	24	96

#### Performance improvement actions

1. To improve performance, an outcomes-based service specification has been written and will be agreed.
2. The interfaces and pathways with the National Child Measurement Programme and physical activity interventions have been joined up.
3. Public Health is undertaking a local obesity evaluation to evaluate the impact of local child weight management and physical activity programmes, with the aim of improving the impact.
4. Based on the outcome of the evaluation the allocation of the public health grant will be reviewed.

#### Number of four-week smoking quitters

The four-week smoking quitter indicator measures the number of individuals who have successfully quit for four weeks. In July, there were 33 quitters through Tier 2 and 3 smoking cessation services. To date, there have been 13 successful quits in August. The monthly target for quitters is 250 people; therefore, this target is highly unlikely to be

achieved once the number of quitters is finalised.

**Table 2: Number of smoking quitters by provider type**

	April	May	June	July	August	Total Achieved to date	Annual Target
<b>GP</b>	6	12	13	5	4	<b>40</b>	2,000
<b>Pharmacy</b>	28	20	22	22	4	<b>96</b>	
<b>Tier 3</b>	5	5	8	6	5	<b>29</b>	1,000
<b>Total Achieved</b>	<b>39</b>	<b>37</b>	<b>43</b>	<b>33</b>	<b>13</b>	<b>165</b>	3,000
<b>Target</b>	250	250	250	250	250	1,250	

Performance since April 2015 (with the exception of June) shows a month-on month decrease in the number of people setting a 4-week quit date. This trend is not unusual for the summer months.

#### **Performance improvement actions**

1. Increasing primary care performance and coverage
2. Improving stop smoking service awareness and accessibility
3. Increasing the number of patients that GPs and pharmacies support to quit smoking, and improving systems to allow better referral and navigation of the stop smoking pathway.
4. Quitters will be signposted to support including access to lifestyle support, nicotine replacement therapy, intensive specialist advice, or through referral to other specialist services, as appropriate.
5. Public Health is scoping potential incentive schemes to support quitters.
6. £15,000 has been budgeted for promotional campaigns (including Stoptober, No Smoking Day and #makeachange) to raise the profile of stop smoking services.
7. As part of the Healthy Schools bronze award programme, Barking and Dagenham has invested £60,000 in smoking prevention via tobacco control and £15,000 towards health promotion, as well as the other investment across the Council in environmental protection and schools.
8. Finally, a procurement exercise is underway to re-procure primary care public health services including smoking cessation by 1 April 2016.

#### **Meeting Attendance**

Good attendance

#### **Action(s) since last report to the Health and Wellbeing Board**

##### **Integrated Sexual Health service**

We have agreed a new contract with Barking Havering and Redbridge Hospitals University NHS Trust (BHRUT) commencing from 1<sup>st</sup> October on the basis of 1 year with the option to extend for a further 2 years (one year at a time). This is based on the current tariff prices

with efficiencies of at least 5% to be achieved each year.

In year 1 we will continue the financial negotiations with BHRUT to reduce the current tariff prices and reduce clinical staffing and operating costs as follows:

- Reduce staffing ratios and operating costs across the existing sites to provide a more cost-effective clinical delivery model
- Negotiate the current tariffs in line with national tariff guide prices, proposed Pan-London arrangements and benchmarking of other sub-regional arrangements where efficiencies have been achieved (we gave the current NCA GUM tariffs from Wandsworth as an example of competitive rates currently being negotiated with competitor Trusts)
- Review first appointment to follow-up activity and ratios to understand patient flows at the current sites in order to determine where FP, LARC and GUM activity can be diverted to primary care and / or the community e.g. home testing for Chlamydia and HIV.

### **Childhood Immunisation**

Director of Public Health and NHS England joint visits to support the 25 practices where coverage requires improvement is ongoing. A report will be due at the Health Protection Committee's next meeting.

**0-5 years Healthy Child Programme and Family Nurse Partnership commissioning**  
Transition completed between the Council and NHS England

### **Action and Priorities for the coming period**

1. Implement the In year savings plan
2. Monitor recovery plans on areas of poor performance.
3. Immunisation improvement report

**Contact:** Pauline Corsan

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## HEALTH AND WELLBEING BOARD

20 October 2015

<b>Title:</b>	<b>Chair's Report</b>	
<b>Report of the Chair of the Health and Wellbeing Board</b>		
<b>Open Report</b>	<b>For Information</b>	
<b>Wards Affected: ALL</b>	<b>Key Decision: NO</b>	
<b>Report Author:</b> Andrew Hagger, Health and Social Care Integration Manager	<b>Contact Details:</b> Tel: 020 8227 5071 Email: <a href="mailto:Andrew.Hagger@lbbd.gov.uk">Andrew.Hagger@lbbd.gov.uk</a>	
<b>Sponsor:</b> Councillor Maureen Worby, Chair of the Health and Wellbeing Board		
<b>Summary:</b> Please see the Chair's Report attached at Appendix A.		
<b>Recommendation(s)</b>  The Health and Wellbeing Board is recommended note the contents of the Chair's Report attached as Appendix A and comment on any item covered should they wish to do so.		

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*In this edition of my Chair's Report, I talk about the success of the Older People's Day event on 1<sup>st</sup> October and the work carried out at the Mental Health Strategy Workshops. I also provide an update on the work of the Safeguarding Adults Board and the Safeguarding Children Board. I would welcome Board Members to comment on any item covered should they wish to do so.*  
 Best wishes,  
**Cllr Maureen Worby, Chair of the Health and Wellbeing Board**

### Older People's Day

Older people were celebrated for their contribution to community and family life in Barking and Dagenham earlier this month as part of this year's event programme marking 50 years as a London borough. Nationally, Older People's Day is held annually on 1 October. Barking and Dagenham Community organisations and the Council went six days better by holding free events and activities, around the borough, over the whole week.



Events like Older People's Day are important because too often we hear about the pressures of an ageing population and its needs, forgetting just how much those very same people have given to their communities and continue to give. We value our elders in Barking and Dagenham, and we're showing that with this annual celebration, as well as continuing to offer an excellent 'Ageing Well' activity programme. We're also pointing the way to services and resources that people might need to help live a healthier, longer life.

Councillor Darren Rodwell, leader of the Council, took part and thoroughly enjoyed a Zumba Gold session (see picture below) as well as chatting to residents and the many voluntary sector groups taking part.



## Older People's Day continued

Hilary Kurt-Webster, star of Sky TV's 'Live! Laugh! Linedance!', was a particular hit at the event in Barking Town Square. She led line-dancing sessions with a running commentary on the joys of 'older life', having just celebrated her own 60th birthday.

The programme on the day included Zumba Gold, Tai Chi, self defence, aqua aerobics, Bokwa Step, line dancing, Boccia, Treasured memories sessions, crafts sessions, talks from authors, and socialising with the Elderberries.

Groups and centres running sessions included Chadwell Heath Community Centre, Studio 3 Arts, Memory Lane Resource Centre, Valence House and Library, Dagenham Library, Eastbury House, Barking Learning Centre, and Abbey and Becontree Heath Leisure Centres. Participants were also given a voucher to use at the new Abbey Spa at Abbey Leisure Centre in Barking.

There is more information about activities for older people in Barking and Dagenham on the 'Ageing Well programme' page at [www.gettingactive.co.uk](http://www.gettingactive.co.uk).

## Mental Health Strategy Workshops

Two of the three planned Mental Health Strategy workshops have now taken place, with the third and final one planned for 26<sup>th</sup> October.

The first workshop focussed on 'My Life', looking at how people can stay healthy, resilient and engaged with the community. It also looked at improving mental health awareness and reducing stigma as well as supporting people into education, training and employment.

The second workshop looked at 'My Home and Community', including housing options and models for the wide range of levels of support required, maintaining a home and maintaining and developing social networks.

The third workshop will be based around 'My Care', which will look at all aspects of care and support. The workshop will focus on service user journeys, including a service user's real story to tell us about their needs, their journey through the system, what worked well and what didn't work well about the care that they received.

Information will be provided on shrinking budgets against the rise in acuity, with workshops focussing on service user journeys and the money that has been spent on that individual throughout their journey. Participants will be asked how could the care have been delivered differently to this individual with a 50% smaller budget and to think creatively, particularly about the interventions that could have been implemented throughout the service user's journey.

Participation in the workshops has been good, with a wide range of commissioners, providers and service users involved. The findings will be used to inform the new Mental Health Strategy, which will be developed by the Mental Health Sub-Group and presented to the Health and Wellbeing Board in the New Year.



## News from NHS England

### Commitment to Carers

In May 2014, NHS England published their commitment to carers to give them the recognition and support they need to provide invaluable care for loved ones. With 1.4 million people providing 50 or more carer hours a week for a partner, friend or family member, they make a significant contribution to society and the NHS. There is a growing awareness that the NHS will only be sustained if it appreciates the potential of not just the professionals working within it but also the value individuals and their carers bring.

There are 37 commitments to carers spread across eight key priorities which include raising the profile of carers, education and training, person-centred coordinated care and primary care. These have been developed in partnership with carers, patients, partner organisations and care professionals. The recently published end of year progress summary on commitment to carers provides a review of the progress achieved against the commitments to carers that NHS England made last year. It demonstrates that there has been good start, but that there is still more work to be done. 32 of the commitments have either been completed or the initial action is complete and further work will be required in 2015/16. 5 commitments still require work for 2015/16. The commitments have been overseen by a delivery group comprising of carers organisations and they have agreed the content of this report.

NHS England remains committed to continuing work to support carers, with the 37 commitments representing the start of a journey and a step in the right direction.

### Have your say on maternity services in England

The NHS Maternity Review wants to hear your opinions on maternity services. All comments will contribute to the work of the review which will publish its recommendations by the end of the year. The consultation is open until 31 October 2015 to anyone with an interest in maternity, including women and their families, professionals, commissioners and other organisations.

### Role of pharmacists set to grow?

The Chief Pharmaceutical Officer for NHS England highlighted the important role that pharmacists play while addressing the Royal Pharmaceutical Society Annual Conference 2015. Dr Keith Ridge explained that demand for clinical pharmacy has never been greater but that clinical pharmacy had more to offer.

This includes addressing admission to hospital due to avoidable medicines issues, as well as reducing the level of wastage of medicines use and over use of medicines. Expansion of clinical pharmacy in all settings can deliver patient benefits and system efficiencies through using medicines optimally. Technological progress, such as the use of robotic dispensing in hospitals, can help to free up clinical staff to deliver more direct patient care.

Changes in community pharmacy, such as centralised dispensing facilities already present in some places in England, or through developing click and collect and more home delivery could make dispensing more efficient and safer. This will free up highly trained staff to work closer with patients, to deliver clinical pharmacy and medicines optimisation and to help people live healthier lives.

## Safeguarding Adults Board

The Safeguarding Adults Board met on 25<sup>th</sup> September, where they agreed and signed off the Safeguarding Adults Board Annual Report which will be presented to the Health and Wellbeing Board in December. The Board also discussed the draft Strategic Plan, which is underpinned by the six safeguarding principles set out in the Care Act 2014 of empowerment, prevention, proportionality, protection, partnership and accountability. The draft Performance Assurance Framework was also discussed, which is a dashboard that will provide assurance about the performance of the safeguarding systems across the partnership.

There has been a delay in the publishing of the London Safeguarding Adult and Policy and Procedures while NHS England and Police legal teams review them. All Safeguarding Adults Boards will be required to approve these prior to them coming into force on 1 Jan 2016. This will take place at the next meeting on 9 December.

## Safeguarding Children Board

At the LSCB Board meeting on 17<sup>th</sup> September 2015, the partners agreed their Annual Report 2014-15. Wider circulation of the report is in progress and presentation is scheduled to the HWBB in December.

In 2013, following the tragic death of a Child resident in Barking & Dagenham, the LSCB undertook a serious case review. This review has now concluded and the Overview report was agreed. This will be published on 12 October 2015. Multi agency briefings sessions are being arranged for later in the year, to disseminate the information found within the report and share lessons.

The LSCB have just commissioned a Serious Case Review in respect of an infant who was subjected to serious injuries on three occasions. An independent reviewer has been appointed and the serious case review panel are due to have their first meeting on 4<sup>th</sup> November 2015.

## Barking and Dagenham Clinical Commissioning Group's 2015 Awards

The first annual awards event took place at the annual general meeting of Barking and Dagenham Clinical Commissioning Group on 8 September 2015 to celebrate the individuals and teams working to improve local health services and to support people to stay healthy.

Winners included Integrated Care Clusters 1 and 5, with Cluster 1 receiving the "Over and Above" award, and Cluster 5 winning the "Partnership Working" category. Another winner was Alan Spencer, who has volunteered much of his spare time to chair the highly successful patient participation group (PPG) at Gables Surgery in Dagenham. Respected by staff and patients alike, Alan was recognised as an Engagement Champion for his work to involve patients in the work of the NHS.

## Health and Wellbeing Board Meeting Dates

Tuesday 8 December 2015, Tuesday 26 January 2016, Tuesday 8 March 2016, Tuesday 26 April 2016, Tuesday 14 June 2016.

All meetings start at 6pm and are held in the conference room of the Barking Learning Centre.

## HEALTH AND WELLBEING BOARD

**20 October 2015**

<b>Title:</b>	<b>Forward Plan</b>
<b>Report of the Chief Executive</b>	
<b>Open</b>	<b>For Comment</b>
<b>Wards Affected: NONE</b>	<b>Key Decision: NO</b>
<b>Report Authors:</b> Tina Robinson, Democratic Services	<b>Contact Details:</b> Telephone: 020 8227 3285 E-mail: <a href="mailto:tina.robinson@lbbd.gov.uk">tina.robinson@lbbd.gov.uk</a>
<b>Sponsor:</b> Cllr Worby, Chair of the Health and Wellbeing Board	
<p><b>Summary:</b></p> <p>The Forward Plan lists all known business items for meetings scheduled for the coming year. The Forward Plan is an important document for not only planning the business of the Board, but also ensuring that information on future key decisions is published at least 28 days before the meeting. This enables local people and partners to know what discussions and decisions will be taken at future Health and Wellbeing Board meetings.</p> <p>Attached at <b>Appendix A</b> is the next draft edition of the Forward Plan for the Health and Wellbeing Board at the time of the agenda's publication.</p>	
<p><b>Recommendation(s)</b></p> <p>The Health and Wellbeing Board is asked to:</p> <ol style="list-style-type: none"> <li>a) Note the draft Forward Plan and to advice Democratic Services of any issues of decisions that may be required so they can be listed publicly in the Board's Forward Plan, with at least 28 days notice of the meeting;</li> <li>b) To consider whether the proposed report leads are appropriate;</li> <li>c) To consider whether the Board requires some items (and if so which) to be considered in the first instance by a Sub-Group of the Board;</li> <li>d) To note that the next issue of the Forward Plan will be published on 10 November 2015. Any changes or additions to the next issue should be provided before 6.00p.m, on 4 November.</li> </ol>	

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

None

**List of Appendices**

Appendix A – Draft Forward Plan

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# **HEALTH and WELLBEING BOARD FORWARD PLAN**

DRAFT December 2015 Edition

Publication Date: Due on 10 November 2015

# THE FORWARD PLAN

## Explanatory note:

Key decisions in respect of health-related matters are made by the Health and Wellbeing Board. Key decisions in respect of other Council activities are made by the Council's Cabinet (the main executive decision-making body) or the Assembly (full Council) and can be viewed on the Council's website at <http://modern.gov.barking-dagenham.gov.uk/mgListPlans.aspx?RPId=180&RD=0>. In accordance with the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 the full membership of the Health and Wellbeing Board is listed in Appendix 1.

## Key Decisions

By law, councils have to publish a document detailing "Key Decisions" that are to be taken by the Cabinet or other committees / persons / bodies that have executive functions. The document, known as the Forward Plan, is required to be published 28 days before the date that the decisions are to be made. Key decisions are defined as:

- (i) Those that form the Council's budgetary and policy framework (this is explained in more detail in the Council's Constitution)
- (ii) Those that involve 'significant' spending or savings
- (iii) Those that have a significant effect on the community

In relation to (ii) above, Barking and Dagenham's definition of 'significant' is spending or savings of £200,000 or more that is not already provided for in the Council's Budget (the setting of the Budget is itself a Key Decision).

In relation to (iii) above, Barking and Dagenham has also extended this definition so that it relates to any decision that is likely to have a significant impact on one or more ward (the legislation refers to this aspect only being relevant where the impact is likely to be on two or more wards).

As part of the Council's commitment to open government it has extended the scope of this document so that it includes all known issues, not just "Key Decisions", that are due to be considered by the decision-making body as far ahead as possible.

## Information included in the Forward Plan

In relation to each decision, the Forward Plan includes as much information as is available when it is published, including:

- the matter in respect of which the decision is to be made;
- the decision-making body (Barking and Dagenham does not delegate the taking of key decisions to individual Members or officers)
- the date when the decision is due to be made;

## Publicity in connection with Key decisions

Subject to any prohibition or restriction on their disclosure, the documents referred to in relation to each Key Decision are available to the public. Each entry in the Plan gives details of the main officer to contact if you would like some further information on the item. If you would like to view any of the documents listed you should contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: [tina.robinson@lbbd.gov.uk](mailto:tina.robinson@lbbd.gov.uk)).

The agendas and reports for the decision-making bodies and other Council meetings open to the public will normally be published at least five clear working days before the meeting. For details about Council meetings and to view the agenda papers go to <http://moderngov.barking-dagenham.gov.uk/ieDocHome.asp?Categories> and select the committee and meeting that you are interested in.

The Health and Wellbeing Board's Forward Plan will be published on or before the following dates during the 2014 / 2015 Council year, in accordance with the statutory 28-day publication period:

<b>Edition</b>	<b>Publication date</b>
December 2015 edition	10 November 2015
January 2016 edition	29 December 2015
March 2016 edition	9 February 2016
April 2016 edition	29 March 2016
June 2016 edition	17 May 2016

## Confidential or Exempt Information

Whilst the majority of the Health and Wellbeing Board's business will be open to the public and media organisations to attend, there will inevitably be some business to be considered that contains, for example, confidential, commercially sensitive or personal information.

This is formal notice under the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 that part of the meetings listed in this Forward Plan may be held in private because the agenda and reports for the meeting will contain exempt information under Part 1 of Schedule 12A to the Local Government Act 1972 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it. Representations may be made to the Council about why a particular decision should be open to the public. Any such representations should be made to Alan Dawson, Democratic Services Manager, Civic Centre, Dagenham, Essex RM10 7BN (telephone: 020 8227 2348, email: [committees@lbbd.gov.uk](mailto:committees@lbbd.gov.uk)).

## Key to the table

Column 1 shows the projected date when the decision will be taken and who will be taking it. However, an item shown on the Forward Plan may, for a variety of reasons, be deferred or delayed.

It is suggested, therefore, that anyone with an interest in a particular item, especially if he/she wishes to attend the meeting at which the item is scheduled to be considered, should check within 7 days of the meeting that the item is included on the agenda for that meeting, either by going to <http://modern.gov.barking-dagenham.gov.uk/ieListMeetings.aspx?CId=669&Year=0> or by contacting contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: [tina.robinson@lbbd.gov.uk](mailto:tina.robinson@lbbd.gov.uk)).

Column 2 sets out the title of the report or subject matter and the nature of the decision being sought. For 'key decision' items the title is shown in **bold type** - for all other items the title is shown in normal type. Column 2 also lists the ward(s) in the Borough that the issue relates to.

Column 3 shows whether the issue is expected to be considered in the open part of the meeting or whether it may, in whole or in part, be considered in private and, if so, the reason(s) why.

Column 4 gives the details of the lead officer and / or Board Member who is the sponsor for that item.



Decision taker/ Projected Date	Subject Matter  Nature of Decision	Open / Private (and reason if all / part is private)	Sponsor and Lead officer / report author
<b>Health and Wellbeing Board: 8.12.15</b>	<p>Substance Misuse in Barking and Dagenham</p> <p>The Board will be provided with an information report to highlight the current situation regarding the misuse of illegal drugs, prescribed and over the counter medication.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	Glynis Rogers, Divisional Director, Commissioning and Partnerships (Tel: 020 8227 2827) (glynis.rogers@lbbd.gov.uk)
<b>Health and Wellbeing Board: 8.12.15</b>	<p>Local Safeguarding Children Board Report</p> <p>The Local Safeguarding Children Board report will include the Children's Death Overview Panel (CDOP) report and will be presented to the H&amp;WBB for information.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	Helen Jenner, Corporate Director of Children's Services (Tel: 0208 227 5800) (helen.jenner@lbbd.gov.uk)
<b>Health and Wellbeing Board: 8.12.15</b>	<p>Market Position Statement Refresh Consultation</p> <p>An addendum to the Market Position Statement (MPS) is being produced to reflect the Care Act 2014 and market updates.</p> <p>This Board will be asked to sign-off of the addendum and agree to the production of a new MPS for the Autumn of 2016 to reflect Ambition 2020 and the Growth Commission.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	Mark Tyson, Group Manager, Integration & Commissioning (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk)

<b>Health and Wellbeing Board: 8.12.15</b>	<p>Local Account 2014/15</p> <p>The Local Account is the Council's statement to the local community about the quality of adult social care services. It explains how much the Council spends, what it spends money on, what services are provided and commissioned, performance over the past year, together with achievements and future plans for improvements. This year a Local Account film will be shared with our partners, the community and will be on the Council's website.</p> <p>The film is being presented to the Health and Wellbeing Board for information only.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	<p>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk)</p>
<b>Health and Wellbeing Board: 8.12.15</b>	<p>Child Sexual Exploitation</p> <p>The report will set out the current position and prevention of Child Sexual Exploitation; for which the Barking &amp; Dagenham Local Safeguarding Children Board (LSCB) has strategic oversight.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	<p>Teresa DeVito, Acting Divisional Director – Strategic Commissioning, Safeguarding &amp; Early Help (Tel: 020 8227 2318) (Teresa.Devito@lbbd.gov.uk)</p>
<b>Health and Wellbeing Board: 8.12.15</b>	<p>Revisions to the Care and Support Charging Policy</p> <p>In February 2016 the Cabinet will be asked to agree revisions to the Care and Support Charging Policy as part of a review of areas of local discretionary charging under the Care Act 2014.</p> <p>The Health and Wellbeing Board is asked to give its views on the proposals as part of the consultation process.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	<p>Ian Winter, Care Act Programme Lead (Tel: 020 8227 5310) (ian.winter@lbbd.gov.uk)</p>

<b>Health and Wellbeing Board:</b> <b>8.12.15</b>	<p><b>Contract - Mental Health Supported Accommodation Scheme - Request for Delegated Authority</b> : Community,: Financial</p> <p>The Board will be provide with an overview of the plan to commission a 24 hour supported living scheme in the Borough for service users with mental health needs.</p> <p>The Board will be asked to approve the seeking of tenders and to authorise delegated authority for the acceptance of the tender.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	<p>Mark Tyson, Group Manager, Integration &amp; Commissioning  (Tel: 020 8227 2875)  (mark.tyson@lbbd.gov.uk)</p>
<b>Health and Wellbeing Board:</b> <b>8.12.15</b>	<p>Lessons Learned Report Following a Neighbouring Borough Coroner's Report Detailing Circumstance of a Death.</p> <p>A Neighbouring boroughs Coroner's report concluded that a service user with Learning Disabilities had died as a result of natural causes contributed by neglect. The lessons learned in the Coroner's report were discussed at the Learning Disabilities Partnership Board, with recommendations for an Action Plan to be presented to the Health and Wellbeing Board.</p> <p>The Board will be asked to note the actions and recommendations to ensure Barking and Dagenham GP's and Hospitals support people with Learning Disabilities appropriately.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	<p>Glynis Rogers, Divisional Director, Commissioning and Partnerships  (Tel: 020 8227 2827)  (glynis.rogers@lbbd.gov.uk)</p>
<b>Health and Wellbeing Board:</b> <b>26.1.16</b>	<p><b>Barking and Dagenham Sport and Physical Activity Strategy</b> : Community</p> <p>The Board will be asked to approve a new Sport and Physical Activity Strategy aimed at increasing Borough residents' participation in physical activity to improve the health of local residents. The Strategy will also set out plans to help the Council, its partners and local sports clubs to raise funds to support improvements in service delivery as well as enable a joined up approach that will encourage participation levels.</p> <ul style="list-style-type: none"> <li>• Wards Directly Affected: All Wards</li> </ul>	Open	<p>Paul Hogan, Divisional Director of Culture and Sport  (Tel: 020 8227 3576)  (paul.hogan@lbbd.gov.uk)</p>

**Membership of Health and Wellbeing Board:**

Councillor Maureen Worby, Cabinet Member for Adult Social Care and Health (Chair)  
Councillor Laila Butt, Cabinet Member for Crime and Enforcement  
Councillor Evelyn Carpenter, Cabinet Member for Education and Schools  
Councillor Bill Turner, Cabinet Member for Children's Social Care  
Anne Bristow, Deputy Chief Executive and Corporate Director for Adult and Community Services  
Helen Jenner, Corporate Director for Children's Services  
Matthew Cole, Director of Public Health  
Frances Carroll, Chair of Healthwatch Barking and Dagenham  
Dr Waseem Mohi, Chair of Barking and Dagenham Clinical Commissioning Group (Deputy Chair of the H&WBB)  
Dr Jagan John, Clinical Director (Barking and Dagenham Clinical Commissioning Group)  
Conor Burke, Accountable Officer (Barking and Dagenham Clinical Commissioning Group)  
Jacqui Van Rossum, Executive Director Integrated Care (London) and Transformation (North East London NHS Foundation Trust)  
Dr Nadeem Moghal, Medical Director (Barking Havering and Redbridge University Hospitals NHS Trust)  
Chief Superintendent Sultan Taylor, Borough Commander (Metropolitan Police)  
John Atherton, Head of Assurance (NHS England) (non-voting Board Member)