AGENDA

1. Apologies for Absence

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

3. Minutes - 12 November 2013 (Pages 3 - 6)

4. Scrutiny of Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT)
   
   (a) Sunrise A and B Wards: Enter and View Findings (Pages 7 - 22)
   
   (b) CQC Inspection Report (Pages 23 - 32)

5. Urgent Care Surge Pilot Scheme (Pages 33 - 36)

6. Sickle Cell Disease in Barking and Dagenham (Pages 37 - 39)


8. Any other public items which the Chair decides are urgent
9. 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 Adult Services Select Committee, 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.

10. Any other confidential or exempt items which the Chair decides are urgent
Barking and Dagenham’s Vision

Encourage growth and unlock the potential of Barking and Dagenham and its residents.

Priorities

To achieve the vision for Barking and Dagenham there are five priorities that underpin its delivery:

1. Ensure every child is valued so that they can succeed
   - Ensure children and young people are safe, healthy and well educated
   - Improve support and fully integrate services for vulnerable children, young people and families
   - Challenge child poverty and narrow the gap in attainment and aspiration

2. Reduce crime and the fear of crime
   - Tackle crime priorities set via engagement and the annual strategic assessment
   - Build community cohesion
   - Increase confidence in the community safety services provided

3. Improve health and wellbeing through all stages of life
   - Improving care and support for local people including acute services
   - Protecting and safeguarding local people from ill health and disease
   - Preventing future disease and ill health

4. Create thriving communities by maintaining and investing in new and high quality homes
   - Invest in Council housing to meet need
   - Widen the housing choice
   - Invest in new and innovative ways to deliver affordable housing

5. Maximise growth opportunities and increase the household income of borough residents
   - Attract Investment
   - Build business
   - Create a higher skilled workforce
76. Declaration of Members' Interests

There were no declarations of interest.

77. Minutes - 1st October 2013

The minutes of the meeting held on 01 October 2013 were confirmed as correct.


Mark Tyson (Group Manager, Service Support and Improvement) gave a presentation to the HASSC which re-capped the evidence gathering, suggested recommendations for the HASSC, and made conclusions from the findings of the review. Cllr Worby, Cabinet Member for Health and Chair of the Health and Wellbeing Board, was present to engage with the HASSC on their findings.

Cllr Worby believed that awareness of and information about services and interventions that can help people with stress, anxiety and depression needs to be developed among GPs (especially those with single-handed practices). Cllr Worby shared the HASSC’s concern that the prescribing of anti-depressants dominates the care pathway developed by the CCG and wanted to see more treatment choices for patients within the pathway. Cllr Worby highlighted non-standard approaches that have been commissioned by the Council (Beating the Blues, Big White Wall, and Mental Health First Aid) as examples of different types of interventions that are non-clinical and effective.

The HASSC asked how the impact of the recession and austerity was being monitored and what relevant intelligence was coming out of performance reporting. Cllr Worby explained that the Health and Wellbeing Board is in the process of developing its performance framework and is assigning indicators to each of its sub-groups. Once this exercise is complete the Health and Wellbeing Board will receive exception reports from the sub-groups for the Board to address; this system will ensure that issues are escalated and commissioners are aware of performance issues.

The Council has also established a Welfare Reform Officer Group to specially track the impact locally; mental health impacts are included within the terms of
reference for this group as the links between financial hardship and mental health are well documented. The work of this group will be disseminated throughout the Council to inform service delivery and decision-making.

The HASSC asked if the Health and Wellbeing Board was addressing the wider determinants of health, especially unemployment which is known to have a negative impact on wellbeing. Cllr Worby advised the HASSC that in her position of influence she was putting pressure on relevant areas of the Council to address unemployment. Cllr Worby also felt it important that support is given to local employers to recruit people with mental health conditions and support them once in employment. Arising from this exchange the HASSC suggested a recommendation that the Council conducts a ‘Mental Health Audit’ to ensure that it is maximising employment opportunities for people with mental health conditions so that the Council can become a beacon of good practice for other local employers.

The HASSC asked that recommendations around the provision of advice and information are written to be specific so that gaps or weaknesses are addressed. The HASSC wished to see further information about practical issues, self-help, and non-clinical support developed as a result of the scrutiny. Cllr Worby supported this recommendation and asked that the information offer is simplified and presented in a way that does not make the recipient feel stigmatised.

The HASSC discussed the need to build resilience and support people’s recovery and recommended that training and volunteering opportunities are created for that purpose. The HASSC highlighted the importance of training for professionals who encounter people with signs of stress or depression or those with already diagnosed mental health conditions. The HASSC believed that a key task for the Health and Wellbeing Board would be for member organisations to satisfy themselves that their workforces were suitably trained. Cllr Worby shared the HASSC’s view that residents need mental health services delivered by specialists in that field and assured members that should this recommendation be issued it would be taken forward by the Board.

A member of the public commented that people with mental health conditions need training to support them back into employment. Training on IT, literacy and numeracy is important so that people who may have not achieved good educational attainment can compete in the jobs market. It was noted that up-skilling people with mental health conditions helps to build their confidence and improve wellbeing.

The HASSC discussed with Cllr Worby the value of appointing an elected member ‘Mental Health Champion’. The exact duties and responsibilities of the role would need to be worked out as would where the role fits within the Council’s political appointments and health and wellbeing governance arrangements. Cllr Worby felt that to be fair and consistent a champion would need to be appointed to further each of the health and wellbeing priorities. Cllr Worby also believed that elected member representation on sub-groups of the Health and Wellbeing Board would help keep a focus on patient/service user experience. The HASSC felt that making such an appointment on a short term basis to lead a borough-wide initiative to destigmatise mental health problems would be worthwhile. Having discussed the possibilities and issues around appointing an elected member Mental Health Champion the HASSC wished to reflect on this recommendation during the report.
The HASSC agreed recommendations around measuring the impact of the recession and austerity locally, and the promotion and delivery of Mental Health First Aid training. The HASSC also agreed a recommendation that would see peer support from user-led organisations for people with mental health conditions developed.

Further to the recommendations proposed in the presentation, the HASSC wished for the report’s recommendations to explore the balance of the care pathway between prescribing medicines and providing other more holistic interventions including talking therapies.

The HASSC requested that officers prepare a draft report to be circulated to Members in early December for editing and comments. The draft report will then be presented to the 14 January 2014 meeting of the HASSC for approval following which the report will be passed to the Health and Wellbeing Board for an initial response and development of a delivery plan for the recommendations.

79. Primary Care Urgent Care Surge Pilot Scheme

Sharon Morrow (Chief Operating Officer, B&D CCG) introduced the report to the HASSC.

It was noted that 9 of the 40 practices did not apply to be a part of the surge scheme pilot. These practices will be re-offered the chance to participate at the CCG’s next Executive Committee meeting. Some practices found it difficult to get organised in time for the start of the pilot. It is hoped that these practices are now ready to participate.

The HASSC conducted a mystery shopping exercise to see how urgent care appointments were being promoted within practices. Of the 12 practices visited by Members none displayed any information about urgent care appointments. Sharon Morrow assured the HASSC that more resources will be channelled into the communications programme for urgent care appointments.

Sharon Morrow confirmed that there have been 2653 urgent care appointments created through the Surge Scheme (82% of target) which is in-line with the CCG’s forecast for this period. All of these appointments were with the patient’s GP.

The HASSC asked at what time of day urgent care appointments were being given. Sharon Morrow did not have this level of detail to hand but confirmed that the GP practice at Broad Street will be taking appointments between 8am -8pm to ensure there is no loss of provision. Provision of out-of-hours appointments remains a concern for the HASSC although it was noted that a 7 day working model for primary care would make more of an impact than improved out-of-hours access as it is the failure to get a same day appointment that often leads to A&E attendance.

Sharon Morrow conveyed to the HASSC that a key outcome of the pilot is to better understand the appointment capacity for each GP practice. Initial data from the pilot has revealed that some practices have been able to provide more appointments than were required. The CCG hopes that the pilot will establish the
baseline capacity for each practice and work out the variance of capacity between practices. Once the baselines are known the CCG can refine the contracts it issues to GPs to ensure that they are only paid for urgent care appointments that are above the baseline. The HASSC was concerned that until the baseline is known GPs would be getting paid for urgent care appointments that should be delivered as part of their basic contract.

Members stated their disappointment at the process for conducting the pilot. Members felt that it is disingenuous to close Broad Street Walk-in Centre before the Surge Scheme pilot has been properly evaluated. Sharon Morrow advised the HASSC that the surge scheme responds directly to the wishes of patients who want better access to their GP, the pilot will thoroughly test the new model. Sharon Morrow explained that the CCG is working hard to build capacity within primary care to ease pressure on the acute sector. The HASSC was reminded that residents can access urgent care services through the centres at Upney Lane, Queen’s Hospital and King George’s Hospital after Broad Street Walk-in Centre is closed.

The HASSC agreed to receive an interim evaluation of the Surge Scheme Pilot before the end of the municipal year. The HASSC requested that the evaluation process is expedited so that there can be thorough scrutiny of the pilot and its impact. The HASSC noted that due to a time lag on A&E data it is not possible to complete the evaluation any earlier than currently planned.

80. Diabetes Scrutiny - Review of Action Plan

Matthew Cole (Director, Public Health) reported progress against the recommendations made by the HASSC following their scrutiny review of local diabetes services. The HASSC noted the following:

- Recommendation 6 – it was confirmed that Diabetes Booklets have been revised and sent to practices.
- Recommendation 7 – Young working age adults to not identify with current support networks. Work is required better understand this cohort of diabetics in order that a support offer can be developed for them. Healthwatch will work with 40-50 year old age group to further explore their support needs.
- Recommendation 9 – there has been a lack of progress in comparing the Porters Avenue Clinic with the SWECS Clinic. It is expected that progress will be made before Christmas by NELFT on this issue.
- Recommendation 10 – a Diabetes Steering Group has been established to review the care pathway.

The HASSC asked what evidence there was that referrals to the DAFNE and DESMOND programmes had increased. Matthew Cole advised the HASSC that evidence can be given once performance data is issued on the next audit of the 9 health checks for diabetics. The HASSC wanted assurance that nurses and health professionals had the necessary training to make referrals to the DAFNE and DESMOND programmes.
Title: Sunrise A and B Wards: Enter and View Findings

Report of Healthwatch Barking and Dagenham

Open For Decision

Wards Affected: NONE Key Decision: NO

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Accountable Director:
Marie Kearns, Chief Executive, Harmony House

Summary:
Healthwatch Barking and Dagenham carried out an announced Enter & View visit on 20th August 2013 to Sunrise A & B wards at Queens Hospital. The wards provide in-patient hospital services for older people. The visit was part of a wider programme of work that Healthwatch Barking and Dagenham has undertaken to gather the views and experiences of patients specifically from Barking and Dagenham.

The purpose of the visit was to ascertain patients’ views on the choice and quality of the food and drink they receive; the quality of personal hygiene support they receive and to ask patients and their visitors about the staff interaction with them.

As a result of the visit, Healthwatch Barking and Dagenham made 9 recommendations. The Trust accepted the report as a fair reflection of activity and patient care on the wards and provided an action plan to address the recommendations. Healthwatch Barking and Dagenham will monitor the progress of the action plan.

Recommendation(s)
Members of the Health and Adult Services Select Committee are recommended to:
1. Note and comment on the findings of the Enter and View visit
This page is intentionally left blank
Enter & View Visit 20th August 2013

Older Peoples’ In-Patient Services -
Sunrise ‘A’ & ‘B’ Wards

Queens Hospital, Romford, Essex

For further copies of this report, please contact

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**Introduction**

Healthwatch Barking and Dagenham is the local independent consumer champion for health and social care. We aim to give our citizens and communities a stronger voice to influence and challenge how health and social care services are provided for people in the borough.

Enter & View is carried out under 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 gather information through the experiences of service users, their relatives/friends and staff 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.
Summary

On the day of the visit, from a possible 48 beds across the two wards, 10 patients (21%) were from Barking and Dagenham - the majority of others were from Havering and Brentwood areas.

Overall, patients were satisfied with the way they were treated - one patient spoke about ‘the lovely Nurses’.

Patients indicated they did not always get enough time from nursing staff - ‘they always seem so busy’.

Patient visitors said their relative was ‘well looked after but staff were rushed off their feet’.

Healthwatch representatives found that patient areas and facilities were clean and tidy.

Calls for assistance from patients using their call buttons were ‘not always answered quickly enough’.

The wards operate a policy of addressing patient/relative complaints immediately, rather than allowing them to escalate.

Patients felt overall that the quality of the food was ok, although some patients commented ‘the choice was limited’, ‘food is tasteless’, ‘I would like bigger portions’, ‘sandwiches are dry’.

Generally, patients were happy with the personal care support they received; some patients would prefer ‘a choice of male or female staff’, ‘I would like to have a shower sometimes instead of a bed bath’.

Communicating with and understanding softly spoken staff or those with strong accents presented a challenge for some patients.

A patient said they were admitted ‘without their hearing aid and false teeth’, causing them ‘difficulty eating and understanding staff’.
Details of the Visit:

Premises Visited:
Sunrise ‘A’ & ‘B’ Wards,
Queens Hospital
Romford

Date and Time:
20th August 2013 - 4pm to 6.30pm

Enter & View Authorised Representatives:
Richard Vann - Lead Officer
Val Shaw - Volunteer
Frances Carroll - Volunteer
Jenny Furneaux - Support Worker to Richard Vann

Specific Areas Identified for Observation:

- Nutrition
- Personal Hygiene
- Interaction between Staff and Patients

Reasons for the Visit:
To visit wards that provide in-patient hospital services for older people - to gather the views and experiences of patients from Barking and Dagenham about the services being provided to them. This Enter & View visit is part of a wider programme being undertaken by Healthwatch Barking and Dagenham around issues concerning health and social care services for older people and is as a consequence of findings from the Francis Report.

Purpose of the Visit:
To ascertain 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.
The Wards’ Services:

Sunrise ‘A’ and ‘B’ are in-patient wards specifically for older people. Each ward is run by a Ward Sister with a Matron having overall responsibility for both of them. The wards are split into 6 bays, each one with 4 patient beds and set up as single sex units.

The flow of patients on to the wards is controlled by a triage system in the Accident & Emergency Department and by referrals from the Medical Assessment Unit. Representatives were informed that on average, patients stay on the wards for between 7-10 days.

Visiting times start at 10.30am and are spread across the day to enable relatives to visit during daylight hours. The Matron advised that much of the service relies on finding out a patient’s routine and gaining the trust of family members.

Staffing arrangements:

AM: 5 Qualified Nurses and 4 Health Care Assistants

PM: 4 Qualified Nurses and 4 Health Care Assistants

Evening: 3 Qualified Nurses and 3 Health Care Assistants

Representatives were advised that there is an option to ‘buy in’ extra nursing care when it is required. Additional staff are drawn from a bank of Nurses employed by the Trust. Agency staff are employed as an alternative option; it was emphasised however, that there are times when Trust staff work extra shifts to support staffing needs.

During the visit, the staff from both wards were very helpful and assisted by providing all information that was requested. Representatives agreed that staff have a strong team ethic and sense of pride for the job they do. Representatives spoke with a qualified Nurse who had undergone part of their training on the Ward and once qualified, requested to return there on a permanent basis.

It was evident from the visit that the Matron and Ward Sisters want to create a positive working culture. The Matron told representatives that when looking to recruit staff to the Ward, they are selective about those they bring on board, to ensure that they choose the right staff to work with older people.

Healthwatch Barking and Dagenham would like to thank Matron Juliet Kumar and all her staff for their assistance and co-operation during our visit.
Information and Observation:

On entering the wards, each one has a sink near the entrance to encourage visitors to wash their hands as well as use the alcohol hand rubs.

Lists of patients on the wards at the time of the visit were clearly displayed. When asked to identify patients from Barking and Dagenham, the Ward Sisters provided details of which bays and beds they occupied.

Information boards were observed on the wards’ reception areas and behind patients’ beds in the bays.

A system of red trays and water jugs with red lids was observed being used to identify patients that required help with feeding and drinking.

Representatives were told that patients are weighed on admission to the wards and are monitored weekly to check for any weight loss. Where appropriate, patients are referred to a Dietician. Finger foods are provided to patients who are reluctant to eat meals. This is to try to increase their food intake. Family members are encouraged to bring in any favourite foods for their relatives.

The Ward Sister on Sunrise ‘A’ advised that when patients require a softer diet, their food is pureed. This is served up as individual items on the plate and not mixed together. An example of a plated pureed meal was shown to the representatives.

A policy of ‘protected mealtimes’ is used on the wards. At this time, no medication rounds are carried out by staff so that they can focus on assisting patients that need help with eating and drinking.

Representatives observed that moving and handling equipment was available on both wards.

There were toilet and shower facilities in each of the bays. On observation of 2 of these areas, representatives found them to be clean and tidy.
Patients’ Experiences:

Nutrition:

Healthwatch representatives were not looking at nutrition on the wards from a Dietician’s perspective, but from the point of view of the patients. The questions asked centred on the help patients get to eat and drink, whether they can choose the food they eat and whether it is of good quality.

Generally, patients found the quality of food to be satisfactory. Representatives were present when hot food was being served and it was established that jugs of water were available for patients throughout the day. Patients’ opinions varied on the choices of food and the size of the portions.

Two patients said that they were not given a menu the previous day to choose the food given to them on the day of our visit. They did not like the sandwiches they were given for their tea and described them as tasteless and dry to eat.

A representative observed that one patient was struggling to eat their sandwich. The patient said it was brown bread and that it was hard for them to digest - a member of the Nursing staff overheard this and offered to replace it with a white bread option.

One patient said that they liked fruit and wanted to be given the option to have more.

Another patient said the food portions were small and they felt hungry a lot of the time.

One patient a representative spoke with had specific foods they were able to eat listed on a board behind their bed. The patient commented that they felt like they had lost a lot of weight but that the amount of food given was enough for them; sometimes too much.

During the visit, soup was offered to patients as part of their evening meal. One patient said the soup was too thick to suck through the straw and was told by a member of staff to drink the soup without the straw and with the lid off the beaker.
**Personal Hygiene and Care:**

Being looked after whilst unwell was a focus for Healthwatch representatives when recording information from this area of enquiry. Patients were asked for their views and experiences of the services, to determine how personal care support was meeting their needs and whether it was being carried out in a way to preserve their dignity.

Overall, patients were fairly satisfied with the way they were being cared for and said that they were treated with dignity and respect. All patients that were asked said that their beds were changed every day and they were given clean sleepwear as necessary.

Some patients said they could choose to have a shower while other patients said they were not given a choice and were being washed whilst in bed.

One patient said they needed to be hoisted if they wanted a shower and that it was a ‘difficult and undignified’ experience for them.

Some patients said that they were checked regularly for pressure sores, although one patient said that they had developed pressure sores whilst on the ward and that they were not being moved every 2 hours to relieve their discomfort (see details in additional information on page 12).

A female patient said that when they get a bed bath they were embarrassed when being washed by a male member of staff. They did say that on a previous in-patient stay on another ward, that they were offered the choice of a male or female member of staff.

One patient said they were washed in bed every day; however felt that it could be done better as they did not feel thoroughly washed and cleaned.

One patient said that they were treated with dignity most of the time, but there was one incident which they were not happy about, but did not wish to discuss it with the representative.

Patients commented that when using the ‘call button’, staff were not always very quick to answer - one patient said that when this happened to them it often resulted in them soiling themselves and that they ‘felt degraded and embarrassed’.

It was observed during the visit that three patients’ call buttons were hanging behind their beds and out of their reach.

Oral hygiene was highlighted by two patients that said they had gone days without help to clean their teeth. Another patient said that they were not always given a beaker of water when cleaning their teeth.
Patients’ Experiences of and Interaction with Staff:

Healthwatch representatives wanted to explore the experiences that patients and relatives had when interacting with hospital staff. By speaking with patients, we wanted their views to find out if they had been treated with respect and dignity during their stay; that the staff responded to requests for assistance in a timely way and whether patients understood why they were in hospital and the treatments they were being given.

Overall, patients were generally satisfied and happy with the way the staff on the wards treated them.

In discussion with a patient’s visitors, a representative was told that they were happy with the way the staff treated their relative and that they were always treated well. They also felt that staff often appeared to be under pressure - there was not enough of them - and were not always able to give the time to help with the little things that can make the biggest differences.

Patients said that the staff were polite, pleasant (lovely Nurses), that they were treated with dignity and respect; staff introduce themselves and were very kind. Some patients said that they found it difficult to understand some Nurses as they spoke quietly and/or with strong accents.

Some patients said they are given an explanation about why they are in hospital and of procedures as they take place; others said they are not told what is going on.

One patient explained that they were told they needed rehabilitation for mobility but that the Doctor had not taken the time to fully explain the process and reasoning. They felt unsettled and wanted to discuss this with their partner before making a decision.

One patient told a representative that they had been taken off of their usual medication but were given no explanation why.

Another patient said that they had been in hospital for several weeks but that they had not been told why they were unwell. The Doctor had told them they would return and explain things to them but this had not happened.

One patient said they had received a visit from a priest to support them with their religious needs.

One patient said that they had been admitted to hospital without their hearing aid and false teeth. This was causing them some difficulties with eating and communicating with staff. They told the representative they had no relatives but did have a team of carers to support them at home.
**Recommendations:**

At the time of the visit, there were 10 patients (21%) from Barking and Dagenham (3 male, 7 female). Healthwatch representatives were able to speak with 7 patients and 2 relatives who were visiting at the time.

1) A number of patients told us that they found their food lacked flavour. Condiments and sauces could be made more readily available to accommodate personal tastes.

2) Patients said that it was difficult to drink thick soup through the drinking straws provided. Wider straws with a larger hole could be made available so that it is easier for patients to drink soup in this way.

3) Some patients said they were not given a choice of brown or white bread sandwiches. Ward staff and the catering services should ensure all food choices requested by patients are made available to them.

4) Two patients said they had not had any help with cleaning their teeth. Staff should ensure all patients are asked if they need help to clean their teeth.

5) Patients should be asked and offered the choice to select a male or female staff member, who can support them with the intimate aspects of their personal care, during their stay.

6) One patient who usually received a bed bath said that they did not always feel thoroughly clean afterwards and expressed a desire to have a shower on occasions. To ensure patients feel clean and comfortable during their stay, they should be asked if the help they get with washing meets their personal care needs.

7) It was observed that some patients could not reach their call buttons. Some commented that after calling for assistance, there were occasional delays in getting a timely response. To support the well-being and dignity of patients, staff should endeavour to respond to calls for assistance in a timely manner and ensure that call buttons are positioned within patients’ reach.

8) Three patients said they were not given a proper explanation about decisions made for their treatment. Time should be taken by medical staff to explain about changes to their health and the treatment they will be given.

9) One patient was admitted without their hearing aid and false teeth. They said they had a team of carers to support them at home. This has highlighted a gap in services - where a person receives a Personal Budget for care support, hospital staff should be prepared to work with patients and their social care staff in an integrated way, to resolve these types of issues. Further consideration could be given to enabling patients with social care provision to have that support available to them whilst in hospital.
Additional Information:

This was an announced visit - written notification was sent to Barking, Havering & Redbridge University Hospitals Trust, outlining the intentions for the visit. A representative from the Trust acknowledged our intention and provided the appropriate contact information for the Matron on Duty, Juliet Kumar, who has overall responsibility for both wards.

During the visit, it was brought to the attention of the Lead Officer that one patient had told a representative that they had been put in a chair about 12pm that day and had been left there without any help (5.30pm at the time). The patient said they had pressure sores on their bottom and that these were causing great discomfort.

The Lead Officer decided that this should be raised there and then as a concern with the Ward Sister. The Ward Sister spoke with the member of staff responsible for supporting the patient and asked them to give an explanation about the issues the Lead Officer had raised on behalf of the patient.

The staff member gave a verbal explanation and produced a timeline of written records of contact for the patient during the day. This included times when they were assisted with toileting, were visited by a Physiotherapist and that they were checked on every 2 hours.

From the information provided, the representatives were satisfied that the person had not been left unattended for longer than 2 hours. This highlighted a positive example of a policy that encouraged the staff on the ward - with the support of the Ward Sister - to work with patients and/or their representatives and address issues before they escalated further.
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<tr>
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| 1. Availability of condiments | • Staff to ensure that condiments are offered to patients at mealtimes | • Condiments available on ward  
• Staff offering to patients | 1.10.13 | Green |
| 2. Availability of wide straws to aid soup drinking | • To source large bore straws | • Currently being sourced by Sodexo  
• Alternative beakers available and being used | 1.12.13 | Amber |
| 3. Appropriate food choice available to patients | • Choice is offered via daily menu systems  
• Availability to be monitored by ward manager | • Menu system in place  
• Ward manager monitoring via patient feedback | 1.10.13 | Green |
| 4. Staff should ensure all patients are asked if the need help to clean their teeth | • All patients to have a mouth care assessment within 12 hours of admission  
• Mouth care pathway commenced for appropriate patients | • Mouth care pathway in place  
• Ward manager monitoring | 1.10.13 | Green |
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<tr>
<td>5. Patients should be offered the choice with regards to the member of staff who supports their hygiene needs</td>
<td>Consent will be gained from patients regarding who undertakes their intimate aspects of care</td>
<td>Staff are gaining consent from patients prior to undertaking any hygiene needs</td>
<td>30.11.13</td>
<td>Amber</td>
</tr>
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<td>6. Patients are asked if the help they get with washing is meeting their personal care needs</td>
<td>All nurses to offer patients a choice of a shower or bed bath as appropriate</td>
<td>Patients are being offered a choice of a shower or a bed bath as appropriate Ward manager to audit at regular intervals</td>
<td>1.1.3</td>
<td>Green</td>
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<td>7. Staff will respond to call bells in a timely manner and ensure call bells are positioned within patient’s reach</td>
<td>To monitor availability of call bell weekly via the Quality of Care audit. Staff encouraged to explain if need cannot be met immediately with a timeframe excluding emergency toilet needs</td>
<td>Quality of Care audits – weekly (part of ongoing assurance process)</td>
<td>30.10.13</td>
<td>Amber</td>
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<td>8. Time should be taken by medical staff to explain about changes to health and treatment</td>
<td>Consultants are now based on the wards on a weekly rota, so that there is senior medical presence at all times</td>
<td>Completed. Need more consultants to cover any gaps that may arise</td>
<td>1.1.13</td>
<td>Amber</td>
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<td>9. Where a patient receives a personal budget for care support consideration should be given to enabling that support to be available whilst in hospital</td>
<td>Ward staff as part of admission process to liaise with social services if access to home is required for personal items</td>
<td>Being introduced as part of admission process</td>
<td>30.11.13</td>
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<td></td>
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<tr>
<td>Glen Oldfield, Scrutiny Officer</td>
<td>Tel: 020 8227 5796</td>
<td></td>
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<td></td>
<td>E-mail: <a href="mailto:Glen.Oldfield@lbdd.gov.uk">Glen.Oldfield@lbdd.gov.uk</a></td>
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<td>Accountable Director:</td>
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<td></td>
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<tr>
<td>Fiona Taylor, Head of Legal and Democratic Services</td>
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**Summary:**

The Care Quality Commission’s (CQC) report into Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) - based on its investigation in October last year - was published on 18 December 2013. The report confirmed that despite some improvements, longstanding performance issues remain. As a result of the findings and judgments of CQC the Trust has been placed into ‘special measures’.

Averil Dongworth (Chief Executive) will be attending the Health and Adult Services Select Committee meeting to field questions and comments from Members on the CQC’s findings and their implications for BHRUT.

Information provided by BHRUT is attached at Appendix 1. This information will be supplemented by a presentation at the meeting.

The report overleaf provides further background information for Members on the inspection process and CQC’s findings. It also highlights issues of concern for possible exploration by Members and outlines Barking and Dagenham’s involvement in the sector/system response to the problems and challenges that BHRUT is facing.

**Recommendation(s)**

Members of the Health and Adult Services Select Committee are recommended to:

1. Discuss the findings of the CQC inspection with BHRUT and explore any issues that have arisen from the inspection report, such as poor patient feedback and record keeping (Section 2 and 3).

2. Ask BHRUT to update Members on staffing and recruitment at BHRUT, particularly the recruitment of consultants in A&E (Section 3).

3. Highlight Barking and Dagenham’s involvement in the sector/system response to the
challenges that BHRUT is facing. Members may particularly wish to explore the assertion made by CQC that BHRUT is not working effectively in partnership with the three local authorities concerned, including Barking and Dagenham (Section 6).

1. About the inspection

1.1. BHRUT were inspected 14 - 17 October 2013 as part of the first wave of the new hospital inspection regime undertaken by the CQC. The changes to the CQC regime ensure that it is a more robust assessment undertaken by a larger inspection team, who are selected for expertise in the services being reviewed. BHRUT were selected as one of the first Trusts to undergo this new type of inspection because they were seen to be at 'high risk' - facing significant financial challenges and seriously underperforming on key indicators over the last few years.

1.2. The findings of the CQC’s inspection were published on 18 December. The full inspection report can be found at this link: [http://www.cqc.org.uk/sites/default/files/media/reports/20131213_-_cqc_quality_report_barking_havering_and_redbridge_university_hospitals_nhs_Trust_final.pdf](http://www.cqc.org.uk/sites/default/files/media/reports/20131213_-_cqc_quality_report_barking_havering_and_redbridge_university_hospitals_nhs_Trust_final.pdf)

2. Summary of findings

Under the new inspection regime CQC ask five key questions. The CQC’s judgements against those questions are summarised below.

I. Are services safe?

Many of the services are safe but require some improvements to maintain the safety of patient care. The A&E departments are at times unsafe because of the lack of full-time consultant and middle-grade doctors. There is an over-reliance on locum doctors with long waiting times for patients to be assessed to be assessed by specialist doctors.

II. Are services effective?

The Trust had some arrangements in place to manage quality and ensure patients receive effective care, but more work is needed in medicine, end of life care and outpatients. Effective care in the A&E departments is hampered by long waiting times for patients to be seen by a specialist.

III. Are services caring?

National inpatient surveys have highlighted many areas of care that need improvement and work has been undertaken to improve the patient experience. Significant work has been undertaken to improve patient care and many patients and relatives were complimentary about the care they received and the way staff spoke with them. We observed that staff treated patients with dignity and respect. However, more work is required to improve care in the end of life service and ensure improvements in patient care in all services is reflected in national patient surveys.
IV. **Are services responsive to people’s needs?**

The longstanding problem of waiting times in the A&E department at Queen’s Hospital has not been addressed. Poor discharge planning and capacity planning is putting patients at risk of receiving unsafe care and causing unnecessary pressure in some departments. A lack of effective partnership working with other health and social care partners has contributed to the problems.

V. **Are services well-led?**

The CQC found examples of good clinical leadership at service level and staff were positive about their immediate line managers. The Trust Executive Team need to be more visible and greater focus is needed at Board level to resolve longstanding quality and patient safety issues.

3. **Issues of concern**

In light of the headline findings above, and in exploring the detail within the CQC’s report, Members may wish to raise or consider the following issues when discussing the inspection results with Trust representatives:

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**Poor patient feedback**

The Trust scored low overall on the Friends and Family Test, especially in A&E and Gastroenterology (Clementine B ward). The results over the last four months place the Trust in the bottom 10 Trusts nationally for the A&E component of the Friends and Family Test.

The key themes in complaints from patient surveys included a lack of privacy, respect, information on discharge, cleanliness, delays in care, positive staff and nurse attitude, and patient included in care decisions.

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**Poor discharging**

Poor discharge planning and capacity planning is putting patients at risk of receiving unsafe care and causing unnecessary pressure in some departments.

There are delays in discharging patients from the ITUs at both hospitals. Between April 2012 and April 2013, 50% of patients experienced a delayed discharge from the ITU and 64 patients were transferred to other hospitals for non-clinical reasons.

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**Record keeping**

Nursing staff at both hospitals were not routinely documenting the care patients required or received. Discharge plans, along with nursing notes, were not up to date. Many patients were transferred between Queen’s and King George Hospitals with transfer checklists not always completed which meant staff at both hospitals may not be aware of a patient’s needs or requirements e.g. whether patients are diabetic or allergic to a certain type of medication or food.

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**High weekend mortality**

The Trust was identified as having higher-than-average mortality rates for patients with pneumonia, septicaemia and most cancers and reviews have been carried out. In June 2013, information showed that elective patients who were
admitted over the weekend were at a higher risk than those admitted during the week.

- **Waiting times in A&E (4 hour target)**

  BHRUT’s performance against this key performance indicator remains below the 95% target. Although there has been a gradual upward trajectory, performance fluctuates. Latest figures from January 2014 show performance is at 91.48%, for the year to date performance falls to 87.74%.

  Members should note that the Urgent Care Board agreed on 27 January 2014 that Winter Pressures money should be reallocated in order to mitigate the number of breaches of the 4 hour A&E target.

- **Staffing and recruitment**

  The Trust faces significant difficulties in recruiting medical staff for A&E, and has done since 2011. The College of Emergency Medicine recommends that, for the number of patients seen in the A&E at Queen’s Hospital, it should have 16 consultants to provide cover 16 hours a day, seven days a week. The Trust has eight consultants in post out of an establishment of 21 to cover both A&E departments at Queen’s and King George Hospitals. At the Urgent Care Board on 27 January 2014 it was discussed that the number of consultants had reduced to approximately six. The heavy reliance on locum staff is putting patients at risk of receiving suboptimal care. Joint work with other Trusts has not achieved the desired results and additional work is underway, including recruiting staff from overseas.

  At the Health and Wellbeing Board on 10 December 2013, Stephen Burgess (Interim Medical Director) reported that the Trust had recruited 18 middle grade Doctors, 10 middle grade Anaesthetists, and 2 Consultants for the Emergency Department. Members may wish to ask how many of these appointments are in post and on the wards.

- **Utilisation of the Urgent Care Centres**

  Utilisation of Urgent Care Centres is at 27.57%\(^1\) for the month of January 2014 (target is 40%)

- **Financial position**

  The financial position of the hospital remains a critical issue as BHRUT continue to operate at a substantial annual deficit. The NHS Trust Development Authority (NTDA) is working with BHRUT on this, but there appears to be no concrete plan for resolving it. Money to offset the costs of the PFI is dependent on other quality indicators improving. Members should be concerned that the Trust’s financial position constrains and delays its recovery.

4. **‘Special Measures’ and its implications**

4.1. The Chief Inspector of Hospitals, Sir Mike Richards, stated that the scale of challenges faced by BHRUT were the highest that he had seen. Although it was acknowledged in the CQC report that the Trust Board were starting to work together as a team to address the longstanding issues at BHRUT, the report stated that the

\(^1\) Integrated Performance Report – BHRUT Board Papers (8 January 2014)
leadership was ‘inadequate to address the scale of the challenges that the Trust is facing and additional support is required.’

4.2. The NHS Trust Development Authority has therefore put the Trust into ‘Special Measures’ on the advice of the CQC. In particular, this means:

- A focused regime to deliver improvement over a 12 month period, at which point there will be another inspection and the Chief Inspector will review whether ‘Special Measures’ continues;
- Developing an improvement plan (better than the existing one);
- Reviewing leadership and governance of the Trust in the next month;
- Linking with a high-performing Trust as peer support; and
- Appointing an Improvement Director to work with BHRUT executive team.

4.3. The Trust is required to develop an improvement plan to address the need to:

- Improve clinical and management support to deliver improvements to patient safety and quality, and improve ownership of improvement activity at every level of the Trust;
- Resolve problems in A&E departments of King George and Queen’s Hospitals, which are resulting in unsafe care;
- Put a protocol in place for the transfer of patients between Trust locations;
- Address the Trust’s discharge planning and patient flow problems, including improved working with local partners;
- Implement infection control procedures consistently in every ward and theatre across the Trust.

5. Capability and Governance Review

5.1. Following being placed into special measures the Trust was required upon request of the NTDA to review its leadership and governance. Sir Ian Carruthers\(^2\) was appointed to lead this process and a session was held on 15-16 January 2014 to which the three CCGs and three local authorities were invited to participate. Anne Bristow (Corporate Director, Adult and Community Services) and Graham Farrant (Chief Executive) represented LBBD.

5.2. The following issues were raised at the session:

- NELFT was not invited despite the inextricable links with the services they provide, nor were they invited to the CQC Quality Summit back in December.
- Local authorities refute criticisms of partnership working and support to aid BHRUT recovery (this is further explored in section 6)
- The implementation of ‘special measures’ should not be seen as an attempt to “start again” in the development of the improvement plan. Instead, it is crucial that all partners build on the progress that the health and social care economy has made.

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\(^2\) Sir Ian is the Chair of the Healthcare UK Governance Board which is a joint initiative between the Department of Health, NHS England and UK Trade and Investment (UKTI) to promote the UK healthcare sector abroad.
There is a need to develop and maintain a single integrated improvement plan for the issues at BHRUT as there is insufficient resources available to deliver and contribute to multiple plans.

6. Support from LBBD and other partner organisations

6.1. CQC have made assertions within the inspection report that BHRUT is not working effectively in partnership with the three local authorities and that this may have contributed to hospital discharge delays. Members should be assured that the Council, along with the wider health and social care economy, is committed to supporting recovery at the Trust.

6.2. The Council is working well with BHRUT, NELFT, the CCGs and the local authorities concerned to address problems at the Trust and feel that we have effective partnership relationships in place. Whilst there may be operational difficulties at times, there is very clearly both the appetite and the systems in place to ensure that these are jointly resolved (please see below under 6.3). The latest monthly statistics show that social care in Barking and Dagenham were responsible for none of the delayed transfers of care (DTOC) in October or November 2013. The Council has worked hard to reduce average DTOC figures and the average now stands at 0.9 DTOCs per 100,000 population for the year so far, in comparison to 4.5 last year. Patient flow issues within the Trust itself are currently thought to be causing the majority of the discharge issues: for example, delays in the dispensing of medicine within the pharmacy, or the arrangement of passenger transport for patients.

6.3. Additionally, there are several important elements of partnership working that are not picked up in the briefing supplied by the hospital which Members may wish to explore with BHRUT:

— Integrated Care Coalition (ICC)

Senior leaders across health and social care in Barking Havering and Redbridge have committed to working together in a coalition of strategic partners to develop a joint approach to integrated care to build a sustainable health and social care system. The ICC brings together senior leaders in the BHR health and social care economy to support the three CCGs and the three LAs in commissioning integrated care and ensuring a sustainable health and social care system. The Coalition is chaired by Cheryl Coppell (Chief Executive, London Borough of Havering).

— Urgent Care Board (UCB)

The UCB was established in June 2013 as an advisory Board, following agreement at the Integrated Care Coalition that there was a need to bring together senior leaders in health and social care in Barking and Dagenham, Havering and Redbridge to drive improvement in urgent care at a pace across the system. The UCB was established in the context of poor A&E performance at BHRUT and the recognition that getting this part of the system fit-for-purpose is crucial for system effectiveness and the strategic aims of the sector. The UCB is focussed on six priority areas:

1) A&E recruitment
2) Urgent care centre utilisation
3) 7 day working
4) Primary care improvement
5) Discharge arrangements
6) Frail elderly services

— **Joint Assessment and Discharge Service (JAD)**

As part of our work on the Urgent Care Board, LBBD is leading on the design and implementation of a Joint Assessment and Discharge (JAD) service responsible for the safe and timely discharge of patients from acute settings. The JAD service has been agreed to be jointly funded and resourced by BHRUT, LBBD, Barking and Dagenham CCG, LB Havering, Havering CCG, NELFT and Redbridge CCG.

— **7 day working**

Hospital social care teams within the Council have been working seven days a week as standard since November 2013 to ensure that essential care and support services are in place when patients leave the hospital setting.
1. Introduction

1.1. The Care Quality Commission’s report into Barking, Havering and Redbridge University Hospitals NHS Trust - based on its investigation in October last year - was published on 18 December 2013.

1.2. The report highlighted where the Trust has made positive changes over the last few years - in particular the high standard of patient care provided. It also identifies issues, some of which are long-standing.

1.3. As a result, the CQC placed the Trust into special measures.

1.4. The Trust is disappointed at this outcome on the back of such a positive report. However, as a Trust we have been asking for support for some time to tackle our financial deficit and to improve waiting times in our emergency departments.

1.5. Special measures have been recommended for the Trust as support for our management team to help them tackle some of the major issues. Day-to-day frontline services will be unaffected, with services continuing as usual.

2. Positive Feedback

2.1. Patient care

Patients were positive about the care they received from staff, and this was reflected across all eight of the core service areas.

The inspection team was especially impressed with the care provided to patients who have had a stroke, with the Trust performing well against a number of data indicators.

2.2. E-handover

The CQC praised the e-handover system in the medical services, allowing doctors to manage their workload more effectively, which benefits patients.

2.3. Maternity services

The Trust's maternity services, which have undergone a huge transformation over the last two years, maintained the improvements following the transfer of the delivery unit from King George Hospital last year.
2.4. **Virtual ward**

The feedback from patients about the virtual ward – allowing people to be cared for at home - showed they valued the service.

2.5. **End of life care**

Patients received safe end of life care. They had support to make decisions about their care and staff working in the service were experienced, knowledgeable and passionate about providing good care outcomes for patients. Patients and their families had positive views about the end of life service.

3. **Areas For Improvement**

3.1. **Emergency care**

People experienced excessive delays in being assessed, reviewed, and treated. On some nights there are too few full-time doctors on duty, and at other times there are too many patients in the department. Patients were also not seen and treated effectively by specialist staff, and were waiting too long to be either admitted or discharged.

3.2. **Surgery**

Nursing documentation was inconsistent. Where patients had been transferred between the hospitals, there was no documented handover and staff were not always aware of a patient’s medical history. At KGH patients were put at risk of infection in theatres due to inadequate cleaning and poor practices by staff.

3.3. **Sepsis**

The CQC asked several nurses how they would recognise sepsis and how they would respond to this, but none knew if a guideline was available or were able to clearly define what sepsis was.

3.4. **Note taking**

Some of the nursing staff observed on both medical and surgical wards were not routinely documenting the care patients required or received. Discharge plans, along with nursing notes, were not up to date. Many patients were transferred between Queen’s and King George hospitals with transfer checklists not always completed.

3.5. **Discharge**

Delayed discharges, particularly in medical services, and high occupancy rates meant that the service could not be as responsive as required, and this put unnecessary pressure on departments and increased the risk of poor outcomes.

3.6. **Outpatients**

The outpatient service did not always provide safe and effective care. Patients received treatment and follow-up appointments, although these were not always held in appropriate private locations. Patients were able to ask questions to help understand their treatment and monitoring plans but sometimes this could be rushed. Some clinics were very busy and patients had to wait, but staff were caring and waiting times were displayed, although some patients felt they were not kept informed.
Some clinics were not managed efficiently and areas of the service needed to improve.

4. **CQC actions**

4.1. Ensure the Chief Operating Officer has clinical and management support to deliver improvements to patient safety and quality. The improvement plan should be agreed at Board level with progress monitored at each Board meeting.

4.2. Ownership for improvement must be embedded at every level of the Trust and the visibility of the Executive Team at Queen’s Hospital and King George Hospital must be improved.

4.3. The Trust needs to urgently focus on resolving problems in the A&E departments of King George and Queen’s Hospitals which are resulting in unsafe care.

4.4. A clear and unambiguous protocol must be put in place for the transfer of patients between Trust locations. All care must be documented.

4.5. The Trust must also address its discharge planning and patient flow problems which will require improved working with local partners.

4.6. Infection control procedures must be implemented consistently in every ward and theatre across the Trust.

5. **Next Steps**

5.1. A draft compliance plan has been developed, this will feed into the overall improvement plan focussing on issues raised in the CQC Report and recognising a number of existing work plans.

5.2. Sir Ian Carruthers undertook a capability and governance review on 15 and 16 January 2014. His report and recommendations to the Chief Executive of the NHS Trust Development Authority (NTDA) will form the basis of a Board to Board meeting between the Trust and the NTDA. We await confirmation of the date. The final improvement plan will be agreed at that meeting.

5.3. An Improvement Director, Steven Russell, joined the Trust on 13 January 2014.

5.4. The Trust has established a Rapid Improvement Group, Chaired by Dr Ian Hosein, to develop, oversee and monitor progress with the improvement plan.

5.5. For all other staff, focus will be on providing the best care for patients as always.
**Title:** Urgent Care Surge Pilot Scheme

**Report of the Barking and Dagenham Clinical Commissioning Group**

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**Report Author:** Simi Bhandal, Practice Improvement Lead, Barking and Dagenham CCG

**Contact Details:**
- Tel: 020 3644 2379
- E-mail: gemma.hughes@barkingdagenhamccg.nhs.uk

**Accountable Director:**
- Sharon Morrow, Chief Operating Officer, Barking and Dagenham CCG

**Summary:**
This report provides an update to the HASSC on the activity to date for the Primary Care Urgent Care Surge pilot scheme which started on 1 October. Monthly activity reports show an overall increase in capacity, however the impact of this on patient experience and activity in other urgent care settings will be evaluated at the end of the pilot. The evaluation report is planned for May 2014.

**Recommendation(s)**
- The HASSC is recommended to:
  1. Note the update on the pilot scheme
  2. Receive a further report of the evaluation following the end of the pilot in Spring 2014.

**Reason(s)**
This report provides an update to the HASSC on the Urgent Care Surge Scheme that is being piloted in Barking and Dagenham. A further report will be available once the scheme has been evaluated.
1. **Introduction and Background**

1.1 In response to feedback from stakeholders, Barking and Dagenham CCG has developed a local pilot scheme to deliver additional urgent appointments in primary care and improve access to urgent appointments with GPs. This pilot scheme makes up part of the CCG’s strategy to improving urgent care across the borough.

1.2 NHS England delegated the commissioning of the scheme to the CCG, practices across Barking and Dagenham were invited to take part. The application process for the pilot concluded with 31 successful applicants. Those practices were subsequently commissioned to provide in total 19,278 extra surge appointments over and above their individual “baseline” capacity levels, equating to approximately 3200 additional appointments each month. Baseline levels were derived from activity data submitted by practices for April, May and June 2013 as part of the application process.

The 9 practices that did not apply to take part in the scheme/were unsuccessful in making their application have since been invited to apply in the second wave of applications. It is expected that successful applicants will join the scheme in mid January.

2. **Pilot Scheme Criteria**

2.1 In order to participate in the pilot, practices had to demonstrate to the CCG that capacity is above that expected to be delivered through their core contract.

2.2 Surge appointments are offered on the day for urgent cases. As part of the application process practices were asked to describe what procedures are in place to identify urgent and emergency cases, enable rapid assessment and ensure patient is seen quickly in line with best practice.

2.3 Consultations should be offered at a time that matches demand for urgent care services. Therefore the scheme does not specify whether surge appointments should be provided in core hours, out of hours or weekends, and timings of these additional appointments may be different at each practice.

2.4 Practices must submit an activity report each month which allows the CCG to identify:
   a) How many practices are meeting their “baseline” capacity levels
   b) How many additional urgent care appointments have been offered
   c) How many additional urgent care appointments have been used

3. **Communication**

3.1 Practices are using a range of media, such as Jayex boards and prescription scripts, to inform patients of the increased access to urgent appointments. In addition, the CCG has also provided communication materials for practices to use, including posters and graphics for TV content.

3.2 The scheme has been discussed with Patient Participation Groups (PPGs) in practices in order to gain feedback for the practice and CCG. The CCG is
supporting practices to develop their PPGs where they have not been set up or are not very active.

4. Activity

4.1 Current Activity
2,303 and 2,887 additional appointments were provided in October and November respectively and utilisation rates (number of appointments booked compared to offered) for October and November were 83% and 82%. A breakdown of appointments offered by locality is provided in Appendix A.

At this point, it is not possible to evaluation the impact this additional capacity has had on other urgent care settings as data from those providers is received with a time delay of approximately 2 months.

4.2 Planned Activity
Following a decision by the Executive Committee to re-open applications, the 9 practices not currently participating in the scheme have been invited to apply in the second wave.

It is estimated that of the 9 practices that have been invited to apply, some are likely to remain unable/unwilling to participate in the scheme. It was agreed that these practices would be asked to partner up with another practice in the locality so that their patients could also benefit from the scheme. The remainder of the unallocated surge appointments will be redistributed resulting in approximately 5,000 urgent surge appointments across the borough.

5. Evaluation

5.1 The pilot scheme will be evaluated in terms of its effectiveness in reducing urgent care attendances at the walk in centres and urgent care centres and its impact on patient satisfaction. Quantitative analysis of activity data will show any increase in capacity in primary care as well as changes in activity in other urgent care settings, while qualitative data, via patient surveys and “mystery shopping”, will allow for evaluation of patient experience.

5.2 An interim evaluation will be completed at the end of March 2014 and the evaluation will be complete 6-8 weeks after the scheme ends with the final evaluation report completed in May 2014. The evaluation will inform the CCG’s ongoing strategy to improve urgent care in Barking and Dagenham.

List of appendices:

Appendix A - distribution of urgent care surge appointments in Barking and Dagenham
## Practices Participating in the Surge Scheme

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<td>Dr. B K Jaiswal, Gables Surgery, Markyate Surgery</td>
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<td>John Smith House, Ripple Road MC, King Edwards Medical Group, Abbey MC, Thames View HC, Porters Avenue</td>
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<td>Barking Medical Group Practice, Dr Chawla, White House Surgery, Child &amp; Family Centre</td>
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*started scheme in November*
### Summary:

On 5 November 2013 Members requested that Dr Ian Grant (Consultant Haematologist, BHRUT) returns to the HASSC to report on the development of sickle cell services locally.

Dr Grant will be giving a presentation at the meeting. The report overleaf is produced by Public Health and sets the scene, in terms of background and demographics, for members to discuss with Dr Grant developments in sickle cell services.

### Recommendation(s)

Members of the Health and Adult Services Select Committee are recommended to:

1. Note this report in preparation for receiving Dr Grant’s presentation.
1. **Sickle Cell Disease**

1.1. Sickle cell disease is the fastest growing genetically inherited condition in the UK affecting around 10,000 people. Sickle cell disease and sickle cell trait have been becoming progressively more visible amongst the populations of outer north east London (ONEL), most notably in Barking and Dagenham. This reflects the growing ethnic diversity of the population and the fact it now affects over 1 in 2,000 live births.\(^1\)

1.2. Sickle cell disease describes a group of conditions caused by the ‘sickle’ mutation of the haemoglobin molecule (Hb). Hb is responsible for transporting oxygen in the red blood cells of humans, and the sickle mutation reduces the ability of the red blood cell to carry oxygen.

1.3. Clinically significant sickle cell disease is a result of individuals inheriting the sickle gene from both parents or a sickle gene and another specific variant. Sickle cell carrier status, also sometimes called sickle cell trait, occurs when individuals only inherit one sickle gene; carriers rarely have clinical symptoms except in extremis and so rarely are aware they carry the gene unless screened.

1.4. Sickle cell disease is more common amongst individuals from Africa, the Mediterranean, the Middle East, parts of India, the Caribbean and South and Central America. Prevalence of the sickle cell gene is generally higher in areas with a history of malaria and this is because sickle cell trait protects against malaria.

1.5. Sickle cell disease can cause deformed blood cells to clog up small blood vessels starving the surrounding tissue of oxygen which may lead to organ damage. Other presentations include overwhelming sepsis, acute chest syndrome, priapism, lung disease, recurrent chronic leg ulceration, visual loss and stroke.\(^2\) Sickle cell disease can also lead to premature death and the median age of death for men with sickle cell disease is 42yrs and for women is 48yrs.\(^3\)

1.6. National standards have been published for health services for adults and children with sickle cell disease in 2008 and 2010. The aim of sickle cell disease management is to improve survival and reduce the frequency, duration and severity of painful crises and other complications. This involves prophylaxis through immunisation, drug treatment and in some cases blood transfusion, lifestyle support and management, psychological and social/welfare support.

2. **Prevalence in Barking and Dagenham**

2.1. The demographic profile of outer north east London has been evolving over the last ten years and the increasing ethnic diversity is reflected in the growth in the case load of patients living with and affected by sickle cell disease.

2.2. Estimated demand was modeled using the generic North East London prevalence estimate of 2.18 significant conditions\(^4\) per 1,000 babies screened\(^5\) applied to the GLA 2011 population estimated for the ONEL boroughs.\(^6\) The estimated number of

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\(^1\) Sickle cell disease in childhood: Standards and guidelines for clinical care. 2Ed. Oct. 2010. NHS Screening Programmes. p5

\(^2\) Standards for the clinical care of adults with sickle cell disease in the UK. Sickle Cell Society. 2008. p16


\(^4\) Significant conditions comprise the following results: FS, FSC, FS other and FE (F, foetal haemoglobin; S, S haemoglobin; C, C haemoglobin; E, E haemoglobin).


\(^6\) GLA 2005 extrapolations for 2011 population
patients with clinically significant sickle cell disease is 1,366 patients in the ONEL boroughs.

<table>
<thead>
<tr>
<th>Borough</th>
<th>Projected New Births</th>
<th>Projected Case Load 1 to 8 yrs</th>
<th>Projected Case Load 19 to 74 yrs</th>
<th>Projected Case Load 9 to 18 yrs</th>
<th>Total Estimated Case Load</th>
</tr>
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<tbody>
<tr>
<td>Barking &amp; Dagenham</td>
<td>3,724</td>
<td>45,722</td>
<td>118,546</td>
<td>258.4</td>
<td>366.2</td>
</tr>
<tr>
<td>Havering</td>
<td>2,836</td>
<td>48,569</td>
<td>163,416</td>
<td>356.2</td>
<td>466.3</td>
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<tr>
<td>Redbridge</td>
<td>4,196</td>
<td>60,531</td>
<td>179,089</td>
<td>390.4</td>
<td>531.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10,756</strong></td>
<td><strong>154,822</strong></td>
<td><strong>461,051</strong></td>
<td><strong>1005.1</strong></td>
<td><strong>1366.1</strong></td>
</tr>
</tbody>
</table>

Table 1 shows the estimated case load of sickle cell patients broken down into age groups in the ONEL.

2.3. In 2010 the service at BHRUT saw 14 live births to women with sickle cell disease. These women are seen in a joint consultant haematologist/obstetric clinic and reviewed monthly for the first two trimesters and then fortnightly in the third trimester and weekly as they approach full term.

3. Developments in Sickle Cell Services

3.1. The 2010/11 QIPP plan for Barking and Dagenham identified the need to undertake focused work to explore the potential for sickle cell disease community services in the Barking, Havering and Redbridge University Hospital NHS Trust healthcare economy. This was because of the growing case load of patients registered with Sickle Cell Disease at BHRUT which reflects the changing populations in Barking and Dagenham, Havering and Redbridge.

3.2. A review was undertaken by the Barking and Dagenham Public Health Team, which reported in December 2010 and recommended that a tariff based community service was commissioned to buffer the acute costs of the growing demand and meet the national guidance of best practice, the review also recommended a block contract for ante-natal screening and support.

3.3. Currently the three boroughs, Barking and Dagenham, Havering and Redbridge spend around £240K on outpatient services for patients with sickle cell disease and around £290K on admissions at Barking, Havering and Redbridge University Hospital NHS Trust.

3.4. More information including services available to local people can be found in the Barking and Dagenham Joint Strategic needs assessment (JSNA): [http://www.barkinganddagenhamjsna.org.uk/Pages/jsnahome.aspx](http://www.barkinganddagenhamjsna.org.uk/Pages/jsnahome.aspx)
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<table>
<thead>
<tr>
<th>Title:</th>
<th>Update Report - Scrutiny Review on the Impact of the Recession and Welfare Reforms on Mental Health</th>
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<tbody>
<tr>
<td>Report of the Corporate Director of Adult and Community Services</td>
<td></td>
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<tr>
<td>Open</td>
<td>For Decision</td>
</tr>
<tr>
<td>Wards Affected: NONE</td>
<td>Key Decision: NO</td>
</tr>
<tr>
<td>Report Author:</td>
<td>Contact Details:</td>
</tr>
<tr>
<td>Louise Hider, Business Services Unit Manager</td>
<td>020 8227 2861</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:Louise.Hider@lbld.gov.uk">Louise.Hider@lbld.gov.uk</a></td>
</tr>
<tr>
<td>Accountable Divisional Director:</td>
<td></td>
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<tr>
<td>Glynis Rogers, Commissioning and Partnerships</td>
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<tr>
<td>Accountable Director:</td>
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<td>Anne Bristow, Adult and Community Services</td>
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<tr>
<td>Summary:</td>
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<td>The Health and Adult Services Select Committee (HASSC) has now completed its scrutiny review on the impact of the current recession and the welfare reforms on the mental health and wellbeing of residents in Barking and Dagenham. Over the course of the review, the Select Committee met for formal meetings on four occasions, attended two site visits and hosted a World Mental Health Day event with local residents. They have received information from a wide range of sources, including Council services (Revenue &amp; Benefits, Housing and Employment &amp; Skills), the Citizens Advice Bureau, Richmond Fellowship, the Samaritans, and representatives from the Clinical Commissioning Group (CCG) and North East London Foundation Trust (NELFT).</td>
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<td>At the last Select Committee meeting in November, the HASSC discussed their initial findings with Councillor Maureen Worby, Cabinet Member for Health and Chair of the Health and Wellbeing Board. Councillor Worby provided useful additional information for the review, particularly in how the Health and Wellbeing Board and the subgroups are taking forward the mental health agenda. A summary of the session with the Cabinet Member is included in this report.</td>
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<tr>
<td>Members of the Committee also discussed the draft recommendations at the November meeting and proposed amendments and additions. Officers have made revisions and the final report and recommendations for the scrutiny review is attached at Appendix 1 for HASSC approval. Following this, the report will be presented to the Health and Wellbeing Board and its relevant subgroups for discussion and agreement in how the recommendations of the review can be taken forward.</td>
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Recommendation(s)

Members of the Health and Adult Services Select Committee are recommended to:

1. Approve the final draft of the review into the impact of the recession and welfare reforms on mental health, with any amendments they wish to see.

2. Note that the Health and Wellbeing Board will receive the final scrutiny report at its meeting on 25 March 2014 for review and discussion in how the recommendations will be taken forward.

1. Introduction

1.1 The Health and Adult Services Select Committee (HASSC) chose to conduct a scrutiny review on the impact of the recession and welfare reforms on mental health and wellbeing as their scrutiny topic for 2013/14. The review began in June 2013 and the final information gathering session was held in November 2013.

1.2 The review has sought to answer three key questions:

(1) How are economic austerity and the Welfare Reforms impacting on our citizens?

(2) Will the austerity measures, reduction in income levels and increases in poverty lead to more mental ill health?

(3) What can we do, or what are we currently doing, to mitigate the likely impact?

1.3 Members have been proactive in their investigations in answering these questions and have attended a number of formal meetings with representatives from the Council, voluntary sector, Clinical Commissioning Group (CCG) and North East London Foundation Trust (NELFT) to inform their findings, as well as two site visits with Job Centre Plus and the NELFT Service User Reference Group. Members of the HASSC also hosted a focus group event with residents and mental health service users on World Mental Health Day (10 October 2013) to find out further views on how the current recession is affecting mental health and wellbeing in the Borough.

2. Summary of the session with the Cabinet Member for Health (12 November 2013)

2.6 Councillor Maureen Worby, Cabinet Member for Health and the Chair of the Health and Wellbeing Board was invited to the November HASSC meeting. This session was an opportunity for the Select Committee to discuss the initial findings of the Mental Health Scrutiny Review with the Cabinet Member, in particular asking her to comment on mental health service provision in Barking and Dagenham, future commissioning intentions and priorities, and how issues that have been raised in the review may be explored in further depth by the Health and Wellbeing Board.

2.7 Councillor Worby stated that mental health was one of her top priorities for the Health and Wellbeing Board and provided some useful additional information for the Select Committee, particularly on how the Health and Wellbeing Board and the subgroups of the Board are working on mental health in Barking and Dagenham. This included:
- The work that the mental health subgroup is conducting on service delivery, particularly integrated mental health services between the Council and NELFT (conducted through a Section 75 agreement).
- The preventive ‘public mental health’ interventions that the Public Health Programmes Board subgroup are coordinating on behalf of the Health and Wellbeing Board. This included projects such as the Big White Wall, a free online 24/7 support network which is commissioned by Public Health for residents over the age of 16 who are going through a difficult time with family, work, money, relationships and need some support to help them self-manage their condition.
- Funding to mental health social workers to work as part of the integrated care cluster arrangements with GPs, to support those presenting with lower-level mental health issues, not requiring specialist mental health service intervention.

2.8 The Cabinet Member also discussed some of the initial findings of the scrutiny review and particularly agreed with the Select Committee that GPs and health colleagues should ensure that they are suggesting a range of therapies as an alternative to antidepressants. It was suggested that the Health and Wellbeing Board could discuss this issue when they receive the final scrutiny report, as a result of which the Committee indicated that they would like to see the Clinical Commissioning Group provide evidence of effectiveness on the implementation of the Primary Care Depression pathway, and explore the inclusion and prominence of talking therapies within that pathway.

2.9 Additionally, Councillor Worby stated that she agreed that a review of the information and advice available to residents on welfare reform, the recession and mental health would be welcome, and that better promotion of the services that are available to residents was required. It was discussed that the Health and Wellbeing Board is currently looking at the way that services engage with residents on health and wellbeing issues and that mental health was one area that the Board will be focusing on when delivering their engagement strategy.

2.10 Officers have used the information and discussion from the session with Councillor Worby to inform the final report and shape some of the recommendations, particularly those which HASSC are proposing that the Health and Wellbeing Board take forward over the coming months.

3. Approval of the final report

3.1 A final draft of the Mental Health Scrutiny Review has now been completed, taking into account all of the analysis and information gathered during the review and comments that have been made by Members of the Committee on draft versions of the report. The final report and recommendations is attached at Appendix 1 for approval by the Health and Adult Services Select Committee.

3.2 It should be noted in particular that the report contains a revised version of the recommendations following the discussion that the Select Committee had on the draft recommendations at the November meeting. In particular, these changes were:

- The recommendation regarding 'access to information and advice' to include ways to help reduce the stigma around mental health, as well as practical advice.
• An additional recommendation under ‘training and employment’ to include that the Health and Wellbeing Board should satisfy themselves that sufficient training for professionals on mental health and mental health awareness is in place across the Partnership.
• Refinement of the draft recommendation about the appointment of a Mental Health Elected Member Champion, to suggest that this should be in a ‘task and finish’ capacity, focusing on one mental health issue such as the stigma attached to mental health.

3.3 Following the approval of the final report, the report will be presented at the Health and Wellbeing Board in March 2014 for further exploration and action of the recommendations. The delivery of any recommendations will be monitored by HASSC through a series of progress reports on the action plan produced by the Health and Wellbeing Board in response to the review.

4. The invisible costs of mental ill-health

4.1 On 22 January 2014, the Greater London Authority published a report titled ‘London Mental Health: The Invisible Costs of Mental Ill-health’. This landmark report:

• Highlights the scale of the problem and London’s health inequalities in respect of mental health
• Issues a call to action for London to confront and recognise mental health issues and treat them as equal to other health issues
• Quantifies the economic and social costs of mental ill-health. The report estimates that mental ill-health costs London £26 billion; of which £10 billion is borne by the public sector.
• In exploring the social costs of mental ill-health, the GLA report echoes findings of the HASSC that show the disproportionate impacts of people with mental health conditions who are unemployed (or in low paid work), and worklessness as a stress factor leading to mental ill-health. The GLA report, along with the HASSC’s review, also takes into account reduced quality of life due to stress anxiety and other mental health conditions.

4.2 It is hoped that the timely work of the HASSC can act as a catalyst for Barking and Dagenham responding to the GLA’s call to action and help to raise the profile of mental health issues locally.

4.3 The full report of the Greater London Authority can be found at this link: http://www.london.gov.uk/sites/default/files/Mental%20health%20report.pdf

5. Publicising the findings of the review

5.1 It is important that the work done by the HASSC gets the necessary exposure it needs to influence other relevant work being undertaken on this issue (or related issues). To this end, the HASSC’s review will be publicised in the following ways:

• A press release will be issued summarising the findings of the Committee to inform residents of the HASSC’s work
• The following individuals or organisations will receive copies of the report:
  
  o All stakeholders who participated in the review
  
  o London Councils - to inform the work taking place at a London-wide level into the impacts of the economic downturn
  
  o The Mayor of London’s Office
  
  o The Centre for Public Scrutiny - to be uploaded to their archive of scrutiny investigations
  
  o The LBBD Strategic Welfare Reform Group (an officer group chaired by Darren Henaghan, Corporate Director, Housing and Environment)

6. List of Appendices

Scrutiny Review

Barking and Dagenham Health & Adult Services Select Committee

June 2013 – November 2013

Review on the potential impact of the recession and Welfare Reforms on Mental Health
Lead Member Foreword

The current cost of living crisis and the crippling harsh austerity measures that the Tory-led government have steered us through over the past three and a half years have been felt quite strongly amongst our residents. Unemployment remains high in this Borough and welfare reform as well as the bedroom tax means that households that were already struggling, are finding it more difficult to manage their finances day to day.

After a six month in depth review, looking into the impact of the welfare reforms on mental health, our Committee has found that increased financial pressures have led to more people suffering from stress, anxiety and depression. Our resident’s mental wellbeing has been affected by continuing to live in hardship and uncertainty.

We have had a particular focus on what crucial support is available to our residents during these troubled times. Where do people suffering from emotional distress go to for help? How do our local services cope with increased demand, when our council is being forced to make cuts to so many of our services? Because our review found that the recession has had a negative impact on our residents, it is imperative that we ensure that they receive the support they need at an early stage, so that they are able to cope.

Our review comes at a time where the government’s welfare reforms and the introduction of the bedroom tax are having a severe negative impact on household incomes, both on those who are working and those who are unable to work for legitimate reasons. The Committee felt that it was important to understand the snowball effect of the bedroom tax, housing benefit cap, universal credit and loss of disability allowance, so that we and are stakeholders could help residents deal with the changes.

I would like to extend my thanks to the members of the Health and Adult Services Select Committee who have contributed a lot of time during our investigative sessions and meetings. Their contribution has really helped us to understand the impacts so that the recommendations were developed accordingly, that can be used by commissioners and those on the front line helping people.

Councillor Sanchia Alasia

Chair of the Health and Adult Services Select Committee
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Executive Summary

The scrutiny process for the review took place between June 2013 and November 2013, with Members drawing information from a wide range of sources to gain an in-depth understanding of how mental health, voluntary and statutory services work to support local residents who are impacted by the recession and welfare reforms.

The Council has historically found that the tipping point that has led families, vulnerable adults and older people to need input from Council-funded social care services is often the result of a number of factors and life events that combine to reduce people’s overall resilience. It was therefore hypothesised that the impact of the recession and welfare reforms may lead to a similar reduction in resilience, resulting in negative emotional and mental wellbeing being exhibited.

It was decided that the review would seek to answer the following three key questions:

1. How is economic austerity and the Welfare Reforms impacting on our citizens?
2. Will the austerity measures, reduction in income levels and/or poverty lead to more mental ill health?
3. What can we do/are we doing to mitigate the likely impact?

The following key findings were found as a result of the review. The findings should be read in conjunction with the recommendations on the following page which have been put forward for further exploration and action by the Select Committee as a result of their investigations.

1. How is economic austerity and the Welfare Reforms impacting on our citizens?

As the reforms are yet to be fully implemented the likely impact remains difficult to assess at this point in time and would benefit from further analysis in the future to fully determine the scale of impact. However from undertaking this review there is sufficient evidence to support that increased numbers are experiencing homelessness and presenting to the Council for support with Housing need. In addition large numbers are experiencing debt through rent and council tax arrears. Overall numbers of residents experiencing financial hardship continue to increase with a high number of applications for funds to cover basic needs such as food, electricity and gas.

There is also evidence to support that levels of mental health needs in the Borough are increasing. The review has found that increased numbers of people have been presenting with mental health needs since 2008 in GP practices. However it must be noted that causal factors are difficult to evidence.

The evidence collated within this review would reflect that early indications show that residents are experiencing financial hardship and many are also experiencing increased levels of anxiety and or depression with increased numbers presenting to GPs and other health colleagues.
2. Will the austerity measures, reduction in income levels and/or poverty lead to more mental ill health?

From the findings presented within the report it would suggest that potentially residents who have been directly impacted by the reforms are experiencing financial hardship due to the cuts and are therefore more likely to experience some level of anxiety and depression.

Early indications show that increased numbers of residents are presenting to mental health services and GP surgeries with depression. However it must be noted that it is much more difficult to quantify if this will translate into a diagnosed mental health condition, as this would be dependent on other variables such as the individual’s resilience factors and how services were able to intervene at an early stage to prevent crisis.

3. What can we do/are we doing to mitigate the likely impact?

Locally there is a vast amount of work being undertaken from a proactive perspective. There has been a significant amount of assertive outreach work by the Council and its Partners to engage those who the Council has identified will be impacted by the welfare reforms and cuts in benefits and to work with them to establish solutions, e.g. gaining employment, moving home and downsizing.

There are already a number of services in place that offer information, advice and advocacy to help inform residents of their options and provide guidance around financial hardship and benefits advice, including practical support in the shape of the Barking and Dagenham Credit Union and Local Emergency Support Service.

North East London Foundation Trust (NELFT) also has clear pathways in place for those experiencing mental health problems and clinical support is available to support professionals in NELFT, as well as GPs, with the implementation of the Primary Care Depression Pathway. However, there are concerns that this pathway is overly-reliant on the prescribing of antidepressants and that more focus needs to be given to holistic treatment options.

There remain areas that can be further developed to prevent crisis or trigger additional mental health needs. The areas in which most impact can be achieved is a comprehensive approach in the sharing and dissemination of information, training for front line staff and ongoing analyses of information to inform ongoing plans to mitigate the further expected impact of the reforms.

This scrutiny review has been timely and has been conducted at the same time as a great deal of media coverage, debate and discussion at a national and London-level. In particular, the Greater London Authority have conducted research into mental health in London and published a report in January 2014. Although the report was published at the end of the Barking and Dagenham scrutiny process, it gives a helpful context to the HASSC’s own review, discussing prevalence levels, mental health inequalities and the socio-economic impact of mental health issues in London. The report can be found by visiting the following link: https://www.london.gov.uk/sites/default/files/FINAL%20-%20LMH%20-%20Full%20Report.pdf
Recommendations

Following the scrutiny review, the Health and Adult Services Select Committee have put forward the following recommendations for further exploration and action:

**Recommendation**

1. **Access to Information & Support**

   It is identified clearly within the report that receiving advice early is a key determinant in enabling residents to minimise the impact of welfare reforms and prevent financial hardship which could lead to detrimental effects on general health and mental wellbeing. It is evident that generally people suffer greater anxiety during times of financial difficulty, therefore early intervention and prevention is essential to residents in preventing crisis.

   Information about services offering welfare benefits advice and advocacy should be readily and widely available to three key groups to ensure that residents can access services, support pathways and practical advice when they need it most. Information and advice should also be available to help reduce the stigma of mental health. The three key groups identified are:

   - Residents
   - Practitioners
   - Those already known to mental health services

   The importance of up to date, easy to understand and timely information and advice was raised on a number of occasions during the review. It is therefore recommended that a mapping and consultation exercise on access to information, advice and support is carried out by the Health and Wellbeing Board. This exercise would be beneficial in order to ascertain whether there are any gaps in information provision and to establish whether the information formats that are currently available are the right ones.

2. **Training & Volunteering**

   During the review process it was reiterated on many occasions that volunteering played a valuable role in mental health and wellbeing and also provides opportunities to prevent isolation, gain necessary skills and experience, and increases local social capital. It is therefore recommended that the Health and Wellbeing Board:

   - Recognises the importance of volunteering in maintaining recovery and mental health and wellbeing, using all the opportunities provided by the Council’s volunteering programmes and the Third Sector.
   - See Recommendation 7 below on Mental Health First Aid training.
3. Peer Support Opportunities

It is recommended that the Council and the Health and Wellbeing Board continues to monitor user-led organisations to ensure that robust peer support opportunities continue to be provided to prevent isolation, provide emotional support and aid access to information and advice services as required.

4. Joint Working & Partnerships

The Committee considered the appointment of an Elected Member Champion around mental health and recommends that the Cabinet Member for Health considers the appointment of a Mental Health Champion on a fixed term basis on a specific issue, for example reducing the stigma of mental health. It is accepted that this would not be taken forward until after the elections in May 2014.

The Committee felt strongly that a holistic approach needed to be considered in the treatment options available to patients, particularly as the Committee felt that there was an over-reliance on antidepressants as a treatment option in the Primary Care Depression pathway. The Health and Wellbeing Board should give this consideration, as a result of which the Clinical Commissioning Group (CCG) could be tasked to provide evidence of effectiveness on the implementation of the Primary Care Depression pathway and explore inclusion of alternative therapies, particularly talking therapies, within the pathway. As part of this work, the Committee would like to see the CCG undertake a review to determine whether the prescribing of antidepressants is in line with the practice in other areas.

The Committee were very positive about the availability of emotional health support for employees in Barking and Dagenham Council. It is recommended that the Council draw on this good practice to support local small employers to provide similar support to their employees.

5. Continued Measure of Need

The Committee are aware that within the Council, a Welfare Reform Officer Group is coordinating the response to the austerity and the welfare reforms for Barking and Dagenham residents. The Committee supports their ongoing work to bring together data sources that describe the scale of the problem and wish to see this brought to Members at regular intervals. This is particularly important as this review has been taken at the early stages of welfare reform implementation and so significant further impacts are to be expected.

Commissioning Officers within the Council to continue to ensure that services that are commissioned by the Council continue to remain fit for purpose and meet the needs of residents in the Borough. These services include:

1. Enhanced Welfare Rights
2. Specialist Advocacy
3. Local Emergency Support services
4. Credit Union

7. Mental Health First Aid Training

It is recommended that the Council and the Health and Wellbeing Board offer Mental Health First Aid to professionals across the partnership, as well as other local employers. It is suggested that the Health and Wellbeing Board may wish to look at whether the training that is offered to professionals across partnership organisations is sufficient and offer additional mental health awareness training if appropriate.
Introduction

What is the Health and Adult Services Select Committee (HASSC)?

The Health and Adult Services Select Committee (HASSC) is one of five themed scrutiny commissions established by the Council to hold local decision-makers and providers of public services to account. Its remit covers all aspects of adult social care and health and wellbeing including mental health, public health, primary care and acute care. Because of the nature of its remit, HASSC is the delegated holder of the Council’s health scrutiny powers granted by the provisions of the Local Government Act 2000, Health and Social Care Act 2001, NHS Act 2006, and Health and Social Care Act 2012. The HASSC exercises these powers and functions to scrutinise health service providers, NHS bodies and the Council itself. Within this framework the HASSC is empowered to scrutinise any matter in relation to the planning and delivery of health and adult social care services and to make recommendations in order to drive improvements and improve the patient/service user experience. It is on this constitutional basis that the HASSC conducts this scrutiny review.

Membership of the HASSC

The HASSC consisted of the following nine Councillors in the 2013-14 municipal year:

- Councillor S Alasia (Lead Member)
- Councillor E Keller (Deputy Lead Member)
- Councillor S E Ahammad
- Councillor E Carpenter
- Councillor A Gafoor Aziz
- Councillor M McKenzie MBE
- Councillor T Saeed
- Councillor A Salam
- Councillor J Wade

Anne Bristow, the Corporate Director of Adult and Community Services, nominated as the HASSC Scrutiny Champion, Bruce Morris Divisional Director Adult Social Care and Matthew Cole Joint Director of Public Health supported the Select Committee throughout the review and provided expertise and guidance to the Select Committee. In addition a wide range of Council partners, contributed to the collation of review findings. It should also be noted that valuable input from local residents and service users also contributed to the overall report and informed recommendations.

Methodology

Over the course of the review, the Select Committee met for formal meetings on four occasions and four further occasions (site visits and the World Mental Health Day event) as part of the scrutiny of this topic. They have received information from a wide range of sources, including Council services (Revenue & Benefits, Housing and
Employment & Skills), the Citizens Advice Bureau, Richmond Fellowship, the Samaritans, representatives from the Clinical Commissioning Group (CCG) and North East London Foundation Trust (NELFT) and discussed the findings of the review with Councillor Maureen Worby, Cabinet Member for Health. The comprehensive notes from these sessions can be found in Appendix 4 of this report.

The information collated to inform the review has been sourced through the following channels:

- Desktop research;
- Consultation with the Cabinet Member for Health and Service Leads from a range of Council, Health and Voluntary service areas – see Appendix 4
- Reviews of research findings, local data on mental health and deprivation, and national good practice by the Council's Public Health team.
- Site visits to mental health services, Job Centre Plus and the NELFT Service User Reference Group;
- Members' open meeting with residents as part of World Mental Health Day to discuss their experiences of the impact of economic downturn and welfare reforms on mental health.

Structure of the Report

Rather than structuring the report around the evidence gathered from each of the organisations, meetings and site visits, this report has grouped the findings of the scrutiny review under three key questions which the Select Committee were seeking to answer:

1. How is economic austerity and the Welfare Reforms impacting on our citizens?
2. Will the austerity measures, reduction in income levels and/or poverty lead to more mental ill health?
3. What can we do/are we doing to mitigate the likely impact?

At the end of the scrutiny process, Members of the Health and Adult Services Select Committee agreed a suite of recommendations, many of which were suggested to be taken forward by the Health and Wellbeing Board. Recommendations are presented within the relevant sections and can be found as a whole under the ‘Recommendations’ section at the beginning of this report.

Timeliness of the Review

This scrutiny review has been timely and conducted at the same time as a great deal of coverage in the media and debate and discussion at a national and London-level. This coverage has picked up on a number of issues that have also been explored by the scrutiny review and commented upon by the Health and Adult Services Select Committee.

Some of the poignant articles and debates have been included below, and readers are recommended to read these discussions as context to the findings in the scrutiny review. In particular, it is recommended that this review should be read alongside the
Greater London Authority report called ‘London Mental Health - The invisible costs of mental ill health’. The report was published in January 2014, after the conclusion of the Barking and Dagenham scrutiny review, and analyses the wider economic and social impacts of mental ill health in London, giving a helpful context to the findings in this document.

In exploring the social costs of mental ill-health, the GLA report echoes findings of the HASSC that show the disproportionate impacts of people with mental health conditions who are unemployed (or in low paid work), and worklessness as a stress factor leading to mental ill-health. The GLA report, along with the HASSC’s review, also takes into account reduced quality of life due to stress anxiety and other mental health conditions.

It is hoped that the timely work of the HASSC can act as a catalyst for Barking and Dagenham responding to the GLA’s call to action and help to raise the profile of mental health issues locally.

The full report of the Greater London Authority can be found at this link: http://www.london.gov.uk/sites/default/files/Mental%20health%20report.pdf

**Media coverage on the recession, welfare reforms and mental ill health during the scrutiny review**

Last summer, the Centre for Social Justice Thinktank report ‘Maxed Out’ found that personal debt in Britain had reached £1.4tn, with almost half of households in the lowest income bracket spending more than a quarter of their income on debt repayments in 2011. The report also found that 5000 people are being made homeless every year as a result of mortgage or rent debts. The report stated that debt has a ‘corrosive impact’ on mental health, relationships and wellbeing.¹

At the end of 2013, the BBC and the Guardian ran a series of articles focusing on how families are struggling to meet the increasing costs of basic essentials. Food prices have risen 12% over the past five years with the average household weekly spend on food being just £54.80 and many young families are cutting back on fresh fruit and vegetables in favour of cheaper, less healthy processed food.² In September 2013 the BBC’s Inside Out programme focused on feeding a family for £5 to help reduce weekly food expenditure.

There have also been a number of media reports about the impact of the recession on people with existing mental health conditions, particularly in the job market. Last year both the BBC and ITV published findings from the Public Library of Science ONE research which found that the gap in unemployment rates between people with and without mental health problems had widened, and that ‘people with mental

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¹ The Guardian, Wednesday 20 November 2013
http://www.theguardian.com/money/2013/nov/20/personal-debt-mental-health-report
health problems were more likely to be unemployed. Members received similar comments from service users at the HASSC session on World Mental Health Day last October.

In November 2013, the Guardian ran a think-piece on the soaring use of antidepressants, publishing the results of a questionnaire that was undertaken with 100 GPs throughout the UK and Europe who stated that they felt that there was a ‘prescribing culture’ in their country because other help for people with depression was inadequate. During the scrutiny review, Members questioned both the Clinical Commissioning Group (CCG) and Chair of the Health & Wellbeing Board about the Primary Care Depression Pathway, stating that they felt that there was an over-reliance on prescribing antidepressants and that a holistic approach needed to be considered in the treatment options available to patients by all agencies in the Health and Wellbeing Board. This echoes the findings of the August 2013 ‘Building Resilient Communities’ report published by Mind and the Mental Health Foundation which calls on Councils and other agencies to prioritise mental health within their strategies by adopting holistic approaches to prevent mental ill health developing into a long-term problem.

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4 The Guardian, Thursday 21 November 2013,
http://www.theguardian.com/society/2013/nov/21/prescribing-culture-blame-rise-antidepressants?CMP=EMCSOCMEML657
5 MIND and the Mental Health Foundation, August 2013,
Background

What is Mental Health?

Mental Health refers to a broad array of activities directly or indirectly related to the mental well-being component included in the WHO's 6 definition of health: "A state of complete physical, mental and social well-being, and not merely the absence of disease". It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.

This review will use the term ‘mental health’ to encompass conditions ranging from anxiety and depression to schizophrenia. This is used because the term ‘mental health’ is commonly understood to include all forms of mental distress. It is important to differentiate between mental health and mental capacity issues, which will not be included within the scope of this review. Mental capacity means being able to make and communicate decisions.

Cause of Mental Illness 7

Ideas about the 'causes' of mental illness and health come and go, and at any time social, medical and other explanations will all be supported by different groups, or disputed. The current picture seems to be that broadly, more than half of poor mental health can be explained by a range of societal stress such as emotional neglect and violence in families when children's basic mental and emotional capabilities are developing, and also by the wider determinants such as poverty, debt, bullying at work or school, discrimination and, vitally by the extent to which society has major inequalities. Physiological and genetic factors may then to some extent influence whether people fall ill to a greater or lesser degree. Most people working in mental health services recognise that it is unusual for people with severe mental illness not to have experienced a range of neglect, losses, and major stresses at key points in their lives. It is important to bear in mind that the more social explanation tends to lead us as a partnership into a more positive position, namely that we can have a major influence on the Borough's mental health. In previous decades, mental illness was often regarded as something inevitable in certain people and the focus was on treatment. Nowadays we recognise that we can influence our borough's mental health and that we can empower and support residents to attain better mental wellbeing.

It is also helpful to remember that while clinicians and psychologists can diagnose mental illness or measure it on an inventory, what really matters to individuals is their internal experience. If our day is filled with stress, misery and fear, then life feels awful, irrespective of whether we are experiencing depression, psychosis or stress as a result of debt, grief or violence.

6 World Health Organisation
7 WebMD Medical Reference 2012
The following factors can influence mental wellbeing:

- Economic and social pressures such as debt, poverty, inequality, and lack of a safe environment.
- Personal stress and fear caused by bad treatment by others.

Although the exact cause(s) of most mental illnesses is not known, through research it is becoming clearer that many mental health conditions are caused by a combination of biological, psychological, and environmental factors.

Other biological factors that may be involved in the development of mental illness include:

- **Infections**: Certain infections have been linked to brain damage and the development of mental illness or the worsening of its symptoms.

- **Brain defects or injury**: Defects in or injury to certain areas of the brain has also been linked to some mental illnesses.

- **Prenatal damage**: Early foetal brain development or trauma that occurs at the time of birth -- for example, loss of oxygen to the brain -- may be a factor in the development of certain conditions, such as autism.

- **Substance abuse**: Long-term substance abuse, in particular, has been linked to anxiety, depression, and paranoia.

- **Other factors**: Poor nutrition and upbringing, education, may play a role in the development of mental illnesses.\(^8\)

- **Genetics (heredity)**: Many mental illnesses run in families, suggesting that people who have a family member with a mental illness are more likely to develop one themselves. Susceptibility is passed on in families through genes. Mental illness itself occurs from the interaction of multiple genes and other factors --such as stress, abuse, or a traumatic event -- which can influence, or trigger, an illness in a person who has an inherited susceptibility to it.

**Common mental illness**

Common mental health disorders, such as depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder may affect up to 15% of the population at any one time.

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\(^8\) Matthew Cole Director of Public Health  HASSC Presentation 2013
Depression and anxiety disorders can have a lifelong course of relapse and remission. There is considerable variation in the severity of common mental health disorders, but all can be associated with significant long-term disability. For example, depression is estimated to be the second greatest contributor to disability-adjusted life years throughout the developed world. It is also associated with high levels of morbidity and mortality, and is the most common disorder contributing to suicide. Further more in general, neurotic disorders affect women more than men (19.7% v 12.5%).

Social impact of severe mental illness

The social impact of a psychotic disorder is marked. Compared with people who do not have one, those with a probable psychosis are more likely to:

- be separated or divorced
- be living in a one person family unit
- have low educational qualifications
- be in Social Class IV or V
- be economically inactive
- live in accommodation rented from a local authority or housing association
- live in an urban area

The above indicates that those with psychosis will often experience increased social pressures; furthermore, links between income and physical and emotional well-being are well established. In general, well-being is dependent upon good health, positive social relationships, and availability and access to basic resources. ‘The worst affected places face financial losses that are twice the national average and four times as much as the least affected places. As a general rule, the more deprived the local authority, the greater the financial hit’. Reforms that reduce income to our poorest citizens are potentially likely to impact on their ability to remain self supporting.

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9 Common mental health disorders: Identification and pathways to care NICE May 2011
10 Matthew Cole Director of Public Health HASSC Presentation 2013
11 Matthew Cole Director of Public Health HASSC Presentation 2013
12 First evidence on overall impact of welfare reform across Britain Sheffield Hallam University
Key Question 1: How is economic austerity and the Welfare Reforms impacting on our citizens?

Nature of reforms

The Welfare Reforms have been gradually implemented in 2013, with full implementation from October 2013. Therefore, it should be noted that although the Select Committee has been able to begin to review the impact of the Welfare Reforms as part of their scrutiny investigations, it is likely that the full impact of the Reforms as a whole will be difficult to assess until 2014/15 and beyond.

There are four key elements to the welfare reform programme, which follow on from reforms that were introduced under the previous government:

- To replace the complex mix of out of work benefits and working tax credits with a single Universal Credit;
- To introduce a single welfare to work programme (the Work Programme), designed to support longer term unemployed people back to work;
- To reassess claims of disability and incapacity related benefit, and particularly individuals’ capability to work;
- To cap the total amount of benefit that working age people can receive so that workless households should no longer receive more in benefits than the average earnings of working households. The cap will be £500 p/wk for couples and lone parents and £350 p/wk for single adults.

It should be noted that within the Council, a Welfare Reform Officer Group is coordinating the response to the austerity and the welfare reforms for Barking and Dagenham residents.

Changes to welfare benefits (see Appendix 1 for a more comprehensive description of the changes)

There are currently, and have been historically, five key types of benefits:

- Out of work benefits - Jobseekers Allowance (JSA), Incapacity Benefit (IB), Employment and Support Allowance (ESA), Severe Disablement Allowance (SDA) and Income Support (IS). These will all be replaced by Universal Credit;
- Housing benefits - Local Housing Allowance (LHA). This will be incorporated into Universal Credit from October 2013 but current reductions in LHA for under 35 year olds and penalties for working age families under-occupying social housing and the benefits cap (to be administered by reductions in Housing Benefit payment) will impact from April 2013;
• Disability benefits - Disability Living Allowance (DLA). Personal Independence Payments (PIPs) will replace DLA with existing claimants of DLA being re-assessed;
• Tax credits - Working Tax Credit (WTC) and Child Tax Credit (CTC). This has sought to supplement the incomes of working families and support the payment for childcare arrangements. These will be incorporated into Universal Credit;
• Council Tax Benefit – This will be replaced with a localised support mechanism from April 2013. Funding for council tax benefit will come from un-ring fenced grants paid.

The decision to offer a claimant an alternative payment arrangement will be made by a Department of Work and Pensions (DWP) decision maker. They will take into account a range of factors to help identify a claimant’s needs, including:

- Drug, alcohol or other addiction problems
- Learning difficulties or mental health conditions
- Temporary or Supported accommodation - Homelessness
- Severe debt problems
- Domestic violence

This list is not exhaustive and all alternative payment arrangements will be considered on a case by case basis. DWP envisage a role for local authorities and Housing Associations in the Alternative Payment Arrangements process. DWP will develop proposals and engage with key partners in time for further Universal Credit rollout.

DWP is not seeking to define "vulnerability" for the purposes of administering Universal Credit, as it is felt that an attempt to do so would risk some people with complex needs falling outside of the prescribed definitions and then not receiving help that they may genuinely need. DWP has already published guidance on this and alternative payment arrangements for the Universal Credit pathfinder in Greater Manchester.  

### Estimated numbers of people effected

#### Housing

The table below represents the number of benefit claimants in the Borough using the most recently published data. As can be seen, housing benefit is by far the highest proportion of need locally. It is reported that 1,600 residents will be impacted on by the bedroom tax losing a minimum of £14 per week in housing benefit, this shortfall in benefit will need to be made up by each claimant however this is dependent on the access to any disposable income or they will face a choice, either:

- Downsize
- Commence work and cease benefit claims

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13 Policy paper: Government response to the Communities and Local Government Select Committee's report: implementation of welfare reform by local authorities
• Take in Lodger

Of those 1,600 residents effected 1,384 have been contacted and visited by Housing Services, the vast majority 81% have indicated that they will make up the shortfall, 4% indicated that they would commence work, with only 13% have indicated their intent to downsize. This would suggest that most residents are willing to make further sacrifices and budget their income to make up the shortfall then having to move home which is often a stressful and anxious time.

*Figure 1.1 Breakdown of Benefits and Support*

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Number</th>
<th>Percentage affected</th>
<th>Latest published data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Benefit</td>
<td>23,102</td>
<td>33.0% (percentage of households)</td>
<td>Mid Aug 2013</td>
</tr>
<tr>
<td>Council Tax Support</td>
<td>23,760</td>
<td>33.9% (percentage of households)</td>
<td>W/c 9 Sep 2013</td>
</tr>
<tr>
<td>Employment and Support Allowance (ESA) and Incapacity benefit</td>
<td>8,610</td>
<td>7.2% (Proportion of the resident population aged 16-64)</td>
<td>Feb 2013</td>
</tr>
<tr>
<td>Job Seekers Allowance</td>
<td>6,432</td>
<td>5.4% (Proportion of the resident population aged 16-64)</td>
<td>July 2013</td>
</tr>
</tbody>
</table>

The potential impact of those wishing to remain in their current home is the increase in Council rent arrears should residents find themselves in financial difficulty. This may then impact on number of evictions across all tenures as a potential impact of reforms.

Since May 2013 there has been a 30% increase in homelessness approaches. As homeless demand increases the availability of accommodation in the rented sector is also reducing for a number of reasons. There is some evidence to suggest that:

• Other boroughs are targeting boroughs with cheaper rent levels
• Private Landlord’s reluctance to take tenants dependent on benefits.

Those families with significant loss of benefits including those placed in the Borough from other boroughs will face additional pressures that may then impact on their health and well being e.g. mental health if they find themselves accruing rent arrears and potentially facing eviction. It is possible that these increased pressures in the home may raise the number of new presentations into Mental Health Services, and those already known to services may need increased support.
Council Tax Support Scheme

The scheme was introduced from 1 April 2013 and residents who previously did not have to pay anything towards their Council Tax now have to pay 15% towards their council tax bills. This translates to around £3.46 pw at the lower end (£15.00 pcm) and £4.15 pw at the higher end (£18.00 pcm). The scheme represents a reduction in residents’ income in real terms and residents are generating debt as a result of the scheme.

Benefits

Between 12 August and end of September 2013 the Council has so far received instruction to cap 523 families in the Borough, 90 of these have lost more than £100 per week. There are various exemptions from the cap e.g. being in receipt of a qualifying benefit such as DLA or PIP. If a resident meets one or more of the exemption criteria then they will not be affected by the cap. Residents who have severe and enduring mental health issues should be in receipt of a qualifying benefit and thus exempt from the benefits cap.

There will be residents with lower levels of mental ill health who will not be exempt from the cap and who will be affected by it e.g. people living in private rented accommodation and not in receipt of a qualifying benefit. This could result in more people approaching the local authority for help with discretionary housing payments in the future. If these residents cannot find a way to make up the shortfall in their rent payments they will be made homeless and this could also have repercussions for the local authority homelessness service.

Magnitude of Impact

The Marmot report suggests that socio-economic consequences of the financial crisis will disproportionately affect London due to demographics, higher living costs and the nature of its housing and employment market. Marmot in his review quotes: “Rates of unemployment are highest among those with few or no qualifications and skills, people with disabilities and mental ill-health, those with caring responsibilities, lone parents, those from some ethnic minority groups, older workers and in particular young people.” (London Health Inequalities Network 2011). The disproportionate effects have been highlighted below:

Disproportionate Effects

15 Annette Cardy Joint Improvement Partnership Barking & Dagenham Economic Downturn 2013
London

- Higher rents
- Limited affordable social housing
- Areas of deprivation & high unemployment
- Health Inequalities

Individuals

- Large families hit by cap
- Lone Parents
- Young & Older under pension age
- Those with a disability
- ‘Vulnerable’ - unequal access to employment & housing

A copy of the *Employment, Income, Housing Impacts on Health & Social Care Needs*’ flowchart is included for information on the next page.
Figure 1.2 Employment, Income, Housing Impacts on Health & Social Care Needs

Unemployment
  - Greater income inequality
    - Increased homocide
    - Higher mortality
    - Depression
    - Increased suicide
  - Job Insecurity
    - Poor self-reported health
    - Increased CVD
    - Depression
    - Stress
  - Redundancy
    - Increased CVD mortality
    - Higher SMR
    - Increased lung cancer mortality
    - Poor self-reported health
    - Increased homicide
    - Domestic Violence
    - Increased suicide
    - Psychological distress
    - Alcohol abuse
    - Poor mental health

Loss of Discretionary income
  - Debts
    - Anxiety
    - Depression
    - Stress
  - Poor housing
    - Poor mental health
    - Increased circulatory disease
    - Increased respiratory disease
    - Childhood asthma
    - Heart attacks
    - Food insecurity
    - Social isolation
    - Depression
  - Unaffordable housing
    - Poor mental well-being
    - Displacement
    - Poor child health & development
    - Childhood Depression
  - Fuel poverty
    - Excess winter deaths
    - Childhood Bosnia
    - Early death
  - Reduced income
    - Poor mental health
    - Increased substance abuse
    - Poor health outcomes
    - Increased mood and anxiety disorders
    - Food insecurity
    - Poor child health
    - Mental health problems
    - Poor mental health
    - Dental problems
    - Mortality
    - Increased respiratory disease
    - Child health depression and behavioural problems
    - Tubercolusis
    - Spread of infectious disease
    - Lower life expectancy
    - Tuberculosis
Emerging impacts of austerity and the Welfare Reforms

From the Select Committee focus group sessions with statutory and voluntary sector partners (see Appendix 4 for full notes from each of the sessions) a number of key areas were identified around the emerging needs and impact.

From the evidence collated as part of the scrutiny review all groups have provided early indications that the impact of reforms may potentially have adverse effects on individuals and families within Barking and Dagenham which is due to increased financial hardship. However it should be noted that those with severe or enduring mental health conditions will remain exempt from any benefit caps and therefore should not experience further significant impacts, although those consulted have expressed that despite exemptions they have still experienced increased levels of anxiety due to impending changes. The main concern is that those not already known to secondary and primary health services may experience increased levels of anxiety or suffer from depression which may lead to new presentations to Health services.

Many factors may contribute to any adverse affects, one of which could be due to high levels of housing need which currently outstrips supply - lower cost social housing is in high demand with almost 12,500 currently on the waiting list. Those on the waiting list may already be experiencing some levels of anxiety as they face long waits to determine housing applications, with the additional pressures of change in benefits and employment status some may experience further anxiety triggering need to access mental health services. It was reported during the focus groups that there have been an increased number of presentations through Housing Advice and Homelessness where mental health has been indicated as a need and potentially triggered or worsened through financial hardship.

Revenue and Benefits reported that they have seen a rise in Council Tax recovery activity which has increased due to residents falling behind with payments. They have also seen three times as many residents receive a summons for Council Tax for non payment. Levels of rent arrears have increased with around 1000 households currently going through the debt recovery process at this time. This would suggest that many households are already experiencing financial difficulties due to bedroom tax and council tax. It is also anticipated that there will be an increase in people migrating to the Borough as Barking & Dagenham rents are slightly lower than caps and will therefore be more financially viable. This would suggest that the Borough may see increased need on other services i.e. Health & Social Care and Education due to families moving to the Borough for affordable housing.

In February 2013, the Borough approximately had 8,760 residents claiming incapacity benefits with around 3,500 claiming for mental health or behavioural related disorders. This outnumbers job seekers (7,240 at that date) as the biggest group of claimants in the Borough. It is predicted that many will be transferred to the government’s Work Programmes. Since June 2011 to March 2013, only 10 obtained employment out of approximately 620 residents. It is estimated around 40% would have had additional mental health needs, however there is no evidence to suggest that those with additional needs were provided with the necessary support or access
to specialist services to enable them to gain employment. Although Job Centre Plus reported that those with additional vulnerabilities do have access to additional support it appears from the statistics that this was perhaps not fully utilised. Potentially there is a concern that those presenting with additional mental health needs may be marginalised if they are not identified and supported appropriately, if assessed and transferred to Work Programmes without adequate support this may further adversely impact on their mental health.

Existing mental health service users also reported that they felt that opportunities for employment was limited although it is recognised that unemployment continues to fall, service users were often offered low paid unskilled work or zero hour contracts which left them feeling demoralised and undervalued although some have skilled backgrounds and felt that they had more to offer the employment market. The importance of good employment is necessary to maintain mental health wellbeing. With the introduction of the cost to individuals to pursue Employment Tribunals service users felt that they would be unable to raise concerns if treated unfairly due to their mental health condition. For service users that have been assessed as ‘fit for work’ and required to seek employment, this has generated high levels of anxiety for those already known to mental health services. Although it was noted that given the right support and information, a small number have successfully returned to work or accessed education or training.

The voluntary sector focus groups all expressed that they have deep concerns that those accessing services whether they are already known to mental health services or not, are experiencing greater levels of anxiety and depression due to financial hardship. Those already accessing secondary mental health services are increasingly requiring more support around austerity related issues particularly when other services have been closed or no longer provide that function. Specialist mental health provision providing vocational support are currently working with around 80\(^{16}\) individuals with most requiring additional emotional support, however the concern is that specialist interventions will become diluted if services are providing more broader support to meet demand for austerity related support.

The Work Capability Assessment process (WCA) is carried out by ATOS healthcare commissioned by the Department of Work & Pensions (DWP) to carry out assessments. However the decision about whether or not a claimant continues to qualify for ESA is made by the DWP decision maker. Citizens Advice Bureau have highlighted that they believe the process is flawed and people with mental health issues are disproportionately affected by the DWP making negative decisions on their claims.

Furthermore, the voluntary sector are receiving more calls and drop-ins as a direct result of welfare reforms, where individuals are worried and anxious about completing forms, benefit and debt issues which has increased by around 25%. Feedback to date suggests that individuals and families are experiencing greater financial hardship and need to access services to help support them through welfare

\(^{16}\) Based on numbers provided in October 2013
reforms that impact on them. Voluntary sector partners continue to remain vigilant to ensure that they identify where possible early indicator for anxiety and distress amongst service users presenting for support.

A number of mental health service users were consulted as part of the review and the majority all responded that the speed of the changes and often lack of information has caused heightened anxiety and in some cases triggering crisis. It was a felt that existing mental health services i.e. Home Treatment Teams are already stretched and would be unable to cope with rising numbers needing support due to the impact of welfare reforms. Many reported that their daily routines have been impacted i.e. budgeting, shopping etc is even more difficult for those with additional needs such as dyslexia. With the additional role of Universal Credit and monthly payments, this will require those receiving benefits to effectively manage and budget finances and for some this may prove to be extremely difficult.

For some, the fear of isolation increases as opportunities for social inclusion become more limited due to financial constraints. Although there was a general consensus that peer support is a valuable aid in maintaining recovery and preventing crisis. Peer support opportunities also allow greater access to information through sharing experiences and knowledge of local services.

Service users expressed the importance of accessing the right support at point of crisis as this experience will have a significant impact on their recovery. In addition having access to information and advice also eases anxieties. Service users were extremely passionate about the importance of volunteering in maintaining service user’s recovery and need for recognition in what service users give back to the community through volunteering.

There is also recognition that in-work poverty is also increasing which is affecting a vast group of the Borough population, further supporting the need for good employment avoiding low paid poor condition employment which is reported by Council Department Employment and Skills.

The rise and demand for services in Barking and Dagenham

As part of the scrutiny focus groups it was reported by NELFT that demand for mental health services is increasing. The Barking and Dagenham Access and Assessment Team in the first 6 months of 2013/14 saw a 19.6% increase in referrals against the same period last year. However it cannot be explicitly attributable to welfare reforms.

The Clinical Commissioning Group\(^\text{17}\) reported that there are increased numbers of residents presenting at GP surgeries with stress and would agree that they are seeing the impact of welfare reforms in general practice. However it should be noted

\(^{17}\) Dr Raj Kumar, Local CCG lead for Mental Health and Vice Chair of Barking & Dagenham CCG
that it is not always explicit as to why more people are presenting but could be due to austerity measures i.e. financial hardship etc.

It would be fair to conclude that there has been a rise in demand of services across both voluntary and statutory services, with significant increase in presentation to mental health services and general practices.

**Recommendation**

1. **Access to Information & Support**

   It is identified clearly within the report that receiving advice early is a key determinant in enabling residents to minimise the impact of welfare reforms and prevent financial hardship which could lead to detrimental effects on general health and mental wellbeing. It is evident that generally people suffer greater anxiety during times of financial difficulty therefore early intervention and prevention is essential to residents in preventing crisis.

   Information about services offering welfare benefits advice and advocacy should be readily and widely available to three key groups to ensure that residents can access services, support pathways and practical advice when they need it most. Information and advice should also be available to help reduce the stigma of mental health. The three key groups identified are:

   - Residents
   - Practitioners
   - Those already known to Mental Health services

   The importance of up to date, easy to understand and timely information and advice was raised on a number of occasions during the review. It is therefore recommended that a mapping and consultation exercise on access to information, advice and support is carried out by the Health and Wellbeing Board. This exercise would be beneficial in order to ascertain whether there are any gaps in information provision and to establish whether the information formats that are currently available are the right ones.

2. **Training & Volunteering**

   During the review process it was reiterated on many occasions that volunteering played a valuable role in mental health and wellbeing and also provides opportunities to prevent isolation, gain necessary skills and experience, and increases local social capital. It is therefore recommended that the Health and Wellbeing Board:

   - Recognises the importance of volunteering in maintaining recovery and mental health and wellbeing, using all the opportunities provided by the Council’s volunteering programmes and the Third Sector.
     See Recommendation 7 on Mental Health First Aid training.
3. **Peer Support Opportunities**

It is recommended that the Council and the Health and Wellbeing Board continue to monitor user-led organisations to ensure that robust peer support opportunities continue to be provided to prevent isolation, provide emotional support and aid access to information and advice services as required.
Key Question 2: Will the austerity measures, reduction in income levels and/or poverty lead to more mental ill health?

What is the expected prevalence of mental health?

Barking & Dagenham Partnership Joint Strategic Needs Assessment

The risk of mental health problems is considerably higher in deprived areas, so prevalence would be expected to be high in Barking and Dagenham. However, diagnosed prevalence of conditions such as phobia is close to the London average, suggesting that there may be under reporting at least for this condition.

Approximately 5.8% of borough residents are accessing care for mental health services for a range of mental health conditions. Recording of mental health conditions is low in primary care with only about 0.6% of residents registered by GPs on their mental health registers. During 2008/9, 411 adult residents of Barking and Dagenham were admitted as in-patients for mental health care, while 4,403 attended either a mental health outpatient’s appointment or had contact with a community service (ICS). Meanwhile in the same year 160 adults were detained under the Mental Health Act.

It is estimated that in any given week 11% of adults in Barking and Dagenham will be experiencing depression. This is higher than the England average (8%) but the same as the London average (11%).

Unemployed people have higher rates of long term limiting illnesses, cardiovascular disease and mental health problems. While most people agree that being in work is preferable to unemployment, in terms of improved physical and mental health, the quality of the work really matters. Moving people off benefits and into low paid and insecure work is not a desirable option and it will not see long term improvements in health, as being in work if the working conditions are poor can lead to worse mental health and musculoskeletal disorders.

There is a circular nature to the relationship between unemployment and poor health, as being unemployed can lead to worsening health but poor health also increases the chances that someone will become unemployed. “Being in good employment is protective of health. Conversely, unemployment contributes to poor health. Getting people into work is therefore of critical importance for reducing health inequalities.”

Once out of work people with mental health problems may find it difficult to get back into the workplace. With the already high rates of unemployment in the Borough it is unsurprising that so few of the population who are known to be in receipt of mental health services in the Borough are also in employment. Barking and Dagenham has
schemes in place to encourage people off benefits and back into work, including apprenticeship schemes.

Projecting future needs for mental health services

It is expected that there will be an increase in the numbers of people needing to access mental health services in the coming years. Modelled estimates predict that the number will increase by about 20% by 2020 (Figure 1.3).

Figure 1.3: Projected number of clients accessing mental health services, Barking and Dagenham, 2009-2020

<table>
<thead>
<tr>
<th>Year</th>
<th>Population</th>
<th>Number of people accessing mental health services</th>
<th>Number of Patients on Mental Health Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>175,239</td>
<td>10,140*</td>
<td>1,132</td>
</tr>
<tr>
<td>2010</td>
<td>177,321</td>
<td>10,260</td>
<td>1,145</td>
</tr>
<tr>
<td>2011</td>
<td>179,361</td>
<td>10,379</td>
<td>1,159</td>
</tr>
<tr>
<td>2012</td>
<td>183,407</td>
<td>10,613</td>
<td>1,185</td>
</tr>
<tr>
<td>2013</td>
<td>187,445</td>
<td>10,846</td>
<td>1,211</td>
</tr>
<tr>
<td>2014</td>
<td>191,475</td>
<td>11,079</td>
<td>1,237</td>
</tr>
<tr>
<td>2015</td>
<td>195,495</td>
<td>11,312</td>
<td>1,263</td>
</tr>
<tr>
<td>2016</td>
<td>199,508</td>
<td>11,544</td>
<td>1,289</td>
</tr>
<tr>
<td>2017</td>
<td>202,262</td>
<td>11,704</td>
<td>1,307</td>
</tr>
<tr>
<td>2018</td>
<td>205,001</td>
<td>11,862</td>
<td>1,324</td>
</tr>
<tr>
<td>2019</td>
<td>207,726</td>
<td>12,020</td>
<td>1,342</td>
</tr>
<tr>
<td>2020</td>
<td>210,437</td>
<td>12,177</td>
<td>1,359</td>
</tr>
</tbody>
</table>

*Figures in bold represent actual figures for 2008-9

Source: Based on GLA SHLAA 2010 population estimates

Inequalities in mental health

The risk to a person’s mental health varies by factors such as gender, age and ethnicity. Women are more likely to experience common mental health problems, and to attempt suicide, however men are more likely to actually commit suicide. One Scottish study on the incidence of severe mental illness, gives a figure of between 11 and 24 per 100,000 for the total population, depending on the definition used. However, men had a higher incidence than women (210 versus 60 per 100,000) at ages 15 to 24, and again at ages 25 to 34 (440 versus 175 per 100,000).

Severe mental health problems including psychosis often manifest themselves in late adolescence / early adulthood. However there is a gender difference in the age at which mental illness can manifest, with women on average presenting with psychosis at a slightly older age than men (31.9 years vs. 27.2 years). This is because women have two peaks in presentation – both men and women present in their early twenties, but women then experience a second peak in presentation between the ages of 45 and 54.

Locally, there are large ethnic inequalities in admissions to adult psychiatric inpatient services in Barking and Dagenham. The admission rate for White ethnic groups in Barking and Dagenham is 24% higher than the England average for all ethnic
groups, whilst the admission rate for Black ethnic groups in Barking and Dagenham is 54% higher than the England average.

Mental ill health is associated with socio-economic deprivation and Barking and Dagenham is the 21st most deprived borough in England. Considerable evidence is emerging of the impact of inequalities on mental health, but the relationship between these factors is not well understood. Although certain social circumstances may lead to mental health problems, it is also likely that experiences of long-term and severe forms of mental health will impact on the socio-economic status of individuals and so there is reverse causality. Employment is a major factor in a person's wellbeing and loss of employment and the financial security employment brings is associated with higher rates of mental and physical ill health. Unemployment in men of working age is a very significant factor in the development of depression and suicide.

Given the anticipated population increases and the high levels of deprivation in the Borough, there is likely to be a much greater demand on services that improve the mental health and wellbeing of Barking and Dagenham residents. This would include a wide range of services and initiatives such as those promoting sports and leisure, access to green space and volunteering.

As the largest employer in the Borough it is recognised that to support local employers and businesses that good practice in supporting employees to avoid sickness due to anxiety and stress must be locally understood so that this can be shared.

**What services exist?**

Barking and Dagenham Council provides mental health services in partnership with North East London Foundation Trust which is managed under a Section 75 agreement which formalises the arrangement under which both partners are equally responsible and accountable for services and functions.

Alongside these there are a number of commissioned services available that offer information, advice and advocacy to prevent further crisis and provide financial support or loans to vulnerable adults in the Borough, including Local Emergency support services, Credit union, Specialist Advocacy and Generic Advice, Hate Crime and Hate Incident Reporting and Enhanced Welfare Rights Advice.

Statutory Mental health services, including social care responsibilities, are provided by North East London Foundation Trust (NELFT) and this is governed by a Section 75 partnership agreement.

**North East London foundation Trust (NELFT)**

NELFT currently provide health care services which include community-based family health services and a broad range of specialist mental health services to people living in Barking & Dagenham. These have broadly been summarised below:

**Barking & Dagenham Access & Assessment Team (BDAAT)** is the single point of access for adults aged 18 to 65 needing community mental health services. They provide an initial mental health assessment.
The Barking and Dagenham Community Recovery Teams (CRT) provides specialist mental health services for adults aged 18 to 65 with serious and/or enduring mental health problems. This includes multi-disciplinary assessments to identify needs with each client/carer, community interventions and a whole range of community-based services formulated in a care plan and delivered through the Care Programme Approach (CPA) process. The team works with clients, carers and other agencies to promote recovery.

The Barking and Dagenham Crisis Resolution - home treatment team provides acute home treatment for adults aged 16 to 65 whose mental health crisis is so severe that they would otherwise have been admitted to a hospital. This integrated service for people with severe and complex mental and behavioural disorders such as schizophrenia, bipolar affective disorder, and severe depressive disorder is usually provided in the person’s own home. The team includes psychiatrists, psychologists, community mental health nurses, social workers, occupational therapists, support, time

The Barking and Dagenham Early Intervention or Estar service offers intensive and assertive support for people aged 14 to 35 who may be experiencing their first episode of psychosis. They support clients with their current problems, promoting recovery and maintaining wellness and helping them return to normal activities in their community life. Symptoms may include hallucinations, odd beliefs and ideas of reference, problems with thinking, paranoia as well as disturbances in sleep, appetite, mood and a decline in function. Early intervention in psychosis is based on research that suggests that intervening early and limiting the duration of untreated psychosis (DUP) can reduce the degree of harm to a person’s mental health.

The Improving Access to Psychological Therapies (IAPT) service provides psychological treatment for people with mild to moderate anxiety and depression that have a GP in Barking and Dagenham.

London Borough of Barking & Dagenham Commissioned Mental Health Provision

The Council currently oversee 3 mental health specialist supported accommodation contracts that were all recently retendered which provides 14 self contained flats and 10 shared units. The services are commissioned to provide support to service users with mental health needs who are unable to live independently in the community with a view to moving services onto independent living.

The Council also recently retendered and awarded a contract for Independent Mental Capacity Advocacy (IMCA) and Independent Mental Health Advocacy (IMHA) which are statutory services. IMCA service provides specialist independent advocacy service to people (aged over 16) who have no one able to support or represent them, who lack the capacity and/or have problems communicating.

IMHAs are specialist advocates who provide an additional safeguard for patients who are subject to the Act (who have been detained) as well as people with a mental health problem (not subject to the Act) but requiring support. IMHA support also includes providing information and exploring options for individuals. IMHA work will take place in the community and psychiatric hospital.
In April 2012 a new contract was awarded to Richmond Fellowship who provides specialist employment support service users with Mental Health needs. They are also commissioned to provide services users with social inclusion opportunities to prevent isolation and support recovery. The Council are also supporting a local User Led organisation (Starlight) who wish to provide peer support opportunities for local residents who also have mental health needs.

The Housing Assessment & Referral and assessment Team (HART) formerly (Tenancy Sustainment Team) provide single point of access to floating support provision to prevent homelessness and reduce crisis situations. They also provide early intervention and support on housing related matters to local residents. The service operates from Boundary Road which is provides temporary housing to vulnerable adults.

Current utilisation of services

In all commissioned supported accommodation, utilisation has remained steady over the past year with very few voids occurring. Locally there are 24 units available which provide supported accommodation which NELFT currently hold 100% referral access to, NELFT and have worked swiftly to accommodate voids as they have occurred. Due to limited move on options for residents throughput has been a struggle for both providers and both continue to work with Housing, NELFT and Adult Commissioning to explore available options to increase throughput.

The current Independent Mental Health Advocacy (IMHA) no longer provides general advocacy support for service users with known mental health needs. However it should be noted that specialist advocacy support is still available within a new structure which was newly commissioned as part of the new Information Advice and Advocacy model (please see Appendix 2)

Richmond Fellowship as a new provider in the Borough took on the role of merging existing service models which included a mental health day provision and specialist vocational support services which has been operation for just over 1 year. During the period 2012/13 the service has worked with around 185 service users to date of which those that requested support to return to work Richmond Fellowship have supported 15 service users to gain paid employment.

In terms of activity relating to NELFT services, please see Figure 1.4 below. It is clear that caseloads have increased over the last year for a number of services, particularly the BDAAT and IAPT.
Figure 1.4 NELFT activity

<table>
<thead>
<tr>
<th>Service</th>
<th>New referrals 2011-12</th>
<th>Caseload Sept 2012</th>
<th>New referrals 2012/13</th>
<th>Caseload Sept 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking &amp; Dagenham Access &amp; Assessment Team (BDAAT)</td>
<td>1748</td>
<td>434</td>
<td>1795</td>
<td>507</td>
</tr>
<tr>
<td>The Barking and Dagenham Community Recovery Teams (CRT).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barking</td>
<td>146</td>
<td>259</td>
<td>118</td>
<td>238</td>
</tr>
<tr>
<td>Dagenham</td>
<td>216</td>
<td>369</td>
<td>163</td>
<td>356</td>
</tr>
<tr>
<td>The Barking and Dagenham Crisis resolution</td>
<td>11</td>
<td>64</td>
<td>19</td>
<td>65</td>
</tr>
<tr>
<td>The Barking and Dagenham Early Intervention or Estar.</td>
<td>47</td>
<td>67</td>
<td>48</td>
<td>67</td>
</tr>
<tr>
<td>The Improving Access to Psychological Therapies (IAPT).</td>
<td>2728</td>
<td>489</td>
<td>2601</td>
<td>767</td>
</tr>
<tr>
<td>Number of people currently on a Care Programme Approach (CPA) for 12/13</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Generic Advice, Hate Crime and Hate Incident Reporting and Enhanced Welfare Rights Advice (see Appendix II)

The above provision includes following three elements:

1. **Generic Advice**

   With the removal of specialist advice from the provision of Legal Aid and the changes to welfare benefits the Council recognised the importance of accessible high quality advice especially in the case of areas evidencing high-levels of deprivation. This service is needed to enable residents to make informed personal choices on matters affecting their wealth, safety and well being. This includes a CAB office open 35 hours a week in Barking and 37, 3 hour sessions in Children Centres and Dagenham Heathway to ensure access across the Borough.
2. **Enhanced Welfare Rights support**

A proportion of the service capacity is dedicated to supporting the needs of adults and families who would meet the social care services eligibility criteria and require intense support. The service includes drop in sessions and home visits as well as support through the appeals process. Service users will also be trained, skilled and supported to provide the service in conjunction with paid staff. DABD (UK) has been subcontracted to deliver this element of the contract.

3. **Hate Crime reporting and case work**

To ensure hate crime and hate incidents and the adverse effect they can have on cohesion within the Borough is properly recorded and reported and that there is sufficient support for its victims.

**Specialist Advocacy (Appendix 2)**

The service aims to provide a clear point of access for vulnerable adults in the community requiring advocacy. The service is delivered through a framework of 3 advocacy providers (Voice ability, DABD and Royal Mencap) with the Gateway Service provider (ILA) managing the access and referrals into the service. It aims to provide advocacy to support clients through the social care complaints process. Provide issue based one-to-one advocacy support during a major life change or decision.

**Clinical Commissioning Group (Appendix 3)**

The CCG have developed a primary care depression pathway to help GPs to support patients appropriately depending on need. The pathway demonstrates clearly progression through 8 steps depending on risk and need which is monitored closely along treatment journey. The pathways support GP decision making and identifying the best course of action. Where medication is required, the pathway prescribes very specific medication and reiterates a patient centred approach.

The Select Committee were concerned to see what was felt to be an over-reliance on antidepressants as a method of treatment and felt that the pathway should include a ‘holistic’ approach to treatment, including more use of talking therapies.

**What has the demand been in previous periods of recession and austerity?**

In ‘Universal Credit: welfare that works’, published on 11 November 2010, the Government set out plans to introduce Universal Credit in 2013, aiming to simplify the benefits system, make ‘work pay’ and reduce worklessness and poverty. Although plans are to introduce Universal Credit from October 2013 it is important to consider the impact of the recession over the past 2 years.

Using the Indicators Framework developed by Institute of Health Equity (IHE) the data below indicates that in 2005 – 06 unemployment rates increased but steadily declined until 2009, overall unemployment is much higher in Barking & Dagenham...
compared to London and England; this would then impact on need for additional support services due to levels of deprivation.

*Figure 1.5 % Rate of unemployment of working age population*

![Graph showing unemployment rate as % of working age population for Barking and Dagenham, London, and England from 2004 to 2011.]

Data in relation to free school meals indicates that need has remained stable until around 2011 after which there has been a steady rise. However in comparison to England and London the need has remained similar to previous years it would suggest that that in the past two years the Borough appears to be suffering more financial hardship than earlier years.

*Figure 1.6 Proportion of primary and secondary school children eligible for free school meals*

![Graph showing proportion of primary and secondary school children eligible for free school meals for Barking and Dagenham, London, and England from 2008 to 2012.]

**Has demand increased since the start of the recession?**

Over the last 10 years the rate claiming out of work benefits in the Borough has consistently been at least 3% higher than the figure for London. Almost 6,000 of these residents (many on Incapacity Benefit or Employment Support Allowance) have been claiming for 5 or more years.
Local Emergency Support Service (LESS)

The Local Emergency Support Service (LESS) is a new service that has recently been commissioned to support local residents experiencing extreme financial hardship.

Legislative change

Crisis loans and community care grants as they were previously known no longer exist. Under the Welfare Reform Act 2012, the Government transferred some aspects of the discretionary Social Fund to Local Authorities to deliver in a way that meets local need, including delivery of the old crisis loan and community care grant support.

The Social Fund was previously administered centrally by the Department for Work and Pensions (DWP). From 1 April 2013 each Local Authority was required to design, administer and deliver emergency support to vulnerable residents experiencing financial hardship. In Barking & Dagenham it was felt that the voluntary sector had the necessary skills and experience to deliver such a service.

LESS provides:

- An assessment of the resident’s presenting needs
- An assessment of eligibility for access to the LESS – this will include an assessment about whether other available funds or services can be accessed by the residents in preference to the LESS
- Referral/signposting to other suitable relevant services
- Provision of direct support including cash/voucher payment to alleviate immediate hardship
- Facilitating access to support through a third party
- Support and voucher to open an account with the Liberty Credit Union

The allocation given to the Council to deliver the service is less than the level of funding on crisis loan and care grants in previous years. The total number of applications to date and reasons have been detailed below which shows that there was a marked increase in applications in July 2013.

To date the most common reason for application is to cover an immediate hardship due to a lack of food/electricity/gas or to cover a delay in benefit; this need has continues to steadily increase since the implementation of LESS in April 2013. This data would suggest the Borough residents are already experiencing the impacts of the recession and are experiencing financial hardship as they are struggling to meet basic needs. Those experiencing such financial hardship are often more likely to suffer from increased anxiety and stress.


**Figure 1.7 Hardship applications (2013)**

<table>
<thead>
<tr>
<th>Month</th>
<th>Food/Gas</th>
<th>Rent in advance</th>
<th>Furniture</th>
<th>Removal</th>
<th>Rejected</th>
<th>Pending</th>
<th>Total Applications</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>58</td>
<td>20</td>
<td>24</td>
<td>0</td>
<td>35</td>
<td>13</td>
<td>150</td>
</tr>
<tr>
<td>May</td>
<td>108</td>
<td>0</td>
<td>43</td>
<td>0</td>
<td>32</td>
<td>31</td>
<td>214</td>
</tr>
<tr>
<td>June</td>
<td>166</td>
<td>22</td>
<td>44</td>
<td>4</td>
<td>12</td>
<td>5</td>
<td>253</td>
</tr>
<tr>
<td>July</td>
<td>212</td>
<td>22</td>
<td>49</td>
<td>6</td>
<td>18</td>
<td>16</td>
<td>323</td>
</tr>
</tbody>
</table>

**Increase in mental health presentations in GP surgeries**

Using the latest available data from NHS information centre on the Quality and Outcomes Framework indicators, the graph below clearly highlights the steady increase in the number of Barking & Dagenham patients over the age of 18 presenting with depression, although this cannot be directly linked to the welfare reforms, along with the previous data discussed LESS etc if individuals are families experiencing increased financial hardships then it is possible that this will impact on their mental wellbeing.

**Figure 1.8 Prevalence of depression in GP registers**

![Prevalence of depression in GP registers, patients 18+, QOF 2011-12](image)

**Prescribing data**

The data provided below from the Clinical Commissioning Group (CCG) Medicine Management Team evidenced that since 2009/10 number of prescriptions for antidepressants have steadily increased, although costs of medication have reduced. This data provides evidence that potentially mental health needs have increased in the Borough.
However the report wishes to acknowledge that recent articles\textsuperscript{18} have indicated that there are raising concerns among doctors that pills are being over-prescribed. Most psychiatrists agree that antidepressants work for people with severe illness but are not supposed to be the first resort for those with mild depression. Counselling and talking therapies, such as cognitive behaviour therapy (CBT), are recognised as just as effective over the long term.\textsuperscript{19}

\textit{Figure 1.9 Total anti-depressant drugs prescribes}

<table>
<thead>
<tr>
<th></th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Antidepressant Drugs prescribed</td>
<td>78,813</td>
<td>90,445</td>
<td>102,337</td>
<td>113,234</td>
</tr>
<tr>
<td>Total cost</td>
<td>£419,858</td>
<td>£473,194</td>
<td>£457,383</td>
<td>£393,054</td>
</tr>
</tbody>
</table>

\textbf{Generic Advice, Hate Crime and Hate Incident Reporting and Enhanced Welfare Rights Advice}

Barking & Dagenham Citizens Advice Bureau (CAB) have seen a 25\% increase in welfare benefits enquiries when comparing Quarter 1 last year with Quarter 1 in 2013/14. The CAB Mental Health Project sees 150 clients per year and these clients are referred to CAB by the NELFT Community Mental Health Teams.

It is difficult to quantify the numbers of clients who are presenting with lower levels of mental distress at the CAB because this client group do not always identify themselves in this way through CAB client monitoring systems. At the CAB they are strengthening social policy team to enable them to gather evidence through client work to highlight the effects of the welfare reforms on local residents. Anecdotally CAB staff has reported an increase in the numbers of clients coming to the bureau who would appear to have some level of mental distress. At a recent Mental Health Opportunities Forum a member of staff from the IAPT service reported an increase in the number of people with lower levels of mental distress being referred to them by their GP.

Numbers of people accessing Generic Advice and Enhanced Welfare Benefits is around 1500 for quarter 1 of this year.

Income raised:

- Children Centres: £815, 769.16
- Enhanced Welfare Rights: £1,656,571.56 (total inc come raised £2,472,367.72, includes back dated claims)

\textsuperscript{18} Alarm over rise in antidepressant use, Society Daily, Nov 2013
\textsuperscript{19} Antidepressant use on the rise in rich countries, OECD finds, Guardian, Nov 2013
In the year April 2012 – March 2013, assisting clients with the Work Capability Assessment (WCA) process and challenging negative WCA decisions, comprised 25% of CAB work. CAB report that WCA process is stressful for clients and they usually express their anxiety and fear of attending the ATOS medical assessment to them directly. Typical comments from clients are “Why are they doing this? Don’t they know how unwell I am?” One client told CAB “this (being called for a WCA) has made me really ill. I felt I was doing ok until this but it has really put me back”. It has been reported that a number CAB clients have been put through this process twice in one year, even though the clients have long term health issues. This does not reflect the commitment that those with enduring mental health conditions will be exempt from the process.

Specialist advocacy

The service aims to provide a clear point of access for vulnerable adults in the community requiring advocacy. The service is delivered through a framework of 3 advocacy providers (Voiceability, DABD and Royal Mencap) with the Gateway Service provider (ILA) managing the access and referrals into the service. It aims to provide advocacy to support clients through the social care complaints process. Provide issue based one-to-one advocacy support during a major life change or decision.

Feedback gathered to date indicates that mental health service users are experiencing some frustration in accessing advocacy due to the revised model as they are no longer able to ‘drop in’ to access advocacy. Although this is primarily due to the misunderstanding of service users understanding of ‘Advocacy’ and what they can use the service for, historically service users would access advocacy for general information and advice which would now be provided under the new enhance model.

Referrals to date are highlighted in table below:

*Figure 1.10 Referral figures for 2013/14*

<table>
<thead>
<tr>
<th>2013/14</th>
<th>DABD</th>
<th>Royal MENCAP</th>
<th>Voiceability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qtr 1 total</td>
<td>20</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Qtr 1 no for dealing with financial affairs, employer or housing</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Qtr 2 total</td>
<td>48</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Qtr 2 no for dealing with financial affairs, employer or housing</td>
<td>19</td>
<td>0</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

Liberty Credit Union

The Liberty Credit Union was established in the Borough in October 2010. The Credit Union is a financial co-operative run for the benefit of its members. The Board of Directors are volunteers and were elected from the membership at the annual general meeting. The Liberty Credit Union provides a secure saving service for members. They also provide reasonably priced loans with free life and loan insurance. The Liberty Credit Union provides free financial advice and signposts
people to debt advice. In these ways members are helped to get control of their finances and are assisted to avoid less favourable products from other lenders.

Since 2010 the Credit Union has seen steady growth within the Borough and is based in Barking. The Credit Union also offer a payroll deduction service for Council staff to make it easier to save regularly.

In April 2013 the Council provided £60,000 of additional funding to the credit union to:

- Launch a community bond for Barking & Dagenham
- Provide a marketing post that will promote and raise awareness of the service
- Purchase and IT system that will provide a better and more efficient service
- Develop the Liberty Credit Union to be more self sustaining

In September 2013, 215 loans were allocated which equates to approximately 20% of current membership. It is the credit union norm that approximately 50% of the membership will lend off the credit union. However in terms of current performance this is showing a movement in loans. The first 200 members have a take up rate of approximately 12% in terms of loans the next 400 have a loan take up rate of 35% reflecting the usual Credit union pattern of saving to lend.

In 2013 (from January 2013) Credit Union have received £284,000 worth of deposits from Barking & Dagenham residents and repaid £228,000 of those shares back out meaning that Credit Union have received a net increase in saving of £56,000 averaging £8,000 a month. In terms of Loans in 2013 Credit Union have undertaken £105,000 worth of lending to Barking & Dagenham residents at an average of £13000 a month. Credit Union we have provided £86, 182 worth of loans to 71 residents.

The above evidences that the Credit Union is being utilised and is a much needed resource locally fir service users which offers a more secure saving option that supports those that may require access to affordable and ethical loans.

**Floating Support**

The Generic Floating Support Service provides housing support service to vulnerable tenants aimed at preventing homelessness and supporting people to manage and maintain independent living. Vulnerable tenants may include people with specific recognised support needs, for example a learning disability, older people, mental health or substance misuse problem or young people or households at risk of homelessness through harassment or victimisation or a those with a general need for support to manage a tenancy and prevent homelessness.

The data collated in 2013/14 which identifies the breakdown of service users based on main area of need has been collated in the table below. The numbers clearly evidences that the greatest need during both quarters has been in relation to benefits support and rent arrears which maybe early indications of impact of reforms.
Job centre plus

Services for those who are long-term unemployed and claiming benefits are being delivered under the government’s Work Programme. Payments are very heavily weighted to the delivery of sustainable job outcomes. Performance is below government expectations across the board but particularly so in respect of claimants with health problems.

A key aim for Jobcentre Plus is to work with local partners to prevent people moving onto the programme by ensuring that they move into work before becoming long term unemployed. They are also faced with supporting those who have now been on the Work Programme for two years and are returning to Jobcentre Plus. Anecdotal feedback from providers indicates that many of these have health problems.

There is some additional help available through Council-funded Job Shops though these are already at capacity and anecdotally there is an increase in the proportion of people with health problems seeking support. The Job Shop service also assists those not claiming any benefits. Barking & Dagenham as Olympic host borough is looking beyond the Games with a commitment to the Olympic legacy and how the Games will deliver a real and measurable impact on improving the employment opportunities for residents.

What are the impacts so far?

It would be fair to suggest that the impacts to date would suggest that individuals are experiencing greater levels of anxiety and distress due to the impact of the reforms. Early indications suggest that residents are experiencing financial hardship and require access to finances to cover the cost of basic food and energy bills. Whether this has directly attributed to the increase of presentations to GP surgeries and increase in numbers being prescribed antidepressants is more difficult to quantify but as suggested by numerous commentators the correlation is likely that residents mental health wellbeing maybe be adversely impacted by welfare reforms. This is often more likely in areas of deprivation therefore, Barking & Dagenham residents are more likely to experience mental ill health.

Figure 1.11 Floating Support Referrals 2013/14
Anecdotally it has been reported that the impacts of recent changes to benefits, bedroom tax, ATOS assessments etc have all negatively impacted on individuals. Voluntary sector providers are seeing increased number of residents that are experiencing levels of stress and anxiety. Those that are already known to mental health services are reporting experiencing crisis and increased need to access primary health services.

Foodbanks have reported increased take up of provision but are concerned that foodbanks are only limited to 3 vouchers within a 3 month period. After that if the family is referred again, the Trussell Trust via the foodbank will need to know what measures were put in place to support that family to improve their situation as the idea is for families not to become dependent on this resource. Ideally, the aim is that the children’s centre is able to support or signpost a client so that they do not need more than one voucher.

Feedback from the Job Centre plus is that residents that are affected by the benefit caps are experiencing higher levels of anxiety but that this is driven by their lack of understanding, however it was felt that when the appropriate information and support was provided enabling residents to make informed choices their anxiety levels appeared reduced. Furthermore residents have expressed their concern that universal credit being paid monthly will add further pressures on them to budget effectively and manage their finances which for some may prove to be extremely difficult for some residents and therefore may find themselves in financial hardship.

Mental health service users have reported that they feel further from the job market due to being out of work for long periods and that work opportunities are limited to low paid and more often unskilled work. To further add to their concerns anecdotally the general feeling is that Work Programme providers are ‘cherry picking’ those that are most likely to secure and retain employment. There are also concerns from practitioners that there are now increased numbers of long term mental health service users being moved JSA but still have significant health related needs and will therefore be more likely to experience benefit sanction if they are unable to actively seek employment. Many mental health service users have concerns that the introduction of universal credit will create further financial hardship due to cuts and need for budgeting to ensure that they can meet daily living expenses.

**What do commentators and researchers say about the links between the reduction in income and mental ill health?**

A substantial amount of evidence has shown an association between socioeconomic status and mental health problems. In short, poverty is both a determinant and a consequence of mental health problems. To date the research undertaken broadly indicates that that through the economic downturn there are three main intervening mechanisms causing health impacts: stress, frustration-aggression and ‘effect

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budgeting’, furthermore indications are that the economic down turn will impact differently on individuals and communities depending on resilience factors.

Social support, social networks and social cohesion can make people more resilient to an economic crisis from earlier evidence and studies it was identified that adverse health effects of rapid economic change were reduced substantially where people were members of social organisations such as trade unions, religious groups or sports clubs, illustrating the protective effects of social support. However, the economic downturn may force individuals to social exclusion if they have to sacrifice social activities.

A study for the Joseph Rowntree Foundation (JRF) looking into how people in the UK are coping with poverty during the aftermath of the current recession, shows that adapting to the rising cost of living creates a considerable stressful burden by having to economise on food, heating and travel, spending more time and effort on shopping and cooking, whilst having less nutritious food. Such effects occur disproportionately among people with disabilities, ethnic minorities, the poor, some women and single mothers (and their children), young unemployed and older people.

Income and education are key determinants of health. Those affected by the benefit changes or housing, etc, and who is in part time work, or in education, may find their ability to stay in work or education potentially disrupted. Education is vital as a way out of poverty and low self-esteem, initiatives that can support them residents are l be important, access to internet and childcare are can be barriers and are therefore important.

**Impacts on physical and mental states**

Studies have consistently shown that unemployment, which increases in economic downturns, is linked to poorer health. The links between poorer health have been explained through the psychological effects of unemployment (e.g. stigma, isolation and loss of self-worth) and the material consequences of a reduced income. Along with poorer mental health there is a reported decline in self-reported health and an increase in limiting long-term illness. However, there is some counter evidence which suggests that some chronic conditions and acute morbidity may actually decrease during economic recessions. Rapidity of economic change appears to be a key hazard to health. The direction of change seems less important.

**Mental health**

The strongest negative effect of an economic downturn is on mental health. There is consistent evidence that the economic downturn may increase suicide and alcohol related death rates, which can be seen as markers of deterioration of mental health - although suicide rates in England and Wales may be underestimated, as since 2001 narrative verdicts are increasingly being used. The majority of new disability claims are on the basis of mental health. Mental health can develop as co-morbidities among those initially out of the labour market through physical conditions. Those still in work but suffering from job insecurity may experience mental health effects that reduce productivity, through stress, anxiety and depression-related disorders. Worries about job losses have made stress the most common cause of long-term sick leave in Britain, and with employers planning redundancies there is most likely
to be a rise in staff mental health problems. Stress in the public sector is becoming a particular challenge through the sheer amount of major change and restructuring. At the same time there is a slowing in the jobs market. With the fear of being targeted for redundancy schemes over a quarter of employees are struggling into work when sick, according to a CIPD survey of nearly 2 million workers. People suffering from financial strain will be particularly at risk of mental health problems.

The diagram below (Figure 1.12), which has been adapted from the Liverpool Public Health Observatory (2009), strongly suggests that due to the high levels of deprivation in the Borough the income loss will further widen income inequality which will potentially impact on individuals stress levels and test their budgeting skills.

The model clearly illustrates that those with pre-existing mental health conditions are then faced with direct impacts i.e. ability to cope, self harm or suicide and mediated impacts such as the ability to maintain basic needs, all of which will affect their recovery and ability to sustain wellbeing. At worst it may trigger a crisis and the need for acute health care interventions and social care support.

For those not already known to mental health services the model suggests that economic downturn impact increases people’s risk of developing mental health problems and with consequences for health and wellbeing in later life.
Figure 1.12 – Accessing the impact of the economic downturn on health and wellbeing

*The strongest negative effect of an economic downturn is on mental health* – Liverpool PHO

The population in question

The Interventions?
- Income loss, especially amongst those already very disadvantaged
- Benefit reductions, especially amongst those already very disadvantaged
- Widening or income inequality
- Cuts in services

Pathways for impacts on population?
- Income
- Unemployment
- Housing
- Networks/relationships
- Safety/crime
- Cuts in services

Evidence shows these impacts on 3 main mechanisms:
- Stress
- Frustration – aggression
- ‘Affect budgeting’

**IMpacts**

People with existing mental health problems

Mediated impacts
via work, housing, engagement, travel ability
- Ability to cope with life events/stressors
- Ability to work
- Ability to own property
- Ability to stay in education
- Poor chronic disease outcomes
- Ability to afford a home
- Ability to maintain relationships/networks
- Ability to participate and gain self-esteem
- Ability for young people to get into higher education
- Chronic disease
- Suicide risk

People at risk of developing mental health problems

Direct impacts
- Incidence of illness
- Severity
- Ability to recover
- Ability to survive
- Ability to protect their health
- Ability to cope at home
- Hospital admissions (e.g., increase of 30% in numbers sectioned since 2009/10)
- Ability to avoid substance misuse
- Self-harm episodes
- Completed suicides (attempted suicides are up to 20 times more likely for unemployed young men compared with those in work with disability)
- WIDENING MENTAL HEALTH INEQUALITIES

Sources: Liverpool PHO – ‘Assessing the impact of the economic downturn on health and wellbeing’
The links between income and physical and emotional well-being are well established. In general, well-being is dependent upon good health, positive social relationships, and availability and access to basic resources. ‘The worst affected places face financial losses that are twice the national average and four times as much as the least affected places. As a general rule, the more deprived the local authority, the greater the financial hit’. Reform that reduce income to our poorest citizens are likely to impact on their ability to remain self supporting. The research\textsuperscript{21} has shown the following forms of impact of welfare reform are important to consider:

**Place impacts**

The welfare reforms are likely to impact differently on different places. The reforms are likely to have a disproportionate impact upon those areas with higher concentrations of benefit claimants, with subsequent potential knock on effects for local economies and demography. This could include the potential for loss (but also increase if employment is gained) in individual and family income and spending powers. There could also be population movement and migration due to changes in housing affordability. In particular, it was considered that benefit changes could cause pressure on people to move out of areas with a shortage of reasonably priced property, bringing increased strain on areas with more supply. Migration could happen over a wider area, with people moving in and out of boroughs, for example, to neighbouring boroughs.

The welfare reforms are likely to impact upon local services. There is particular potential for increased demand for specialist advice around finance, debt and benefits and emergency everyday living services in addition to impact on Adults, Children’s and Health services.

**People impacts**

The welfare reforms are likely to impact differently on different parts of the population. The research undertaken by DEMOS and the Institute for Fiscal Studies highlights the potential for certain groups that may rely on a combination of benefits to be adversely affected. This will include large families on low incomes; carers; disabled people; tenants in private rented accommodation, and people in social housing under-occupying their accommodation.

Disabled people and carers could be affected both through the reassessment for DLA and the move to PIP and through the shift to Universal Credit and the tie in of Carers Allowance. The impact of the WCA is likely to be highest on people with mental health problems who may not comply with the reassessment process or whose conditions are difficult to assess by generalists. The research suggested that there may also be a cohort of the population emerging, who move off benefits

\textsuperscript{21} First evidence on overall impact of welfare reform across Britain Sheffield Hallam University

\textsuperscript{22} The Centre for local Economic Strategies 2012
altogether, but are still in need of support. Therefore, the burden is shifted onto the informal economy and service providers.

**Indicators Framework developed by Institute of Health Equity (IHE)**

A set of indicators has been developed by the IHE and piloted by five local authorities: Lambeth, Greenwich, Lewisham, Southwark and Hackney. These indicators are designed to help track changes in the key determinants of health and the impact of the economic crisis on health and wellbeing in London.

The Indicators Framework covers four domains:

- Employment
- Income
- Housing, and
- Health and wellbeing

The domains and indicators have been generated through the IHE evidence review, discussions within the IHE team and with key stakeholders. The Indicators Framework comprises core indicators which will enable quarterly monitoring at local authority level and will provide useful information that is sensitive to short term change, vital for tracking impact and informing policy, decision making and commissioning. These indicators have been utilised to inform this scrutiny review. Locally, indicators are currently being developed to inform future planning.

### Recommendation

#### 4 Joint Working & Partnerships

The Committee considered the appointment of an Elected Member Champion around Mental Health and recommends that the Cabinet Member for Health considers the appointment of a Mental Health Champion on a fixed term basis on a specific issue, for example reducing the stigma of Mental Health. It is accepted that this would not be taken forward until after the elections in May 2014.

The Committee felt strongly that a holistic approach needed to be considered in the treatment options available to patients, particularly as the Committee felt that there was an over-reliance on antidepressants as a treatment option in the Primary Care Depression pathway. The Health and Wellbeing Board should give this consideration, as a result of which the Clinical Commissioning Group (CCG) could be tasked to provide evidence of effectiveness on the implementation of the Primary Care Depression pathway and explore inclusion of alternative therapies, particularly talking therapies within the pathway. As part of this work, the Committee would like to see the CCG undertake a review to determine whether the prescribing of antidepressants is in line with the practice in other areas.
The Committee were very positive about the availability of emotional health support for employees in Barking & Dagenham Council. It is recommended that the Council draw on this good practice to support local small employers to provide similar support to their employees.

5. Continued Measure of Need

The Committee are aware that within the Council a Welfare Reform Officer Group is coordinating the response to the austerity and the welfare reforms for Barking & Dagenham residents. The Committee supports their ongoing work to bring together data sources that describe the scale of the problem and wish to see this brought to Members at regular intervals. This is particularly important as this review has been taken at the early stages of welfare reform implementation and so significant further impacts are to be expected.


Commissioning Officers within the Council to continue to ensure that services that are commissioned by the Council continue to remain fit for purpose and meet the needs of residents in the Borough. These services include:

1. Enhanced Welfare Rights
2. Specialist Advocacy
3. Local Emergency Support services
4. Credit Union
Key Question 3: What can we do/are we doing to mitigate the likely impact?

What is already in place?

From the consultation undertaken to date, partners across the Borough are already implementing a wide scope of services that will support those that may suffer adverse mental health due to the impact of the Welfare reforms. There is also planning and research being undertaken at numerous levels which include strategic forward planning and operational delivery planning to meet and respond to emerging needs. In addition to what has already been discussed in ‘What services exist?’ and ‘Has demand increased?’ the following areas have been identified as areas of importance in terms of what is currently in place or under development.

Foodbanks – Children’s Centre Distributors

The foodbanks have been well established in the Borough for a number of years and provide short term, emergency food to an individual or family in crisis whilst a long-term strategy is developed to meet needs. The provision is supported by LBBD children’s centres that organise vouchers for the local 6 foodbanks which operate as independent organisations. There are also assessment processes in place to ensure that the foodbanks remain a short term measure and not relied upon by individuals or families as a longer term solution to their finances.

Housing

A number of assertive outreach activities have taken place led by Housing to engage those that have been identified to be affected by the reforms to help them consider options to avoid financial hardship due to cuts. Housing continues to monitor numbers of rent arrears and potential evictions due to reforms. In response to building more affordable homes the following is already underway and will benefit vulnerable residents that maybe more likely to be adversely effected.

- The Council has the biggest Council House building programme in the country with 1000 new homes planned in Riverside Barking.
- The Council has been successful in securing government funding to enhance the rent deposit scheme (Barking and Dagenham Lets) which will provide support to both landlord and tenants and will aim to secure sustainable tenancies.
- Where customers are seeking to re-locate to more affordable areas the Council will assist and support this arrangement.
Generic Floating Support

Generic Floating Support Service provides housing support service to vulnerable tenants aimed at preventing homelessness and supporting people to manage and maintain independent living. Vulnerable tenants may include people with specific recognised support needs, for example a learning disability, older people, mental health or substance misuse problem or young people or households at risk of homelessness through harassment or victimisation or a those with a general need for support to manage a tenancy and prevent homelessness.

In addition the Generic Floating Support Service provides support and assistance to households at risk of homelessness as a result of anti-social behaviour issues, people living in temporary accommodation who have an identified support need and resettlement support for people moving on from supported accommodation.

The Generic Floating Support Service support to individual households can vary in intensity and duration depending on need. The service will also include emergency intervention support to respond to an immediate and critical tenancy crisis.

It provides short-term services for vulnerable adults that are designed to either develop or maintain their independence. The service is provided to individuals wherever they live, and will ‘float off’ as and when the support is no longer required.

Job Centre Plus

The Job Centre Plus are providing satellite advice sessions across the Borough and have in place specialist staff to work with those affected by the caps, to date it has been reported that Job Centre Plus are meeting a 10% target of those who have been identified to fall under the benefit cap criteria to successfully support them to gain employment. Job Centre Plus are undertaking targeted work with those who have been long term unemployed and those returning back from Work Programmes who were unsuccessful in gaining employment. It was reported that there is a local growth in employment in hospitality and care and have been the main areas in which residents have gained employment.

Job Centre plus have clear targets in place to support residents into employment and retrain those that require up-skilling, this would include opportunities for mature residents. There is in place workshops and training opportunities for residents provided by the Job Centre offering additional focused support for vulnerable client’s i.e. mental health Learning Disabilities and young people to seek employment. Although there are specialisms within the Job Centre it was identified that they have not taken the opportunity to train staff in mental Health First Aid to ensure that staff have the necessary training to identify early indicators and signs for mental health.

The Council and the Job centre Plus continue to work together closely to ensure that targets are met and monitor outcomes.
Mental Health First Aid

The Borough has made a local commitment to deliver Mental Health First Aid (MHFA) training to 1500 frontline staff working with both adults and children over the next 2 years that are within the Barking & Dagenham partnership.

MHFA training is an intensive course, aimed at those without specialist mental health training. The course teaches participants to:

- Spot the early signs of a mental health problem
- Feel confident helping someone experiencing a problem
- Help protect a person who might be at risk of harm
- Provide help on a first aid basis
- Help prevent someone from hurting themselves or others
- Help prevent a mental health illness from getting worse
- Help someone recover faster
- Guide someone towards the right support
- Reduce the stigma of mental health problems

The project will also include the delivery of Youth Mental Health First Aid training which would be delivered to professionals who work with young people such as Children’s Social Care, Education, Troubled Families and the Youth Offending Service.

Key areas covered within the programme include:

- Promoting emotional, mental, social and psychological well-being
- Diversity and equality issues
- Child, adolescent and family psychosocial development
- Depression/Anxiety/Psychosis
- Suicide
- Self Harm
- Eating Disorders
- Bullying/Cyber bullying
- Substance/Alcohol misuse
- Promoting protective factors and good parenting

North East London NHS Foundation Trust (NELFT)

NELFT as discussed earlier provides mental health and community services for people living in the London boroughs of Waltham Forest, Redbridge, Barking and Dagenham and Havering. NELFT also provide community health services in south West Essex covering Basildon, Brentwood and Thurrock.

NELFT work with NHS partners and other organisations to provide services that support people out of hospital. Through close collaborative working NELFT seek to enable improved treatment at home or in the local community with the aim of reducing the number of people requiring urgent services and demand on acute care facilities.
NELFT continues to offer a Crisis 24 hour helpline for all residents and concerned others who provide a clinical response to all calls. NELFT are currently coordinating services with The Commissioning for Quality and Innovation (CQUIN) payment framework and GP annual physical health check ups which are currently measured. NELFT are also working with GP’s to have a link a worker with a focus on service development, service delivery and linking back into all NELFT led services.

The North East London (NEL) Recovery College\(^23\), aimed at empowering people with mental health problems to be experts in their own recovery, live well, and make the most of their skills and talents, has been launched by North East London NHS Foundation Trust (NELFT).

The Recovery College uses an educational approach to promote individual learning and development of expertise and recovery for people using mental health services and their carers. Running as a pilot from September 2013 until March 2014, the courses and workshops on offer are intended for people who are currently using NELFT mental health services. The concept and courses have been developed in co-production with people with lived experience of mental illness and NELFT staff.

The philosophy and culture of the Recovery College is based on the recovery principles of hope, control and opportunity, through:

- Valuing and making use of the knowledge and experience of the students attending each course.
- Sharing up-to-date and relevant information about recovery tools and how to use them.
- Having all courses co-developed and co-presented by peer trainers and staff trainers.

**Clinical Commissioning Group**

GP’s endeavour to provide a patient centred approach and aim build trusting relationships with their patients where they feel able to openly discuss their needs. When patients disclose that their concerns or needs are outside of the GP scope they aim to refer or sign post to the appropriate service. GPs spend time looking at the history of the patient to identify if there are any mental health problems to inform how they manage mild-moderate issues within general practice using the Primary Care Depression pathway. GP’s will offer guided self-help (monitored weekly to monthly), anti-depressants and some surgeries (though not many) offer counselling. If a patient requests psychological services they are advised to use the self-referral process.

**Employment and Skills**

The Council is working towards increasing access to work by working with large employers such as Asda and Sainsbury to ring fence jobs for those on long term unemployment.

Revenue & Benefits

To date resources have been focused on working with families who are affected by the benefits tax and to provide assistance with financial management. As discussed earlier there has been assertive outreach by Council staff to offer advice and support to those that has been identified as being affected to enable informed decisions by individuals to avoid potential hardship.

Big White Wall

Big White Wall is an online mental health and wellbeing service which is free, available 24 hours a day, 7 days a week. Big White Wall offers an anonymous, safe environment for residents (over 16) to share their concerns. The support network offers support through community, group and one-to-one peer therapy. The resource is for any resident who is going through a difficult time with family, work, money, relationships and needs some support. Big White Wall has been found to be particularly useful for people who find it hard to access traditional services.

Trained counsellors (known as Wall Guides) are online at all times, checking the content of the site and responding to posts. The website also offers clinical tests and further resources.

People can join by going to www.bigwhitewall.com and entering their postcode. This gives them access to the service for six months.

The Barking & Dagenham Public Health team are funding 300 Big White Wall registrations. Take up has been low but increased in October and there are currently 48 registered users (activity is not known). Public Health and Adult Commissioning are working together to promote the resource and an information and demonstration session is organised for the 12 November to show people how to use the site and allow people to ask questions.

95% of national members say Big White Wall has made them feel better, and 73% say that they disclosed an issue for the first time.

Play in the Parks

Funded by the Public Health Grant it is specifically for people experiencing poor mental health to increase opportunities for social inclusion, breaking down barriers to participate in ‘ordinary activities’ and access mainstream settings. The aim is that the residents are supported to make more use of local parks, green spaces, allotments, community gardens, and the ‘Play in the Parks’ initiative guided walks for people with poorer mental health.

Where are the gaps?

Mental Health First Aid (see below and previous Recommendations 2 and 4)

Through the scrutiny review process and feedback from service users and residents are very much in support of the Mental Health First Aid (MHFA) Council initiative. However, it is apparent that in order to support more residents to be employed
locally there will need to be engagement of local businesses and employers. Although some of this work is already underway, to offer them the opportunity to access the MHFA training would further enable mental health awareness and the platform to challenge potential negative stigma.

There is also an opportunity to target specific staff/organisations to access training if they are not already signed up:

- Job Centre Plus
- LBBD Housing particularly Estate Managers, Housing Advice
- LBBD Revenue & Benefits
- Voluntary sector

Volunteering Opportunities (see Recommendation 2)

The value of volunteering has been raised on a number of occasions during the scrutiny review process as a means to gaining the necessary skills to enable residents to become job ready but also that it is also a powerful tool to enabling recovery for those known to mental health services. The value that volunteering provides to both residents and the local community is immense, and where possible both voluntary and statutory services should aim:

- To support move on to paid employment and gain skills and training
- To increase volunteering resource capacity which could then provide frontline information advice and guidance to residents
- Increase volunteering opportunities for those already known to Mental Health services to aid recovery and maintain well bring
- Increase Time banking opportunities for all residents including those already known to Mental Health service as a means to maintain and aid recovery

Floating Support & HART (see Recommendation 5)

With potential increased need for additional preventative support it is necessary to consider the impact on services that provide early intervention and preventative support to residents. From the data already discussed there is clearly a need for floating support services that help residents to maintain tenancies and avoid homelessness. The current housing information already highlights the high rent arrears across the Borough and potentially as more individuals experience increased financial pressures, residents may find themselves at risk of eviction. However services such as HART will mean that floating support will be able to work with residents to take remedial action to avoid homelessness.

Enhanced Welfare Benefits Advice & Specialist Advocacy (see Recommendation 6)

As with floating support, the need for welfare benefits advice and specialist advocacy is apparent from the data provided so far and analysis of projected needs of impact of reforms on health in the future. Therefore, it is necessary to ensure that the above services continue to be monitored to ensure that residents continue to be able to access services when they need it most. Residents that are most vulnerable to economic changes are supported to also get quick advice on civil justice matters,
and could be an important primary preventive matter. In other words, ensuring good advice could prevent people at higher risk becoming stressed and ending up seeking help from primary care.

Residents will need ongoing support to claim Discretionary Housing payments where appropriate, currently this has been accessed via Enhanced Welfare Benefits Advice. In addition, remedial action to prevent financial hardship will primarily come via residents seeking information and advice regarding changes to their benefits thus enabling them to make informed decisions.

### Recommendation

#### 7. Mental Health First Aid Training

It is recommended that the Council and the Health and Wellbeing Board offer Mental Health First Aid to professionals across the partnership, as well as other local employers. It is suggested that the Health and Wellbeing Board may wish to look at whether the training that is offered to professionals across partnership organisations is sufficient and offer additional mental health awareness training if appropriate.
Conclusions

There is sufficient feedback through the scrutiny review process to conclude that the Welfare Reforms are already having an adverse impact on local residents, and will continue to have a significant impact as the full force of the Welfare Reforms is felt over the coming months. The Council, health partners and third sector organisations are already seeing many residents facing debt, housing issues and financial hardship with pressures on services and information and advocacy provision. Welfare Reforms are also more likely to impact residents of Barking & Dagenham due to existing levels of deprivation in the Borough.

It is more difficult to predict however if the impact of the welfare reforms and recession will trigger a diagnosed mental health condition; however evidence collated to date to inform the review suggests that there has been increased anxiety and feelings of depression in residents accessing services. Early indications show that increased numbers of residents are presenting to mental health services and GP surgeries with depression. Voluntary sector services have also anecdotally stated that they are experiencing a rise in residents demonstrating symptoms of stress, anxiety and depression when they are accessing their information, advocacy and advice services. Those already known to mental health services have reported that anxieties caused by changes to their benefits has lead to some experiencing a crisis and requiring them to access primary health care.

The scrutiny investigation carried out by the Health and Adult Services Select Committee (HASSC) has made some important initial steps into looking at the impacts of the recession and welfare reform on mental health and wellbeing in Barking and Dagenham. Significantly, the HASSC have identified some issues, gaps and concerns and these have been turned into a number of recommendations, found at the beginning of this report. In particular, these have included:

- The availability and accessibility of Information and advice to residents, practitioners and those already known to mental health services.
- The provision and encouragement of training, volunteering and peer support opportunities.
- The need for robust joint working and partnerships – particularly in considering a more holistic approach to the treatment options available for anxiety and depression.
- The importance of continuing to review and bring together data sets which measure the impact of the welfare reforms and the prevalence of mental health and wellbeing issues.
- The requirement for commissioned services to remain ‘fit for purpose’ and respond to changing mental health needs.
- Increasing the take up of Mental Health First Aid training to professionals across the Partnership.

Due to the fact that this scrutiny review has been undertaken during the early stages of Welfare Reform implementation, it is imperative that the Council, Health and Third Sector agencies continue to monitor the impacts of the recession and reforms on mental health and ensure that services are in place to address need. In particular, it
is suggested that the Council and the Health and Wellbeing Board should examine this report in detail and consider taking forward the recommendations put forward by the Committee.
Appendix 1 - Changes to Welfare Benefits

Universal Credit

The Welfare Reform Act will streamline some of the above benefits (with the exception of DLA and some elements of contributory ESA and JSA which are time-limited) and replace it with a single Universal Credit, designed to reduce the administrative burden and cut some of the fraud that currently exists in the system.

The Universal Credit will be implemented in phases from October 2013 on a means tested basis for people of working age, with change in amounts of benefit payment expected for current recipients of the above benefits and credits.

To be eligible for Universal Credit you must be 18 years old and not in education; have accepted a claimant commitment; and satisfy financial conditions on a claimant’s income and capital (if either is above a limit, likely to be £16,000, an individual will not be eligible). Universal Credit will be paid via a single monthly Payment in arrears and will be paid directly to the recipient including tenants of social housing. The amount of Universal Credit paid will depend on a claimant’s level of income and other family circumstances with reference to four elements:

- A standard allowance to cover basic living costs;
- Support for those with children;
- Support for housing costs;
- Support for what the Act terms ‘other particular needs and circumstances’.

From a combination of each of these elements a maximum payment will be calculated, which will then be reduced according to the earned and unearned income of the claimant.

Housing Benefits

Universal Credit will replace most existing benefits including Housing Benefit. The reform to Housing Benefit (or the housing component of Universal Credit as it will become) will introduce a new size criteria or ‘bedroom tax’ in the social rented sector whereby those under-occupying their property may receive a penalty of between 14% for one extra room to 25% for two or more rooms. Benefit will also be received directly by the tenant.

From April 2013, there will be a total benefit cap of £26,000 a year, equivalent to £500 a week for a couple or family; where this is exceeded Housing Benefit will be restricted to a nominal 50p a week. Where it is less, the amount of Housing Benefit paid must not take total income over the £500 a week level. A cap of £18,200 a year or £350 a week applies for single claimants. The policy only applies to people of working age.
Those who are working and receiving Working Tax Credit will be exempt. There is also a new cap on Local Housing Allowance (LHA) which sets LHA at the 30th percentile of Private Rented Sector (PRS) market rents in each Broad Rental Market Area (BRMA), as opposed to the previous median. Following the changes to LHA, the Department for Work and Pensions suggest that the average family in England will lose an average £22 a week. The changes to LHA for private tenants and Housing Benefit for social tenants are likely to have impacts upon the extent to which people can afford to live in certain neighbourhoods. There may be movements to seek cheaper rental property or people downsizing to social housing that better meets their requirements without under-occupancy penalties.

The Work Programme

The Work Programme (WP) is the Government’s key initiative for supporting people into employment. Whilst Jobcentre Plus retains its role as the core mainstream provider of employment support; individuals are referred to a Work Programme prime contractor once they reach a certain point in their claim of out of work benefits. Advisers can also refer claimants to the ‘Next Step’ service (now known as the National Careers Service). If claimants still need support they are moved onto the WP.

Work Capability Assessment and Disability Reassessment

The reassessment of Incapacity Benefit (IB) claimants through the Work Capability Assessment (WCA) has been ongoing since October 2008 for new ESA applicants and is now assessing the fitness for work of the UK’s 2.6 million claimants of IB. It is being carried out by private sector firm ATOS and claimants are being put into 3 groups dependent upon the outcome of their assessment:

1. ‘Fit for work’, where they have the opportunity to apply for JSA and actively seek employment;

2. ‘Support group’, where they are transferred to ESA as they are unable to work;

3. ‘Work related activity group’, where they receive the basic rate of ESA and support in getting back to work. Their medical condition will also be reviewed again.

4. DLA will not be included in Universal Credit, however, but it will be replaced with PIPs to streamline the system.
Generic Advice, Hate Crime and Hate Incident Reporting and Enhanced Welfare Rights Advice

Provider: Citizen’s Advice Bureau subcontracting DABD (UK)

- Help to make claims/appeals (form completion, advice)
- Advice – around poverty, debt, housing, discrimination, illness
- High quality generalist advice service for all borough residents over 16
- Generalist advice outreach Children’s Centres and Heathway centre
- Enhanced welfare rights support service for people (over 18) who would be eligible for social care services
  - Ensure a clear understanding of the level of hate crime and hate incidents and provide support for its victims.
  - Promoting service user led delivery
  - Home visits where necessary

Independent Mental Health Advocacy, Independent Mental Capacity Advocacy and Deprivation of Liberty Safeguards Service (IMHA, IMCA and DoLS)

Provider: VoiceAbility

- IMHA provide an additional safeguard for people (over 18) who are subject to the Mental Health Act. Work will take place in the community and psychiatric hospital. Areas of work include Mental Health Review Tribunals, care planning, services
- IMCAs provide support for particularly vulnerable people (over 16) who lack capacity (including people with a learning disability, dementia, mental health need, and brain injury) and who are facing important decisions around medicine, accommodation, services.
- DoLS aim to ensure that were a person (over 18) is deprived of their liberty in a health or social care setting this is least restrictive, response to risk and in the best interest of the client
- Provide advocacy around practical matters that influence the ability of service users to remain independent within the community which may include housing, employment, education or leisure issues
- IMCA Training to partners

Gateway

Manage referrals and payment for the framework

Specialist Advocacy Services including Social Care Complaints Advocacy

Framework: VoiceAbility, DABD (UK), Royal Mencap Society

- Provide case based advocacy for people (over 18) who would be eligible for social care services may include housing, employment, education or leisure issues
- Support clients (over 16) through the social care complaints process (complaint or grievance related to any aspect of social care described in Health and Social Care Act 2012) including supporting a client through to the Local Government Ombudsman
- Support people to engage with the council on decision making through consultation
Appendix 3 - Depression Pathway

Primary Care Depression Pathway

**STEP 1**
Screening in Primary Care (PHQ-9 + Risk assessment)

- **Widely persistent sub threshold depression**
- **Moderate depression**

**STEP 2**
Consider antidepressant treatment

- **Special conditions**
- **No comorbidity**
- **Long term conditions**
- **High risk of bleed or coagulopathy**

**STEP 3**
Refer to IAPT for screening assessment for psychological therapies for anxiety and depression.

- **IAPT booth**
- **CET (Counselling and one to one therapy)**

**STEP 4**
Refer to NELFT 0300 111 3038, Community Health Direct.

- **Consider starting a Seroquel 100mg a day**

**STEP 5**
Assess efficacy after 2-4 weeks

- **Consider increasing dose to 150mg**

**STEP 6**
Continue for 4-6 months at full treatment dose from remission

- **Switch to a different antidepressant (Appendix 3)**

**STEP 7**
Refer to NELFT

- **Consider potential interactions with concomitant medication and physical illness (Appendix B, BNF appendix 1)**

- **Diabetes**
  - Monitor blood glucose and HbA1c carefully when antidepressant treatment is initiated, when the dose is changed and after discontinuation of antidepressant.

- **Epilepsy**
  - All antidepressants:
    - Have been associated with hyponatraemia and seizures may occur if this is severe.
    - Can reduce seizure threshold and the risk is dose related.

- **Monitoring treatment**
  - Undertake PHQ-9 at every patient visit.

**Low risk of suicide**
See them after 2 weeks and regularly for 2-4 weeks in the first 3 months and then at longer intervals if response is good.

**High risk of suicide or are younger than 36 years**
See them after one week and then frequently until the risk is no longer clinically important.

Monitor closely:
- If experiencing side effects
- If requiring a different antidepressant.
- Short term treatment with a benzodiazepine is usually no longer than 2 weeks and use with caution in people at risk of falls.
Appendix 4 - Notes from Scrutiny Investigative Sessions

Please note that the session notes for the site visits to mental health services, the NELFT Service User Reference Group and Job Centre Plus, as well as the notes taken at the focus group session on World Mental Health Day, are not included in this report due to the fact that they contain personal comments made by service users.

Session with Statutory Services provided by the Council

Date of Session: 29 July 2013

Attendees:
- James Goddard, Group Manager (Housing Strategy - LBBD)
- David Graaff, Group Manager (Revenue & Benefits - LBBD)
- Terry Regan, Group Manager (Employment & Skills - LBBD)

Background discussion about Employment and Skills

| Works to secure positive outcomes for skills development for residents through its work with Job Centre Plus, Borough colleges and working with local businesses. |
| The Job Shop assists clients with job applications and skills development. Part funded by LBBD and based on direct delivery. |
| Employment and Skills do not support people on the government’s work programme as companies who participate in this are paid by results. |
| The Job Shop plays a key role in opening up job opportunities including jobs in construction, apprenticeships and working with companies who are developing new businesses such as ASDA and Sainsburys. Would like to reach a point where positions for local residents could be ring fenced. |
| Job Shop runs a community outreach project which provides advice in Children’s Centres. Work is delivered via DABD, Widow and Orphans and Harmony House and focuses on the 7 key hubs. |

Background discussion about Housing Strategy

| Deals with all housing across the Borough including supported housing, council housing, private landlords, capital programmes and homelessness. |
| Work in partnership with Children’s and Adult Services and have a link into health. |
**Background discussion about Revenues and Benefits**

Responsible for contact centres and One Stop Shops as well as the Revenues and Benefits services as well as the collection of Council Tax and rents.

First hand experience of implementation of the Council’s benefit scheme and Welfare Reform. Will be responsible for administering the Benefits Cap with effect from 12 August 2013.

David Graaff also acts an advisor to London Councils and attends the Steering Group for Universal Credit.

**Q&A SESSION NOTES**

**Of the people who access your service, are you able to say what proportion of people are suffering from minor and major mental health problems as a result of austerity and recession?**

**HOUSING**

Housing is seeing some numbers through Housing Advice and Homelessness where mental health incidences have increased through austerity.

It is an issue for the Borough as B&D has had the largest private rented sector in London for the past 5 years. The private rental market has doubled in size and if it continues at the current rate there will be 3-4 times more private rented houses than Council stock.

There is a massive demand for housing but not enough supply. Many people go to John Smith House seeking advice due to rent increases and/or they are trying to hold onto jobs and saying that the stress is affecting their health and wellbeing. There are currently around 12,500 on waiting lists for housing.

Housing try to measure instances where mental health can be related specifically to austerity. The private rented sector started growing before the crash so it is difficult to measure but there are links between poor health and jobs/overcrowding. Housing hope to get more evidence to help with the scrutiny review.

Rough sleeping numbers are currently at 12, the highest the Borough has ever had.

**REVS & BENS**

The information is not held but people are under pressures. There is an increase in the levels of council tax recovery activity due to people being behind in payments. In June 2013, 3 times as many received summons against June 2012. There are increasing rent arrears as people are hit by size criteria.
There are 900 people likely to be affected by the Benefits Cap. It is affecting people already and the Borough is also being affected by people migrating into the Borough as B&D is still slightly below the cap.

**EMPLOYMENT & SKILLS**

The numbers claiming incapacity benefit have been around 8,760 for quite some time. There are around 3,500 claiming for mental/behavioural disorders and this has been increasing since 2011/12. Many of these claimants will be moved over to the Works Programme. The unemployed job seekers allowance is also falling.

In B&D in the first 18 months since June 2011 to March 2013 of approximately 620 residents (40% of this number would have had mental health problems) only around 10 got into work.

On average, a person looking for work can spend one year with Job Centre Plus, two years on the Works Programme and then they are handed back to Job Centre Plus. Staff are advised that they are being handed back as a result of mental health problems.

Local Services do not have figures for the numbers of people with mental health problems but there are around 100-150 people on incapacity benefits registered with the Job Shop and Job Shop Community Project.

**Can you tell us what some of the main areas of concern are for people accessing your service?**

**HOUSING**

There is not enough available housing. There are over 12,000 on the waiting lists particularly for social rented/affordable housing. Housing are having to switch between building family homes (which create sustainable communities) and 1-2 bedroom homes where the demand is (creating a transient population).

Rents in the private sector are rising and we are edging towards the cap. Landlords don’t have to rent to people on benefits. On average landlords get 4-5 enquiries per property and therefore it’s easier for them not to deal with people on benefits.

There are different levels of rent, 80% are around £800 per month. The ‘Help to Buy’ scheme may create a housing bubble in time for the election.

**Has the bedroom tax had an impact?**

**HOUSING**
Housing identified people in Council housing likely to be affected by the Bedroom Tax and contacted them providing information and advice. They ensure that Housing Associations did the same thing. However, many people feedback that they will deal with it when it hits them. Housing is starting to see evidence of the effects of the tax now.

Temporary accommodation is expensive but the Council has a duty to provide it. Now looking outside of the Borough boundaries.

REVS & BENS

There are around 1,600 people in Council accommodation of which 60% are in rent arrears. There are also another 600 in Housing Association housing likely to be affected. People are struggling already, and there is a question of what the Council should do if they continue to struggle.

There are around 1000 households going through the debt process at the moment. From 12 August 2013 the Benefits Cap will affect around 900 families who will lose their housing benefits. Around 220 will lose more than £200 per week and more than 82 will lose more than £80 per week.

The worst affected are those in temporary accommodation, of which there are currently 63 families. They will lose their housing benefits and then become a cost to the Council.

With will some families who face losing up to £200 per week survive?

EMPLOYMENT & SKILLS

Need to look to move more people into work if the work is there.

How expensive is it for the Council to support a policy of temporary accommodation?

HOUSING

Potentially figures will go up again due to pressures in the system. The Council tries to minimise the use of B&Bs - there are currently just fewer than 200 in this type of placement. It is managed by having a maximum number of B&B placements. Barking Hotel is virtually 100% Council placements. Housing does try to place people in property with B&B’s being a last resort. There are placements outside of the Borough in Redbridge.

Families only stay in temporary accommodation for a few nights and there is a commitment for the family to be looking at sourcing accommodation outside of the Borough. People are very distressed and it is detrimental to their health and wellbeing.
It must make finding employment difficult for people if they have no permanent address.

**EMPLOYMENT & SKILLS**

This group is the most difficult to place and they are the ones who need the work the most.

**In your opinion, what do you think we need to focus on in the Borough to ensure that we are providing the right support and services for our residents?**

**EMPLOYMENT & SKILLS**

There is still a disconnect between health service provision, Job Centre Plus and Work Programme provision. There are three Work Programme contractors and a meeting between the Job Centre Plus and providers have taken place over the last few months.

The key action is how to improve support to people who are receiving support allowance. One of the providers set up a meeting with the IAP Service but felt that IAP many not have the right targets. Need to ensure that the work between health services and other services in the system are joined up and have shared targets.

Using planning agreements to try to ensure as many jobs as possible are given to residents. Would like to try to ring fence jobs for the long term unemployed and those with mental health conditions which both Newham and Tower Hamlets do.

**REVCS & BENS**

Universal Credit will be rolling out between now and 2017. The regional timetable is October 2013 for B&D. DWP announced it will give Universal Credit a “safe landing” so it may be delayed to ensure that it will work properly.

There are a number of areas that people will need support on:

(a) Money will be paid to one person in the household and this may create issues/tensions.
(b) Money will be paid monthly in arrears this will mean people will need to manage their money differently.
(c) Housing costs will be paid direct to the customer so there will be additional responsibility on that person to pay the rent. This could be problematic as the person who receives the money may not be the tenant.

Currently consulting on the Local Support Area Framework. There are a number of key areas in which the Council needs to look to provide better support:

(a) Help with support and mediation to access on-line systems to make a successful claim the first time round.
(b) Help with budgeting, financial and even relationship management.
(c) Getting people into work as they will be better off if they are in employment.
(e.g. it turns off caps on housing costs).

(d) Set out arrangements for emergency payments/loans for payments a month in arrears.

**HOUSING**

The Council has the biggest Council House building programme in the country with 1000 new homes being planned on Barking Riverside.

The Licence scheme means that every private landlord must have a licence, failure to do so will result in prosecution.

B&D have received £26,000 from British Gas to help with fuel poverty. This money is being used to put cladding and solar panels on Council Stock.

There are 200-600 empty properties. We are the 4th best in the country in turning around empty stock. We work closely with landlords to get a quick turnaround.

**Is it possible to find out how many people affected by changes to the benefits cap are likely to attend a food bank?**

Food bank would need to advise.

**Can you explain how council properties are allocated?**

**HOUSING**

Allocations are based on policy which the Council has little control over. There are roughly 12,000 on the waiting list, ¼ of those will have a housing need. The top priority will have the first choice followed by the residents who have been living in the Borough for 5-6 years. There are two officers who focus on under-occupation but it is a complicated area.
Session with Voluntary Sector Services

Date of Session: 29 July 2013

Attendees: Jan Davis, Interim Deputy Director (Citizens Advice Bureau)
Dominic Parkinson, Area Contract Manager (Richmond Fellowship)
Paul Kelsey, Samaritans

Citizens Advice Bureau (CAB)
CAB provides free, independent, confidential and impartial advice. They help people to resolve their problems including debt, benefits, employment and housing.

Richmond Fellowship
The Richmond Fellowship is a specialist provider of mental health services which aims to encourage, support and challenge people with mental health problems on their recovery journey. They also offer an Employment Services to help support people who have or are recovering from mental health problems and wish to return to paid employment, voluntary work or training.

Samaritans
The Samaritans provide an opportunity for people to speak openly about their problems and aim to reduce emotional distress and the incidence of suicide feelings and suicidal behaviour.

The Samaritans reported recently that money continues to be an issue with the recession “affecting the emotional health landscape of the country”. In 2012, one in six calls was recession-related. It notes a “hardening of despair” as people struggle to cope with uncertainty around employment, personal debt and other financial concerns.

There is no Samaritan branch in Barking and Dagenham.

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<th>Background discussion about CAB</th>
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<td>See clients in a lot of different ways. Use the Drop-in Service in Barking and 37 outreaches in Children’s Centres. Have a discreet project working with certain client groups e.g. mental health projects for people with severe and enduring mental health problems. Information is gathered through the project, drop-in service and outreach work and the data indicates that people using the drop-in service tend to experience anxiety and depression.</td>
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Offer a range of services for people with high to low needs including services to help with housing, floating support, day opportunities services and day employment services.

**Notes from Samaritans**

Based in Ilford but cover B&D. There for people in emotional distress/depression. Around 20% of people considering suicide. Contact is taken by phone, text, e-mail and face-to-face. Services are confidential and anonymous and callers are not asked to provide either their name or address if they do not wish to do so.

**Q&A SESSION NOTES**

**Of the people who access your service, are you able to say what proportion of people are suffering from minor and major mental health problems as a result of austerity and recession?**

**RICHMOND FELLOWSHIP**

It is already affecting people. Tend to see people who are already engaged in services but are finding that people are requiring a lot more support around austerity related issues especially as other services close. We are not taking typical referrals and required to take a more holistic approach.

It is difficult at the moment because services either have to forget about doing what they are commissioned to do and provide a more holistic approach or decline cases and refer them to mainstream services. It is not in the nature of services to turn people away so clients can end up with a watered down product as services try to provide broader support.

There is a lack of other services providing emotional and wellbeing support. We are finding that people can be reluctant to move on in recovery due to their being worried about the consequences of support in other aspects. They have no confidence that the right support will be available to help them.

**CAB**

The Mental Health project has up to 150 clients per year. Casework indicates that people often have more than one issues e.g. benefits and debt. People coming through the drop-in often have depression and anxiety.

Tried to run a report to identify if work has increased and the data shows that demand has gone up by 25% against last year for people coming to CAB with benefit and debt issues. Information relating to stress and anxiety as a result of austerity is recorded on case records but is not available via general reports.
CAB is geared up for the Welfare Reforms and dealing with bureau evidence forms and staff are asked to keep an eye out for people presenting with lower level distress.

**SAMARITANS**

It is difficult to quantify. We collect figures nationally but because callers are not asked to disclose addresses it is difficult to say what the local situation is.

There are more calls as a result of the Welfare Reforms, especially people worried about completing forms. We do speak to people who are already in the mental health system when their councillor/nurse is unavailable. Repeat callers often call because they are suffering from a bad spell at that moment in time.

**Question for Richmond Fellowship - Are day opportunity services increasing?**

**RICHMOND FELLOWSHIP**

The ‘Bridge Build’ and Community Link Services are available to get people engaging in mainstream services/activities e.g. joining a local library or attending classes. There are two members of staff supporting people in this way plus we also offer some group work.

**Question for Richmond Fellowship - Over what period of time are people in a programme?**

**RICHMOND FELLOWSHIP**

A year is a reasonable period of time. If they have not moved on by then it is because the client is either in a comfort zone or they are not receiving the right support.

**Can you tell us what steps have you taken to meet an increase in demand in the short and long term?**

**CAB**

There is a group of paid staff but generally rely heavily on volunteers. In the short and long term we need to recruit more volunteers and retain then as many get up skilled and then go onto paid work.

**RICHMOND FELLOWSHIP**

There is a danger of watering down the service. We always work above capacity and there is never a shortage of referrals. It is a question of how far you allow things to be stretched before quality is compromised. Typically operate between a quarter and a third above commissioned capacity.

**SAMARITANS**
Samaritans are all volunteers. There are 80 listening (65 active at the moment). There is a constant turnover of volunteers and we continually train people and advertise for new volunteers. There is a high drop out rate after training and students who volunteer often drop out once they complete their course of study. Volunteers are difficult to retain.

We used to get grants but that has reduced so we are looking for other areas of finance. Do hold awareness and fundraising events.

**Can you tell us about some of the different interventions that you use which have proved effective?**

**Samaritans**

Support is available by phone but we are also embracing email and texting services, the latter two are often used by young people. Face to face support is also increasing (3-5 per week) as well as an outreach programme.

At a national level, we are working in partnership with Network Rail to reduce suicides on railways. Staff are trained to look out for people under stress and keep an eye out on stations. There are posters on some platforms. Also have a relationship with Fords to undertake seminars and an open day.

**Question to the Samaritans – You state that you do not ask callers to disclose their names and addresses. If you need to contact a caller how do you do so?**

**Samaritans**

We do offer a call-back service if need be but the service tends to work on a one off basis. Even if someone does call back they will speak to a different volunteer and this avoids a caller developing a relationship with any one person. We will give a call-back at an appointed time (if the caller wishes us to do so) after a specific event to find out how it went.

**Question to CAB - Has there been an increase in service demand through the work that you do through Children's Centres?**

**CAB**

We get a different type of client coming through the Children’s Centres such as troubled families with a range of problems including debt and housing. We are also taking referrals through the Local Emergency Support Scheme which has broadened the client base.

Council Tax support is also increasing especially people who are going through the recovery process. We put together a list of their expenses to help them workout how they can pay and renegotiate repayment on low priority debt.
The Council could follow the examples other councils have adopted to help provide support. For example

(a) Not passing support payment directly to residents.
(b) Identifying vulnerable residents and not trying to get payment from certain types of residents.
(c) Leeds Council has designated some 2 bedroom properties as 1 bedroom properties.
(d) Looking to support people who have inherited tenancy of a family home (particularly those with a mental health issue) who now find themselves in a position of under occupancy and financial difficulty as a result of the bedroom tax.

We are seeing a lot of mental health patients who are stressed in the current climate. They can get into an obsessive spiral as they are concerned about losing their benefits. They tend not to see the positive benefits only the negatives. Mental health clients are negatively affected by poor decisions.

We need to encourage people to go back into work/training but the government work programmes tend to focus on getting people back to work by results. As a result providers cherry pick clients out of necessity who are job ready but we need to consider how we reach people who require different types of intervention.

RICHMOND FELLOWSHIP

We are offering a lot of one to one support to help understand client aspirations, choices available and their interests to help support and move people forward. Helping people identify things they are interested in is likely to produce a more successful outcome.

One full time member of staff can often support up to 60 people per year with 65% having a positive outcome. That approach works well for people from all backgrounds. Young people are far more likely to engage with a one to one advisor. We also designate certain staff to work directly with specific people and reduce their caseload to enable this.

Question to Richmond Fellowship – If a phone call is deferred what would be the follow up?

RICHMOND FELLOWSHIP

We are used to supporting people while they are getting support elsewhere so a joined up approach is important. However, have experienced a case of an individual took 8 weeks to get an appointment to see an assessment team and we saw that person becoming more stressed. A joined up approach isn’t always there to support people when they need it and this is often because of waiting lists. Because people are always providing the service they should the Richmond Fellowship often have to do it.
We have been told that we may see inward migration into the Borough from inner London Boroughs as a result of the changes to benefits and this could see a higher demand for your services. Are you seeing people with substantial needs accessing services as a result of these changes? Do you think that your service is resilient enough to meet this possible increase in demand? In Barking & Dagenham has seen a population increase between 10-15% over the past few years.

**SAMARITANS**

It is difficult to answer due to a lack of geographical data. Nationally, we are looking at a new phone system which will allow us to match a call to anywhere in the country where there is a volunteer available to take a call so people should always be able to get through to someone.

*Cllr McKenzie noted that he hoped this worked as in view of NHS111he wouldn’t want to see more stress on residents.*

**CAB**

It is a matter of quantity versus quality as there are so many people trying to access services. We are noticing an increase in people coming in from out of the Borough.

We look at the client and what is best for them and which service is best place to support them but there are difficulties with accommodating numbers approaching us for support. For example, Debt Case Workers have advised that appointment times have gone from 2 weeks to 1 month advance booking times. I found that where clients have to wait for 1 month for an appointment we were often left with ‘dead appointments’ and as a result I have advised workers not to book appointments more than 2 weeks in advance. In practice some clients are referred to other services but it is difficult to accommodate everyone.

Can you tell us what some of the main areas of concern are for people accessing your service?

**ALL**

It is the usual sorts of issues e.g. PIP, income maximisation and debt. Welfare Reforms are now factored into this as well.

**Question from CAB to Committee Members – Are you able to advise me what the discretionary housing budget is for the Council and how much is put aside to assist people with rent shortfalls?**

Jan Davis will send an email with additional information and a question about housing budgets to Lisa Hodges. This will be referred to Housing and a response sent to Jan Davis.
Session with Primary Care Services

Date of Session: 1 October 2013

Attendees: Dr Raj Kumar, Local CCG lead for Mental Health and Vice Chair of Barking & Dagenham CCG
Julian Buckton, CCG Senior Commissioning Support Manager Barking & Dagenham CCG
David Horne, Director of Operations, NELFT
Dr Sivasubramaniam Srikumar, Associate Medical Director for Community Recovery Directorate, NELFT
Dr Asif Bachlani, Consultant Psychiatrist, NELFT

Background - Dr Asif Bachlani
Mental Health is a problem in B&D. The Service aims to diagnose, patients are referred into the service. It is an integrated service which includes OT, social work and nursing.

Background - Dr Sivasubramaniam Srikumar
Barking Community Recovery Team covers severe mental illness and has a multi-disciplinary approach including a care programme approach and care coordination for each patient. Joins together the social, physical and psychological needs of the patient. There is no direct route in. Referred via the Access Team. There are teams in both Barking and Dagenham. Also an early Intervention and Psychosis service and a Community Clinic. We also deal with people who are difficult to engage with.

Background - Dr Raj Kumar
Dr Kumar is a GP with a special interest in Mental Health and worked until recently with the Access and Intervention Team.

Q&A SESSION NOTES

Have you seen more people coming into GP surgeries with poor mental health due to the impact of the recession and welfare reforms?

DR KUMAR
Mental Health is an important area for general practice. There are a lot more presenting with stress. GPs spend a lot of time looking at the history of the patient to identify if there are any mental health problems to allow them to be able to deal with the mild-moderate issues within general practice. Offer guided self-help (monitored weekly to monthly), anti-depressants and some surgeries (though not many) offer counselling. If a patient requests psychological services they are told to use the self-referral process. GPs are seeing the impact from the welfare reforms in general practice.

Are people presenting with stress related to austerity/financial issues?

DR KUMAR

It is difficult to tell whether it is due to life stresses or increased stress due to social problems such as unemployment, housing issues but people are seeking help much more.

If it is caused by financial circumstances due to government measures, should the response be cognitive therapies rather than anti-depressants?

DR KUMAR

Treatment is not about formal therapies/medications. Patients are advised to access any support options including family and work (e.g. being signed off work for a short period of time). GPs like to involve Occupational Therapy in the workplace and also with partner agencies when dealing with patients.

The HASSC did a site visit to the SURGE User Group and the opinion there was that when people visit their GPs the reaction to patients is to get on with it. What is the message to GPs in respect to dealing with this?

DR KUMAR

GPs are taught to be respectful to patients. To help clinicians in primary care the B&D, Havering and Redbridge CCGs have developed a ‘Primary Care Depression Pathway’ to help GPs to understand and be empathic. It is a local pathway which helps GPs to identify the best course of action. The pathway enables management in primary care for self help and is used in conjunction with other information on websites (for those who do not have access to a computer or are not computer literate there is an agreement with libraries to help people access the websites). There is also the self referral service via NELFT. Where medication is required, the pathway prescribes very specific medication not a “one size fits all” approach.

It is designed to recognise the problem and determine what to do about it to try to allow more management via primary care.

It is agreed that negative comments are not helpful.

DR SRIKUMAR
We do encounter issues of approach with many young doctors but do include in their training topics such as how to deal with people.

**DR KUMAR**

Primary care and NELFT attempt to destigmatise mental health problems and work with providers and GPs and patients to be sensitive to the pathway the patient wants to follow – it is a patient centred approach.

**What services do you signpost people to if they are feeling depressed or anxious, particularly if it relates to worries relating to the recession and welfare reforms?**

**DR KUMAR**

The relationship between the GP and patient is such that the patient needs to feel that they are in an environment where they can discuss things with their GP. There is usually an underlying cause such as relationships, jobs. Some things are within a GPs control if not then they will sign post as appropriate.

**What care facilities are available in the Borough?**

**DR KUMAR**

Providing care is vital for mental health problems. We work closely with LBBD to provide appropriate levels of care included care homes if that is required but it is decided on a case by case basis.

**How are you ensuring that the patient voice is reflected in the services that you commission? What feedback are you getting from Patient Engagement Forums and Service User Reference Groups about the quality and effectiveness of primary care mental health services?**

**DR KUMAR**

During the commissioning cycle we liaised with Patient Participation Groups (PPGs) and asked about mental health problems and therapies and access. This will help the CCG to commission better services.

A Task and Finish Group was set up in NELFT to help develop best practice which was comprised of service users.

The pathway reminded me of the GP audit carried out earlier this year, about patients who frequently attend A&E. A lot of people identified themselves as having mental health problems. In response LBBD agreed with the CCG to recruit 6 social workers for 12 months (which we are in the process of doing). The view of the CCG/GPs is that there are people who may not want/benefit from formal psychological/medication routes but have more practical problems e.g. finance or housing.
Social work is part of the re-enable funding and I welcome this as it is important when dealing with mental health problems as social workers work with GPs. The pathway is not the whole solution but is part of an answer.

There are issues with recognising the problem. The GP is the first line of defence. What is needed is a pathway which includes a social work approach? Maybe social workers can help people to cope better.

The pathway is an iterative process to put mental health high up on the GP radar. The first step is a discussion with the patient and to work in collaboration with NELFT who have access to aspects of mental health wellbeing.

Do GPs ask why people are stressed?

GPs discuss the problem with the patient and will do what they can to suggest where the patient might go e.g. Housing if it is a rent issue, look at options for signing someone off work for work-related stress. GPs offer patient’s choices and give patients choices as to how they choose to go forward.

Given that there isn’t any more money or additional resources available, how will mental health meet the challenges arising from the recession in delivering services and meeting increasing demand?

Demand is increasing. The BDAC Service in the first 6 months of the year saw a 19.6% increase in referrals against the same period last year. We don’t know why this is.

Resources are decreasing so there has been a reorganisation of management of services to a Borough based approach so that there is more joined up work especially around “Stay Connected, Stay Active...” The service is not a replacement but an adjunct and is encouraging people to do courses as part of the recovery process through opportunities such as the Recovery College.

In the past 2 years service reconfiguration has taken place and we have looked at patients attending out patients on a 6 monthly basis. These patients have now been reviewed and passed back to primary care. Discharging patients ready to leave the programme into recovery focussed areas mean that they exit the service within 6 months. We have had to find a way of working smarter.

How effective is our approach?
**DR KUMAR**

The ethos behind PPGs is very good and there has been much more patient involvement in shaping services. However, our next step is to ensure that patients from all backgrounds need to be encouraged to attend.

Looking to have more monthly meetings but PPG representatives can commit that much time which means that they are roughly quarterly. The CCG needs to take a hold of the process and hold the meetings at a more user-friendly time.

**ELAINE CLARK (Chair of the Improving Patient Experience Group, BHRUT)**

PPG attendance is usually good at the beginning but then drops off. PPGs are not available in all surgeries. It is a good approach to getting a point across and needs better advertising.

Arrangements in NELFT are strong in the SURGE group who are more vocal. SURGE is long established and good at changing membership. The H&WB Mental Health Sub-group is looking to build on a NELFT process and HealthWatch are doing something similar. We need to join up to prevent the same people attending multiple meetings. We could also consider virtual opportunities.

**DR SRIKUMAR**

There is also the Autistic Spectrum pathway which is being firmed up.

**DR KUMAR**

There are a number of community services in general practice and we would like to promote groups such as CAB, Carers of B&D etc.

**DR SRIKUMAR**

There is a group of mental health leads from all boroughs looking at the physical health needs of people with mental health illness and are responsible for looking after these patients.

The social aspect is very important at assessment stage. Need to look at areas such as employment and housing and take a more holistic approach including voluntary sectors.

**DR KUMAR**

Anti-depressants are not the sole treatment but can be a good response in severe cases.
Session with Councillor Maureen Worby, Chair of the Health & Wellbeing Board and the Portfolio Holder for Health

Date of Session: 13 November 2013

Attendees: Cllr Maureen Worby, Chair of the Health & Wellbeing Board and Portfolio Holder for Health

Q&A SESSION NOTES

At the last meeting, the Clinical Commissioning Group (CCG) showed the Committee a copy of the CCG Clinical Depression Pathway which leads to prescribing drugs. Could there be a focus or response from GPs apart from anti-depressives?

CLLR WORBY

There should be. There are challenges for the Health & Wellbeing Board (H&WB). Information and education for primary care providers and individual GPs is needed to raise awareness about the range of services available as regular practices of GPs are not always aware. Medication is an easy option and there needs to be alternatives. The CCG have commissioned work using Public Health grant.

Also need to raise awareness to residents to encourage them to say no to medication and look at alternative therapies.

The CCG can put pressure on GPs for a non-prescription route.

The Committee met with people as part of the scrutiny review and the feedback received shows that some people who visited their GP said that they were told to either “pull themselves together” or take anti-depressants. What can the H&WB/CCG do to address this?

CLLR WORBY

There are a number of pieces of work which is already being undertaken:

1. The Mental Health Sub-Group has been established which reports into the H&WB Board although it does tend to concentrate on those already in the system.

2. The Public Health Programmes Board does commission non-standard
approaches such as the Big White Wall, Mental Health First Aid Training and “Beating the Blues”.

3. Reablement Funding has enabled workers to go into clusters and supplement resources. GPs should be encouraged to use these to reinforce this work.

The H&WB has been exploring how services can be more available in a manner that residents can pick up. Better promotion is needed through the Council website and using formats such as a plan on a page. Other sub-groups are also looking at Mental Health such as the Children’s Sub-group and it is also one of my top priorities. There is a lot more that could be done although we are not doing a bad job we are just not getting people using the services enough.

Do you have information about what is and isn’t working?

CLLR WORBY

The function of the H&WB is not to monitor performance as this is done elsewhere (e.g. Public Health, Commissioning). The Board has agreed to an outcomes framework and the indicators are monitored by the sub-groups e.g. the mental health indicators are reviewed by the Mental Health Sub-group. Many are new bodies and will be better in subsequent years.

A recent CCG survey around the country found that Mental Health has risen as a priority at a national level.

There has been a lot of work done around monitoring mental health as well as a lot of research to look at specific information.

CLLR WORBY

There is a stigma attached to mental health and we need to consider how we package up this information.

Healthwatch - The conditions in peoples lives need addressing especially homelessness. Single people are not a priority on council housing waiting lists and landlords tend not to take them on. There are hundreds in the borough in this situation and housing issues add to anxiety levels.

Is there anything the H&WB can do to help people to get back into employment?

CLLR WORBY

We need to ensure that as a Council, we are providing support to employees who need it. We could put pressure on the CE to do an audit to find out how we are supporting people and then roll this out to other employers. We need to carry out this exercise ourselves so that we can promote it across the borough.
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