Notice of Meeting

HEALTH AND ADULT SERVICES SELECT COMMITTEE

Tuesday, 30 September 2014 - 7:00 pm
Committee rooms 3 & 4, Civic Centre

Members: Cllr Eileen Keller (Lead Member); Cllr Danielle Lawrence (Deputy Lead Member); Cllr Syed Ahammad, Cllr Sanchia Alasia, Cllr Abdul Aziz, Cllr Sade Bright, Cllr Peter Chand, Cllr Faruk Choudhury and Cllr Edna Fergus

Date of publication: 19 September 2014

Graham Farrant
Chief Executive

Contact Officer: Masuma Ahmed
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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 - To note the minutes of the meeting held on 5 February 2014 (Pages 3 - 8)
5. Scrutiny Review on Type 2 Diabetes Services: progress update (Pages 23 - 33)
6. The Joint Health Overview and Scrutiny Committee (Pages 35 - 44)
7. Implications of the Francis Report (Pages 45 - 61)
8. Transforming Services Changing Lives Programme (Pages 63 - 70)
   A presentation will be delivered by representatives of the Programme.
9. Intermediate Care Consultation (Pages 71 - 76)
   A presentation will be delivered followed by discussion, which will inform the
Committee’s response to the Consultation.

10. Work Programme 2014/15 (Pages 77 - 104)

11. Date of Next Meeting

19 November 2014
6.00pm
Chamber, Civic Centre, Dagenham

12. Any other public items which the Chair decides are urgent

13. 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.

14. 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
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81. Declaration of Members' Interests

As a patron of the local Sickle Cell Support Group, Cllr M McKenzie MBE declared a non-pecuniary interest in item 6 (Sickle Cell Disease in Barking and Dagenham).

82. Minutes - 12 November 2013

The minutes of the meeting held on 12 November 2013 were confirmed as correct.

83. Scrutiny of Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT)

(i) Sunrise A and B Wards: Enter and View Findings

Richard Vann (Healthwatch) presented the report to the HASSC explaining the Enter and View process, the findings of the inspection and the response from the Hospital Trust (BHRUT) to date.

The HASSC questioned the timeliness of the report from Healthwatch as the visit was conducted in August. Richard Vann stated this was the earliest the report could be scheduled to HASSC, he also highlighted the report had already been circulated and reviewed by the Integrated Care Sub-group of the Health and Wellbeing Board.

The HASSC raised concern over the RAG ratings on the Action Plan (Appendix 2) and asked if it could be updated since it was last done so in October 2013. Richard Vann stated that Healthwatch has asked for the action plan to be updated but has not received a response from the Trust. Stephen Burgess was not aware of this and would raise it with Trust colleagues to get a response.

The HASSC commented that the Action Plan produced by BHRUT did not give confidence that the Trust was tackling the issues raised by the Enter and View visit in a strategic way, in their opinion the actions did not attempt to rectify deeper underlying problems or issues. For example, the problems with providing patients with narrow straws has been addressed but was this symptomatic of other problems with helping people to eat.

The HASSC were concerned over the failure to maintain patients’ hygiene and their inability to reach calls bells for help. The HASSC was appalled
and found it unacceptable that these basic levels of care were unmet. The HASSC questioned whether these findings from Healthwatch were indicative of problems across the Trust. Stephen Burgess responded that all findings are part of an ongoing learning and a programme of continuous improvement for the Trust. He highlighted CQC’s positive findings with regard to nutrition and nursing care.

Sharon Morrow (Chief Operating Officer, B&D CCG) stated that the CCG’s Director of Nursing has reviewed the findings of Healthwatch and while there were concerns arising from the visit the no risks or contract monitoring issues to take forward.

(ii) CQC Inspection Report

Stephen Burgess (Medical Director, BHRUT) gave a presentation to the HASSC. The presentation outlined:

- Positive feedback from the CQC
- Immediate actions taken by the Trust following the inspection
- Detail about the special measures process
- Development of the Improvement Plan

The HASSC challenged the Trust on the CQC’s finding about failure to keep and update patients’ records. Stephen Burgess was equally disappointed with this finding and stated that there are good practices and systems in place to ensure good record keeping. The HASSC noted the e-handover system’s effectiveness at identifying the most ill patients to ensure that those patients get priority treatment.

The HASSC asked how the financial situation at BHRUT is impacting on the improvement programme. Stephen Burgess advised that the Trust is not expecting to receive financial support to help clear the deficit or manage PFI payments. However, the Trust is getting resource in terms of expertise to help with the programme of improvement. Stephen Burgess assured the HASSC that although the financial position is important the Trust is focussing on quality issues and not pursuing foundation trust status until those issues are resolved. The HASSC noted that the Trust is forecasting a larger deficit and it must deliver further cost savings.

The HASSC discussed the CQC’s finding that surgical wards in King George Hospital did not meet the standard for cleanliness and hand hygiene procedures were not always followed. The HASSC felt that senior clinical staff need to take responsibility for this finding and take immediate action if they see problems. Stephen Burgess pointed to the Trust’s good performance against spread of infection and assured the HASSC that the CQC’s finding was very specific relating to dusty equipment. As a practicing surgeon at the theatres at King George Hospital Stephen Burgess reassured the HASSC that standards of cleanliness were high. The HASSC noted action has been taken to remove old equipment.

The HASSC was concerned by the CQC’s finding that mortality rates are higher at weekends than at other times. Stephen Burgess highlighted that
this was a national problem not isolated to BHRUT. The HASSC noted that
the Trust has a 7 day working policy and between 8am to 4pm on
Saturdays and Sundays there are 6 consultants working across the wards.
Furthermore the Trust has extended the opening times of other parts of the
hospital (pharmacy, physio, and diagnostics) to give better care at
weekends. Stephen Burgess is personally conducting a review of the
Trust’s 7 day working patterns to identify gaps and ensure consultant
presence across the hospitals. It was noted that difficulty in recruiting
consultants is a barrier to a fuller 7 day service.

Marie Kearns (Healthwatch) discussed the patient experience at BHRUT
and commented on the low scores for the friends and family test. Stephen
Burgess advised the HASSC that staff are carrying out hourly comfort
rounds as one measure to improve experience. It was noted that long
waiting times are damaging to improving patient experience scores.

The HASSC asked what the Trust’s plans are for replacing Averil
Dongworth (Chief Executive) who is retiring in the spring. Stephen Burgess
informed the HASSC that there has been no appointment and it is yet
undecided if the post will be filled on an interim basis. Following the
leadership and governance review of Sir Ian Carruthers there may well be
further changes to the Trust’s executive team. The Trust expects clarity
once that review is complete and the NHS Trust Development Authority has
acted on the findings.

Stephen Burgess explained that due to special measures and the
involvement of the NTDA usual recruitment processes may not be applied
to appoint a new Chief Executive. The HASSC thought it was unusual that
the job would not be advertised publicly.

The HASSC sought assurance that the situation at BHRUT was not
comparable to that of Mid-Staffordshire. Stephen Burgess expressed his
confidence that BHRUT was not in a similar position to Mid-Staffordshire.
However, he added that the Trust is mindful of the quality issues found by
the CQC and is taking special measures very seriously. Stephen Burgess
highlighted the CQC’s positive findings to demonstrate BHRUT does not
have the same level of problems that were found at Mid-Staffordshire. He
also stated that the Trust has strengthened its culture of whistleblowing
which is having a positive impact on discovering and resolving issues.

84. Urgent Care Surge Pilot Scheme

Sharon Morrow (Chief Operating Officer, B&D CCG) introduced the report to the
Board. Further to the information outlined in the report, the following issues were
highlighted for Members’ attention:

- The CCG has engaged with the 9 practices that did not join the pilot
  scheme after the first round of applications. As a result two more practices
  have joined the pilot. Clinical Directors are meeting with the remaining
  practices to see how they can improve their urgent care access.
- Individual GP practices are responsible for the communications and
  marketing of the surge scheme. The CCG has issued posters and literature
for use and prescriptions are carrying message about surge appointments.

- The evaluation of the pilot scheme will analyse capacity and access to GPs, impacts on Walk-in Centre and A&E attendances, and patient experience.
- GP practices have submitted baseline information over a three month period giving the CCG intelligence about capacity at each practice.
- Despite surge appointments being offered the CCG have found that not all appointments have been taken up.

The HASSC asked the reasons why residents were not taking up surge appointments on offer. Sharon Morrow advised that analysis has not yet borne an answer to this question and offered that patients might not think of their GP as a first port of call.

The HASSC asked what impact the CCG has found on A&E attendances as a result of the pilot scheme. Sharon Morrow informed Members that due to a lag on A&E data the CCG has been unable to investigate the impact on A&E attendances. By May 2014 the CCG will have 6 months of data to judge the effectiveness of the surge appointments. It was also noted that A&E attendances can result in a patient being re-directed to their GP and this should be considered when the data arrives.

The HASSC asked what the plans were for the GP practice at Broad Street. Sharon Morrow updated that NHS England has started the re-procurement of GP services at the Broard Street site. Care UK, the current provider, will continue to operate until formal re-procurement is resolved. The intention is that new GP service at Broad Street will replicate the 8am to 8pm opening hours. Furthermore, services at Upney Lane Walk-in Centre will be enhanced and the CCG is bidding for the Prime Minister’s Challenge monies and hopes to make further investments if successful.

The HASSC commented on the variation between appointments offered in each locality and remarked on the drop in locality three and upsurge in locality 4. Sharon Morrow explained that locality 4 data is skewed because not all practices joined in time to give a full month of data in October, therefore November’s data looks high. The HASSC felt that the communications and marketing behind the surge scheme was inadequate, of limited reach and that as members of the public they were not aware of the appointments. Sharon Morrow explained that individual GPs were responsible for promoting the appointments and that the CCG has resourced a campaign over the festive period, this tied in with the NHS' wider campaign to reduce A&E attendances. The HASSC suggested that it might be better for the CCG to take responsibility for promoting the surge scheme appointments and centralise the communications and marketing to ensure consistency and reach.

On the issue of communications, Stephen Burgess (Medical Director, BHRUT) felt it would be difficult to develop a universal communications programme because not all practices are participating in the scheme so there is inequity of access to the surge appointments.

Healthwatch representatives informed the HASSC that they have been trying to track surge appointments and engage with patients who have used them. However the GP practices have ignored Healthwatch’s requests for information. Healthwatch would have expected more co-operation from GPs on this matter and
is reluctant to use Freedom of Information requests to get the information. Sharon Morrow was disappointed by this and offered to raise this through Dr Mohi (Chair of the CCG) to ensure co-operation with Healthwatch activities.

Richard Vann (Healthwatch) suggested that using prescription papers to carry messages about surge appointments might not reach people very well. In particular, where the message is carried on a repeat prescription it is unlikely to be read by the person. Sharon Morrow pointed out that the use of prescriptions to carry messages is just one of many ways in which GP practices are communicating with residents.

Richard Vann also challenged the strength of Patient Participation Groups (PPGs) in the process of testing the surge scheme model and asked how many people this involved. Sharon Morrow did not have the number of participants from the PPGs to give to the HASSC but agreed that PPGs need strengthening and better representation; this is a priority for the CCG.

The HASSC agreed to:

- Receive the full evaluation findings at a meeting in the new municipal year
- To write to Dr Mohi to raise concerns about the lack of communications strategy behind the Surge Scheme and request that a strategy is developed ensuring consistency of messages about surge appointments across all GP practices.

85. Sickle Cell Disease in Barking and Dagenham

Dr Ian Grant (Consultant Haemotologist, BHRUT) gave a presentation to the HASSC. The presentation outlined:

- Patient numbers and demographic profile in barking and dagenham and North East London
- Achievements of the Haemoglobinopathy Team
- The business case and QUIPP approach for the development of community based services
- The findings of a peer review conducted in 2013
- Opportunities and challenges

The HASSC asked Dr Grant what he feels the next challenges for sickle cell services are. Dr Grant stated that he would like commissioners to invest in blood transfusion machinery to speed up treatment times. Dr Grant also felt there is a need to develop better services for children who need a lot of care and support. Lastly, Dr Grant highlighted the lack of peer support mechanisms as an area of weakness.

The HASSC congratulated Dr Grant for his achievements in developing hospital and community based sickle cell services.

86. Scrutiny Review on the Impact of the Recession and Welfare Reforms on Mental Health
The HASSC approved the report at Appendix 1 as the final report.

The HASSC asked that the presentation of the final report is enhanced before it is published on the Council's website and shared/publicised.

The HASSC gave special thanks to Louise Hider (Business Unit Manager) and Lisa Hodges (Business Support Officer) for their work to prepare the report and their support throughout the review process.
HEALTH AND ADULT SERVICES SELECT COMMITTEE

30 SEPTEMBER 2014

Title: Update on the Scrutiny Review on the Potential Impact of the Recession and Welfare Reforms on Mental Health

Report of the Corporate Director of Adult and Community Services

Open Report

For Information

Report Author: Gillian Mills, Integrated Care Director, North East London Foundation Trust

Contact Details: Tel: 0300 555 1201 ext 65053 E-mail: Gillian.mills@nelft.mhs.uk

Accountable Director: Anne Bristow, Corporate Director of Adult and Community Services

Summary:

The findings of the Health and Adult Services Select Committee’s scrutiny review on the ‘Potential Impact of the Recession and Welfare Reforms on Mental Health’ were first presented to the Health and Wellbeing Board (HWBB) at its meeting on 25 March 2014.

In response to the review evidence findings the HWBB tasked the Mental Health Sub Group to produce a plan aimed to meet the seven recommendations for further exploration and action. The summarised recommendations are:

- Better information and advice is needed for residents, practitioners and those already known to mental health services on issues of welfare reform, advocacy, and support for coping with stress/depression/anxiety
- Recovery and resilience can be supported/built up through training and volunteering opportunities
- Peer support opportunities must be developed to prevent isolation, provide emotional support, and share knowledge
- The primary care depression pathway should be reviewed to ensure it is holistic and not overly reliant on the prescription of anti-depressants
- The effects of the austerity and welfare reforms should be measured so that the Council and its partners understand the impacts on residents and levels of need
- Demand on local services (advocacy, local emergency support, credit unions, welfare rights) should be closely monitored
- The Mental Health First Aid training programme should be delivered to professionals across the partnership and other local employers. Additional mental health awareness training should be provided where appropriate.
The action plan (Appendix 1) was presented to, and agreed by the HWBB at its July 2014 meeting with a request for six monthly progress reports. The action plan is presented to the Health and Adult Services Select Committee for discussion and comment.

**Recommendations**

The Health and Adult Services Select Committee is recommended to:

i. Note and discuss the implementation action plan (Appendix 1) from the Mental Health Sub Group

ii. Agree that an update on progress of the implementation of the action plan is scheduled to be presented at a HASSC meeting in six months’ time.

**Reasons**

It is best scrutiny practice for the select committees to monitor the progress of recommendations made as a result of investigations carried out previously to evaluate the impact of scrutiny reviews.

1. **Introduction and Background**

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 sought to answer three key questions:

- How are economic austerity and the Welfare Reforms impacting on our citizens?
- Will the austerity measures, reduction in income levels and increases in poverty lead to more mental ill health?
- What can we do, or what are we currently doing, to mitigate the likely impact?

1.3. 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. Through the evidence gathering the HASSC received information from a wide range of sources.

1.4. Following the evidence gathering, HASSC arrived at four broad conclusions:

- Welfare reforms are a source of anxiety (especially to those with pre-existing mental health issues).
- Financial hardship is putting strain on residents and is the cause of emotional distress.
- There is increased demand for voluntary sector services.
- There is increased demand for health service interventions.

1.5. In response to the evidence and findings the HASSC made 7 recommendations which are summarised as follows:
• Better information and advice is needed for residents, practitioners and those already known to mental health services on issues of welfare reform, advocacy, and support for coping with stress/depression/anxiety.

• Recovery and resilience can be supported/built up through training and volunteering opportunities.

• Peer support opportunities must be developed to prevent isolation, provide emotional support, and share knowledge.

• The primary care depression pathway should be reviewed to ensure it is holistic and not overly reliant on the prescription of anti-depressants.

• The effects of the austerity and welfare reforms should be measured so that the Council and its partners understand the impacts on residents and levels of need.

• Demand on local services (advocacy, local emergency support, credit unions, welfare rights) should be closely monitored.

• The Mental Health First Aid training programme should be delivered to professionals across the partnership and other local employers. Additional mental health awareness training should be provided where appropriate

1.6. The review final report was shared with stakeholders who participated in the review, the Mayor of London’s Office, London Councils, the Centre for Public Scrutiny and LBBD’s Strategic Welfare Reform Group.

1.7 The findings of the scrutiny review were first presented to the Health and Wellbeing Board (HWBB) at its meeting in March 2014, which resulted in a request that the mental health sub-group develop an implementation action plan to take forward the reports 7 recommendations and that this to be presented to the HWBB July 2014 meeting.

2. Implementation Action Plan and Governance

2.1 The development of the Implementation Action Plan (Appendix 1) has been overseen by the Mental Health Sub Group members. It has been discussed at each of the last three sub group meetings. The implementation action plan is currently being updated to reflect progress achieved to date based on information received from the responsible lead officers.

2.2 The implementation of the plan is intended to positively impact on the wider health and care systems and services to assist performance and quality improvements aimed at minimising the negative impact that current welfare reforms and austerity measures are having on the people experiencing mental health issues.

2.3 Under the Council’s agreed scrutiny processes the HWBB has responsibility for the implementation of the recommendations and action plan.

2.4 The action plan will be monitored at six-monthly intervals by the HWBB (for quality assurance purposes) and the HASSC (for measuring progress).
3. Options Appraisal

3.1 Not applicable as this paper is to inform HASSC of progress made in the development of an implementation action plan and agreed processes for quality assurance and measuring progress.

4. Consultation

4.1 A service user engagement event to mark World Mental Health Day has been organised in October, at which the recommendations arising from the scrutiny review and associated implementation action plan will be shared to obtain further service user feedback. This feedback will also inform a wider mental health needs assessment that is currently being undertaken within Barking and Dagenham.

5. Financial Implications

There are no financial implications directly arising from this report. However, there are a number of actions in the Action Plan where a further report may be needed to set out the potential costs and how these are to be funded, unless these are from within existing budgets from which savings will be sought. For example, action 5A is to consider enhancing the floating support services that help residents maintain tenancies and avoid homelessness, and to develop fully costed proposals if required.

Implications completed by: Roger Hampson Group Manager Finance (Adults and Community Services) LBBD.

6. Legal Implications

As this report is for noting, there are no direct legal implications relating to the report itself or in the action plan.

Implications completed by: Chris Pickering – Principal Solicitor (LBBD)

7. Other Implications

7.1 Customer Impact

The review found that residents were bewildered by the scale of the welfare reforms and did not always know where to go for support or understand the information they were given. Recommendation 1 should result in better information about welfare benefits advice and advocacy preventing the escalation of problems that might affect a person’s health and mental wellbeing.

It is expected that the delivery of recommendations 2 and 3, which seek to build resilience and support people’s recovery through training, volunteering and peer support, will have a positive impact on those experiencing emotional distress or mental ill-health.
7.2 **Health Issues**

The public’s mental health and well-being is a complex area of policy. It demands our attention because focusing more on mental well-being and improving people’s mental health is the right way to go. This report shows that improving mental well-being is a significant and growing priority in spite of, and because of, the poor economic situation we find ourselves in. It is clear that building community resilience and improving mental well-being will improve social, health and economic outcomes. The pending refresh of the Joint Health and Wellbeing Strategy should continue view the causes of our major health challenges with a mental health lens – from obesity to drug and alcohol misuse to smoking. Without a focus on how people think, feel, behave and relate (their mental wellbeing), we will not make the progress we need to.

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

Health and Adult Services Select Committee’s scrutiny review on the ‘Potential Impact of the Recession and Welfare Reforms on Mental Health’:


**List of appendices:**

Appendix 1 Action Plan: Scrutiny Review on the Potential Impacts of the Recession and Welfare Reforms on Mental Health
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SCRTUINY REVIEW ON THE POTENTIAL IMPACTS OF THE RECESSION AND WELFARE REFORMS ON MENTAL HEALTH ACTION PLAN

This Action Plan should be read and considered in conjunction with the Scrutiny Review report on the potential impacts of the recession and welfare reforms on mental health action (http://www.lbbd.gov.uk/CouncilandDemocracy/Scrutiny/Documents/HASSC%20Final%20Review%20Report%20050214.pdf).

<table>
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<tr>
<th>Recommendation</th>
<th>Actions required to achieve recommendation</th>
<th>Measure of success</th>
<th>Lead responsibility</th>
<th>Date actions due for completion</th>
<th>Date actions completed</th>
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<tr>
<td><strong>Recommendation One:</strong> Improved access and quality of Information and advice about services offering benefits advice and advocacy, and support for coping with stress/anxiety/depression should be readily and widely available to:</td>
<td>1A) Agencies and organisations to complete mapping exercise to identify gaps in current information and advice provision. The Mental Health Sub Group to review the mapping exercise findings, determine next steps for any identified gaps and feed into consultation below.</td>
<td>Mapping exercise completed, gaps in information and advice provision analysed and next steps identified.</td>
<td>NELFT LBBD Primary care (GPs, pharmacists etc.) CCG BHRUT Job Centre Plus</td>
<td>December 2014</td>
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<td>1B) Through public and service user consultation, establish preferred mechanisms and formats for ensuring timely information and advice is readily available.</td>
<td>MH Sub Group to host a service user engagement event and to have commissioned user and carer feedback to inform information and advice formats.</td>
<td>MH Sub Group</td>
<td>December 2014</td>
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<td><strong>Recommendation Two:</strong> To build recovery and resilience, prevent isolation and increase social capital through training and volunteering opportunities.</td>
<td>2A) To promote volunteering opportunities available within the Sub Group member organisations.</td>
<td>Evidence of member organisations having promoted volunteering, demonstrated by a % increase (baseline to be determined) in numbers of volunteers with mental health problems within each organisation’s workforce.</td>
<td>Local third sector groups NELFT LBBD CCG BHRUT Job Centre Plus</td>
<td>December 2014</td>
<td>Baseline to be established by 30 August 2014</td>
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<td>2B) Volunteer Plus to promote the role of volunteers to local statutory and small/medium business enterprises</td>
<td>% increase (baseline to be determined) in the number of volunteers with mental health problems within Barking and Dagenham.</td>
<td>Volunteer Plus</td>
<td>Quarterly reports to MH Sub Group from September 2014</td>
<td>Baseline to be established by 30 August 2014</td>
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<td>2C) Review and alter LBBD, NELFT, BHRUT, CCG websites to promote role of volunteers within these organisations</td>
<td>Evidence of volunteer opportunities on member organisations’ website pages.</td>
<td>NELFT LBBD CCG BHRUT</td>
<td>December 2014</td>
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<td><strong>2D)</strong></td>
<td>Develop fully costed proposals for a training programme for volunteers in B&amp;D.</td>
<td>Training Programme commissioned for volunteers to access. Volunteer Plus to conduct training evaluation and report % levels (baseline to be determined) of volunteer satisfaction, confidence and competence and numbers of people reporting that they feel ‘job ready’.</td>
<td>Volunteer Plus NELFT LBBD CCG BHRUT</td>
<td>Quarterly reports to MH Sub Group from September 2014</td>
<td>Baseline to be established by 30 August 2014</td>
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<td><strong>2E)</strong></td>
<td>Promote utilisation of the North East London (NEL) Recovery College to Barking and Dagenham Mental Health service users</td>
<td>% increase (baseline to be determined) in the number of service users accessing the Recovery College.</td>
<td>NELFT</td>
<td>Quarterly reports to MH Sub Group from September 2014</td>
<td>Baseline to be established by 30 August 2014</td>
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<td><strong>2F)</strong></td>
<td>Ensure continued take up and evaluation of Mental Health First Aid – see Recommendation 7 actions below</td>
<td>See Recommendation 7 actions below</td>
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<td><strong>2G)</strong></td>
<td>Commissioners to continue to ensure that the mental health specialist vocation support service is robust and providing good outcomes in consultation with service users. Commissioners to consider re-investment when the contract is up for re-tender.</td>
<td>Continued consultation with service users and contract monitoring and evaluation. Consideration given to re-tendering in 2015.</td>
<td>LBBD Commissioning</td>
<td>Quarterly reports to MH Sub Group from September 2014</td>
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<td><strong>Recommendation Three:</strong></td>
<td><strong>3A)</strong> Review services commissioned and provided within B&amp;D e.g. Big White Wall that are aimed at younger people.</td>
<td>Review and evaluate current services and identify next steps.</td>
<td>LBBD CCG Public Health</td>
<td>October 2014</td>
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<td><strong>3B)</strong> Enhance use of peer trainer contribution in the co-production and delivery of the NEL Recovery College.</td>
<td>Evidence of increased contribution (baseline to be determined) of peer trainers in development and delivery of recovery-focused training, workshops and courses.</td>
<td>NELFT</td>
<td>Quarterly reports to MH Sub Group from September 2014</td>
<td>Baseline to be established by 30 August 2014</td>
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<td>Recommendation</td>
<td>Actions required to achieve recommendation</td>
<td>Measure of success</td>
<td>Lead responsibility</td>
<td>Date actions due for completion</td>
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<td>3C)</td>
<td>Support local third sector organisations e.g. Alzheimer’s Society to develop role of peer educators in services they offer in B&amp;D.</td>
<td>% increase (baseline to be determined) in number of peer educators available to offer information, advice and services as required.</td>
<td>LBBD Healthwatch</td>
<td>Quarterly reports to MH Sub Group from September 2014 Baseline to be established by 30 August 2014</td>
<td></td>
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<tr>
<td>Recommendation Four: Joint Working and Partnerships</td>
<td>4A) The Cabinet Member for Adult Social Care and Health to consider the appointment of an Elected Member into a role as Mental Health Champion on a fixed term basis.</td>
<td>Evidence of the appointment of the Mental Health Champion</td>
<td>Cabinet Member for Adult Social Care and Health</td>
<td>September 2014</td>
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<td></td>
<td>4B) Review the primary care depression pathway to ensure this is holistic and not overly reliant on the prescription of anti-depressants.</td>
<td>Complete evaluation of the Primary Care Pathway. Evidence of an enhanced holistic approach to managing depression, including alternative therapies e.g. CBT, within the pathway.</td>
<td>CCG Mental Health Clinical Lead NELFT</td>
<td>March 2015</td>
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<td>Recommendation</td>
<td>Actions required to achieve recommendation</td>
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<td>4C)</td>
<td>Determine whether the prescribing of anti-depressants is in line with practices in other boroughs.</td>
<td>Complete benchmarking exercise with comparator Boroughs. Medicines Management team to complete a review report of anti-depressant prescribing and determine next steps.</td>
<td>CCG Medicines Management Team</td>
<td>December 2014</td>
<td></td>
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<tr>
<td>Recommendation Five: The effects of austerity and welfare reforms should be measured so that the Council and its partners understand the impacts on residents and levels of need</td>
<td>5A) To consider enhancing the floating support services that help residents maintain tenancies and avoid homelessness and develop fully costed proposals if required. The MH Sub Group to be kept informed of the financial implications associated with any proposals associated with offering enhanced floating support.</td>
<td>Quarterly reports received from the LBBD Housing service to the MH Sub Group outlining impact of welfare reforms and austerity on B&amp;D residents with known MH problems. Review current floating support services and model proposals for an enhanced floating support service if required.</td>
<td>LBBD Welfare Reform Officer Group</td>
<td>Quarterly reports from September 2014</td>
<td>October 2014</td>
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<tr>
<td>Recommendation</td>
<td>Actions required to achieve recommendation</td>
<td>Measure of success</td>
<td>Lead responsibility</td>
<td>Date actions due for completion</td>
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| Recommendation Six: Continued monitoring of Local Services | **6A)** Commissioning Officers within LBBD to continue to ensure that services commissioned by the Council continue to remain fit for purpose and meet the needs of residents in the Borough. These services include:  
- Enhanced Welfare Rights  
- Specialist Advocacy  
- Local Emergency Support services  
- Credit Union | Continued consultation with service users and contract monitoring and evaluation. | LBBD Commissioning | Quarterly reports to MH Sub Group from September 2014 |  |
<p>| Recommendation Seven: Continued take up and evaluation of Mental Health First Aid | <strong>7A)</strong> Mental Health First Aid to be provided to non-mental health professionals across the partnership, as well as other local employers. | Track number of staff who have completed training. Mental Health First Aid delivered to 1000 non-mental health professionals. | Public Health Commissioning | Quarterly reports to MH Sub-Group from September |  |</p>
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<tr>
<th>Recommendation</th>
<th>Actions required to achieve recommendation</th>
<th>Measure of success</th>
<th>Lead responsibility</th>
<th>Date actions due for completion</th>
<th>Date actions completed</th>
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<tr>
<td>7B)</td>
<td>MH Sub Group to receive training evaluation report that demonstrates the benefits and impact for staff and MH patients/carers.</td>
<td>Two cohorts to be evaluated six months after they receive training by Public Health (August 2014 and January 2015) to review impact. Analysis to be reviewed by MH Sub Group and determine if additional MH awareness training is required.</td>
<td>Public Health Commissioning</td>
<td>September 2014 and February 2015</td>
<td></td>
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</table>
Title: Diabetes Scrutiny Update Report

Report of the Corporate Director of Adult and Community Services

Open Report | For information

Report Author: Ross Kenny, Principal PH Specialist Healthcare
Contact Details: Tel: 0208 227 2799
E-mail: ross.kenny@lbbd.gov.uk

Accountable Divisional Director: Matthew Cole, Director of Public Health

Accountable Director: Anne Bristow, Corporate Director Adult and Community Services

Summary:
This report updates the Health and Adult Services Select Committee on the progress of implementation of the recommendations made by the Committee in 2012/13. Collaborators and stakeholders have worked in a very positive manner to start to achieve change. There is still work to be done but there is now a strategic group (the Diabetes Sub-Group of the Planned Care Steering Group) that can take forward the ongoing work that needs to focus on identifying diabetics within high risk groups in primary care and elsewhere together with the need for NHS England to address the problem of some underperforming GP practices.

Recommendations
The Health and Adults Select Committee is recommended to note that the Health and Wellbeing Board received the Diabetes Action Plan in July 2014. The Health and Wellbeing Board recommend that the Action Plan is now complete and ask the HASSC to discuss the final update of the Action Plan.

Reasons
It is best scrutiny practice for the select committees to monitor the progress of recommendations made as a result of investigations carried out previously to evaluate the impact of scrutiny reviews.

1. Introduction and Background
1.1. Barking and Dagenham has one of the highest rates of Diabetes in London and high rates of complications including kidney failure and amputations. Disease control measures including sugar levels are variable with patients at some practices having excellent results and others having significant room for improvement.
1.2. The actions suggested by the Health and Adult Services Select Committee as part of a scrutiny review it undertook in 2012/13, concerning diabetes have been worked upon for a year and most areas show significant improvement.

1.3. In addition, the review of local diabetes services especially in the Integrated Diabetes service has identified some subtle but important discrepancies from best practice which could be worked upon by NHS Barking and Dagenham Clinical Commissioning Group’s commissioners.

1.4. The report and recommendations were approved by the Health and Wellbeing Board in July 2014 and requested to be presented back to the Health and Adult Social Care Committee.

2. **Proposal and Issues**

2.1 The Diabetes Action Plan been completed (table 1) and been embedded in the Barking and Dagenham, Havering and Redbridge Integrated Care Coalition Five Year Strategy. Apart from the progress outlined in table 1, the action plan has resulted in general improvements in communication, collaboration and pathways:

- NHS Barking and Dagenham Clinical Commissioning Group (CCG) has prioritised diabetes clinical teaching and training for Practice Nurses and GPs from the allocated Public Health Grant.
- The CCG has appointed a Director of Primary Care Improvement (Sarah See) which should improve aspects of performance and organisation.
- The CCG has formed a Primary Care Improvement Group. Diabetes has been made a priority in the group’s 2014/15 Forward Plan based on recommendations from the Director of Public Health Annual Report 2013.
- The Barking Havering and Redbridge group of CCGs has initiated a pathway redesign project to improve the diabetes pathway and rationalise costs.

2.2 The Health and Wellbeing Board has agreed that the Diabetes Action Plan has been completed and is fit for return to the Health and Adult Services Select Committee.
<p>| Number | HASSC recommendation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Responsible Officer:                                                                 | Time Frame                      | Progress:                                                                                                                                                                                                                                                                                                                                 |
|--------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------------------------------------------------------|
| 1      | The Select Committee recommend that a future iteration of the Joint Strategic Needs Assessment provides a clearer account of the source of competing data and the ‘best estimate’ that the borough is using to monitor its progress and identify the challenge it faces in addressing undiagnosed diabetes.                                                                                                                                                                                                                                           | Matthew Cole                    | Completed Jan 2014                                                              | The JSNA 2012/13 has been updated for accuracy and is currently being refreshed for 2014/2015.                                                                                                                                                                                                                                                                                                |
| 2      | The Select Committee recommend that a programme of proactive screening opportunities is established, linked to improved entry routes to an integrated diabetes care pathway, with more medical professionals seeking opportunities for the proactive identification of diabetes in their patients and service users, and for GPs to take a more pro-active role in diagnosis.                                                                                                                                                                                                                                    | Matthew Cole                    | Completed 2013                                                                 | A significant number of undiagnosed diabetics are identified routinely through the NHS Health Check programme. Proactive screening occurring in General Practice around high risk groups Gestational Diabetes and morbid obesity                                                                                          |
| 3      | The Select Committee recommend that action is taken to improve patients’ understanding of the annual diabetes health checks, what they should expect to receive, and their importance in preventing complications.                                                                                                                                                                                                                                                                                                                          | Sharon Morrow (CCG) via Dr Kalkat and Primary Care Improvement Group. | Completed September 2013                                                        | Diabetes patient booklet has been produced and distributed to practices and community services to share with all diabetic patients/carers.                                                                                                                                                                                                 |</p>
<table>
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<th>4</th>
<th>The Select Committee recommend that the CCG takes steps to ensure that all clinicians are familiar with the NICE recommendations for the Annual [Diabetes] Health Check and have arranged the provision of high-quality interventions, with associated processes for prompt arrangement of patient appointments and their reminders.</th>
<th>Sharon Morrow (CCG) via Dr Kalkat and Primary Care Improvement Group and Training Planning Group. Matthew Cole liaising with NHS England over GP performance.</th>
<th>Completed February 2014</th>
<th>G</th>
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<td>5</td>
<td>For the longer term, it is recommended that the data is improved and the baseline for understanding uptake of the nine health checks is brought up to date, with ongoing robust monitoring thereafter.</td>
<td>Matthew Cole</td>
<td>March 2014</td>
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</table>

Continued primary care training programme to ensure GPs and nurses include patient education as part of diagnosis and annual review.

Training bid secured from HENCEL to develop primary care management of Long Term Conditions which will include following NICE recommendations. CCG developing clinical balanced scorecard to prioritise clinical improvement.

The Primary Care Improvement Group has rolled out feedback and peer influencing sessions via the cluster structure. The locality management paper sets out the role of the CCG in influencing primary care improvements through the cluster model.

The Primary Care Group has also selected Diabetes as a priority in their 2014/15 Forward Plan based on recommendations set out in the Director of Public Health Annual Report 2012, particularly around reducing variation in performance and care amongst GP Practices.

The balanced scorecard and clinical champion programme will provide an infrastructure for improvement.

Remuneration has been changed to requiring annual checks (rather than 15 months). Starts in 2013/14 so expect improvement to be ‘visible’ from late 2014/early 2015.

The Quality and Outcomes framework has been altered for 2013/14 to raise the threshold for maximum payment on many indicators. Hence, remuneration structure should improve performance.

Letter also written to NHS England about GP performance governance. CCG has appointed a Director Primary Care Improvement (Sarah See) Integrated Diabetes Service to develop and lead on structured education programme for practices, and to work with the CCG to develop and implement practice improvement plans. This needs to be prioritised in importance by all groups and develop closer working practices to improve attendance.

The CCG, NHS England, The North East London Foundation Trust, The Local Medical Committee and GPs need to work together to focus on consistency in General Practice performance with plans to work with poorer performers.

**For the longer term, it is recommended that the data is improved and the baseline for understanding uptake of the nine health checks is brought up to date, with ongoing robust monitoring thereafter.**

The Diabetes Community Health Profile and National Diabetes Audit are now produced annually and 2012/13 became available in December 2103. Will be incorporated into next JSNA.
<table>
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<th></th>
<th>The Committee recommends that the whole range of information provided to people already diagnosed and people newly diagnosed with Type 2 diabetes is reviewed, ensuring that it gives them what they need to know to improve self-management of their diabetes and their understanding of long-term complications.</th>
<th>Healthwatch</th>
<th>March 2014</th>
<th>G</th>
<th>Diabetes booklets have been revised and distributed to practices. Still need to promote their use in practices, pharmacies and community services.</th>
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<td>7</td>
<td>That the Health and Wellbeing Board facilitates consideration of how young people with diabetes (either Type 1 or Type 2) could be supported in the borough, inviting the participation of the health group of the Barking and Dagenham Youth Forum.</td>
<td>Healthwatch</td>
<td>March 2014</td>
<td>G</td>
<td>Healthwatch Report completed, findings (Appendix A) being taken forward by the Diabetes Sub-Group of the Planned Care Steering Group. Report available from ross.kenny@lb bd.gov.uk</td>
</tr>
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<td>8</td>
<td>That the Diabetes Support Group participates in a short review of the support needs of younger adults developing Type 2 diabetes, and how they may be met from a service user led group, led by an agency to be identified by the Health and Wellbeing Board.</td>
<td>Health Watch – Marie Kearns.</td>
<td>March 2014</td>
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<td>9</td>
<td>That the Health and Wellbeing Board ask Public Health professionals to work with commissioners and North East London NHS Foundation Trust to understand the reasons why services which are on the face of it similar appear to be linked to different outcomes for patients, and to capture the lessons for future local commissioning.</td>
<td>Dr Steve Feast (MD at NELFT) and Matthew Cole</td>
<td>March 2014</td>
<td>G</td>
<td>Report by Dr Sue Levi completed, findings (Appendix B) being taken forward by the Diabetes Sub-Group of the Planned Care Steering Group. Report available from ross.kenny@lb bd.gov.uk.</td>
</tr>
<tr>
<td>10</td>
<td>That the Health and Wellbeing Board oversees a review of the care pathway to ensure that all opportunities for joint working are being harnessed and that the flow of patients between services is effective.</td>
<td>Sharon Morrow/Sarah D'Souza/ Matthew Cole</td>
<td>March 2014</td>
<td>G</td>
<td>The Diabetes Sub-Group of the Planned Care Steering Group is in place covering BHRUT and CCGs and the first workshop took place in October 2013. The purpose of the diabetes project group is to support pathway redesign. Also, overlap with 9</td>
</tr>
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</table>
3. **Consultation**

4.1 This paper was presented to the Health and Wellbeing Board in July 2014.

4. **Financial Implications**

4.1 There are no specific proposals with financial implications arising from the review at this stage.

   Implications completed by: Roger Hampson, Group Manager (Finance - Adults & Community Services)

5. **Legal Implications**

5.1 There are no direct legal implications from this report. However, the author does highlight some deficits in the service and there is a limited risk of litigation if this results in poor outcomes for patients, particularly if the recommendations from this report are not put in place.

   Implications completed by: Chris Pickering, Principal Solicitor - Litigation & Employment, Legal and Democratic Services

6. **Risk Management**

6.1 Please note, these implications have been taken from when this paper was presented to the Health and Wellbeing Board in July 2014

   The risk from this paper is that changes are slow or non-existent and the quality of care remains unchanged.

7. **Customer Impact**

7.1 Improved integrated of diabetes care which will result in enhance services for patients and subsequently better patient outcomes. Furthermore, the action plan has resulted in a better understanding of the needs of diabetes patients in the borough which again will result in improved patient outcomes.

   There are no direct implications on particular populations within the borough in terms of age, gender, ethnicity etc.

7.2 **Safeguarding Children**

   There are no direct safeguarding implications of the report. As outlined in actions 7 and 8 in the table above, specific work has focused around the service provision and views of young people to allow for future commissioning to address the particular service needs of children and young people.

7.6 **Health Issues**

   The proposals are expected to have a positive impact on residents in the borough who currently (or will in the future) suffer from diabetes. More residents should
receive the annual diabetes health-check and a greater emphasis on early diagnosis, particularly in primary care will result in improved outcomes.

Background Papers Used in the Preparation of the Report:

The Health and Wellbeing Strategy 2012-2015:  

The Health and Adult Services Select Committee: Review of Type 2 Diabetes Services across the London Borough of Barking and Dagenham. The report can be accessed here:  

List of appendices:

**Appendix A:** Recommendations derived from the engagement of Young People and Younger Adults conducted by Healthwatch regarding HASSC recommendation numbers 7 and 8

**Appendix B:** Recommendations derived from the Service Review conducted by Dr Sue Levi regarding HASSC recommendation number 9:
Appendix A

Recommendations derived from the engagement of Young People and Younger Adults conducted by Healthwatch regarding HASSC recommendation numbers 7 and 8:

1. Commissioners of diabetic services need to have another look at the exercise programme for diabetic patients and ensure that the service is flexible enough so individuals can access without compromising their employment. It has been highlighted that people would like to access these services but the service only seems to be valid during working hours. Commissioners need to ensure that support is being provided to fit in with the needs and lifestyle of diabetic patients.

2. Many of the respondents have not been on any course/programme to increase their knowledge of their condition. Promotion of available courses needs to reach all diabetic patients and they need to be given the opportunity to attend. All GP practices need to write to their patients to see if they would like to attend a course and who to contact if they would like to go on one.

3. The findings from the questionnaires clearly show that individuals would like an online forum where individuals can; share their issues, exchange information, provide advice, receive advice and meet others who also suffer from type 2 diabetes. Therefore, commissioners and public health need to consider running an online forum as a pilot to see the impact of this on self management for diabetic patients.
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Appendix B

Recommendations derived from the Service Review conducted by Dr Sue Levi regarding HASSC recommendation number 9:

1. **Integration** – all the professionals, carers and patients join together in partnership to own the health outcomes of patients with diabetes in their local area – i.e. the diabetic population’s average glucose control (HbA1C) belongs to the IDS, hospital staff and GPs.

2. **Leadership, partnership and clinical engagement.** The best achieving models of diabetes care have strong leaders, high levels of engagement and care seen as important by all contributors. Decisions need to made locally as to the leadership role of the GP with a Special Interest, GP Clinical Director with responsibility for Diabetes and the Diabetes Consultant.

3. **Integrated IMT/data sharing** - poor outcomes e.g. sugar control, blood pressure and cholesterol must be owned by everyone and be visible to all in the service. This has been achieved elsewhere and auto-extraction would be possible via Health Analytics software access. This aspect could be researched elsewhere to see solutions elsewhere.

4. **Shared governance** – so that all are responsible for outcomes and all learn from poor experiences etc. Have to be accountability to someone even if not formal.

5. **Alignment of finances** – if providers are aligned towards outcomes e.g. blood sugar control or amputations etc then there will be a natural focus and increased cooperation. This could use the same metrics e.g. HbA1C but be used differently in the different organisations e.g. the Quality and Outcomes Framework in primary care but CQUINS (Commissioning for Quality and Innovation) for the community provider.

6. **Reconsider patient education provision** to approximately double availability. Needs new approaches to advertising the service, inviting patients, following up non-attendance etc. Also, increase the knowledge of the professional workforce on the vital role of patient engagement and ownership of their condition.

7. The CCG, NHS England, The North East London Foundation Trust, The Local Medical Committee and GPs need to work together to:
   - Enhance and encourage prioritisation of diabetes care in each General Practice including monitoring if a practice has a named Lead Diabetes Clinician.
   - Monitor if the practice ‘permits’ in-reach training and peer education – and what to do if the practice doesn’t allow entry.
   - How to manage poor Diabetes outcomes e.g. poor sugar control, high level of exception reporting etc.
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Title: Joint Health Overview and Scrutiny Committee

Report of the Chief Executive

Open Report For Decision

Report Author: Masuma Ahmed, Scrutiny Officer
Contact Details:
Tel: 020 8227 2756
E-mail: masuma.ahmed@lbdd.gov.uk

Accountable Divisional Director: Fiona Taylor, Head of Legal and Democratic Services

Accountable Director: Graham Farrant

Summary:

This report is to:

i. Inform the Health and Adults Services Select Committee (HASSC) of the local arrangements for joint health scrutiny and

ii. Ask the Committee to appoint a HASSC member to the Joint Health Overview and Scrutiny Committee.

This report and the appended draft terms of reference explain local joint health scrutiny arrangements amongst the boroughs of Barking and Dagenham, Havering, Redbridge, and Waltham Forest which cover the Outer North East London area.

The terms of reference state that the Joint Health Overview and Scrutiny Committee (JHOSC) will consist of three Members of each local authority represented, appointed by each borough's health overview and scrutiny committee. In previous years the Lead and Deputy Lead members have been put forward to fill two of the three vacancies.

Recommendations

The HASSC is recommended to:

(i) Note the draft terms of reference for the JHOSC; and

(ii) Agree to appoint three HASSC members to the JHOSC

Reason

To accord with joint health scrutiny arrangements.
1. **Introduction and Background**

1.1 Regulations under the National Health Service Act 2006 state that local authorities in England have the power to:

- "Review and scrutinise matters relating to the planning, provision and operation of the health service in the area. This may well include scrutinising the finances of local health services.
- Require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny.
- Require employees including non-executive directors of certain NHS bodies to attend before them to answer questions.
- Make reports and recommendations to certain NHS bodies and expect a response within 28 days.
- Set up joint health scrutiny committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority.
- Refer NHS substantial reconfiguration proposals to the Secretary of State if a local authority considers:
  - The consultation has been inadequate in relation to the content or the amount of time allowed.
  - The NHS body has given inadequate reasons where it has not consulted for reasons of urgency relating to the safety or welfare of patients or staff.
  - A proposal would not be in the interests of the health service in its area".¹

2. **Joint Health Scrutiny Arrangements**

2.1 The Department of Health Guidance ("the Guidance") issued in June 2014 describes two types of joint scrutiny committees; discretionary and mandatory. Discretionary joint committees are set up by local authorities by choice to scrutinise health matters that cross local authority boundaries. Mandatory joint committees are required by regulation to be set up when a relevant NHS body or health service provider consults more than one local authority’s health scrutiny function about substantial reconfiguration proposals.

2.2 In such circumstances, the regulations state that:

- "Only the joint committee may respond to the consultation (i.e. rather than each individual local authority responding separately).
- Only the joint committee may exercise the power to require the provision of information by the relevant NHS body or health service provider about the proposal.
- Only the joint committee may exercise the power to require members or employees of the relevant NHS body or health service provider to attend before it to answer questions in connection with the consultation." ²

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¹ Department of Health, Local Authority Health Scrutiny Guidance, 27 June 2014, p12
² Department of Health, p17
2.3 Individual councils or departments would still be able to respond informally to any consultations but the responsibility to give a formal response would lie with the mandatory JHOSC.

3. **Referrals to the Secretary of State**

3.1 The Guidance makes it clear that the above restrictions do not apply to referrals to the Secretary of State. "Local authorities may choose to delegate their power of referral to the mandatory joint committee but they need not do so. If a local authority had already appointed a discretionary committee, they could even delegate the power to that committee if they choose to. If the local authority has delegated this power, then they may not subsequently exercise the power of referral. If they do not delegate the power, they may make such referrals."³

3.2 The London Borough of Barking and Dagenham's revised Constitution, agreed by the Assembly on 17 September 2014 delegates the power of referral to the Secretary of State to the HASSC.

4. **Outer North East London Joint Health Overview and Scrutiny Committee**

4.1 The Outer North East London Joint Health Overview and Scrutiny Committee (JHOSC) consists of three Members from each of the following boroughs:

- Barking & Dagenham
- Havering
- Redbridge and
- Waltham Forest.

The Essex County Council Health Overview and Scrutiny Committee is permitted to appoint one Member to the JHOSC.

4.2 **Background to the JHOSC**

The Outer North East London JHOSC was established by the health overview and scrutiny committees of the above boroughs, exercising their powers under section 7 of the Health and Social Care Act 2001 and the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002. This legislation, together with directions issued by the Secretary of State for Health in 2003, required all Local Authorities affected by what they consider to be 'substantial variations' in local health services to form a Joint Health Overview and Scrutiny Committee to consider those changes.

5. **Appointment of a HASSC Member to the JHOSC**

5.1 In previous years the HASSC has agreed to appoint the Lead and Deputy Lead members to fill two of the three vacancies. In July 2014 the Scrutiny Officer requested nominations via email for a third HASSC member to be appointed to the JHOSC. This process did not yield any nominations, and therefore if the HASSC agree to the Lead and Deputy Lead members' appointments, there would still remain one vacancy.

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³ Department of Health, p17
5.2 There are typically four JHOSC meetings a year with the four boroughs taking turns to host each meeting. The chair of the health scrutiny committee from the hosting borough chairs the meeting. The meetings are clerked by Anthony Clements, Principle Committee Officer at the London Borough of Havering, who charges the boroughs for the support in proportion to the number of Members they may appoint to the Committee.

5.3 There was a JHOSC meeting hosted by Barking and Dagenham on 22 July 2014, chaired by Councillor Keller. The following matters were discussed at this meeting:

- BHRUT Improvement Plan
- BHRUT - Breast Care Services - Change of Location
- Cancer and Cardiovascular Proposals
- Transforming Services, Changing Lives

5.4 Three further JHOSC meetings have been scheduled for the remainder of the municipal year as follows:

- 14 October 2014, 2.00pm, Havering
- 13 January 2015, 2.00pm, Redbridge
- 14 April 2014, 2.00pm, Waltham Forest

5.5 The appended draft terms of reference describe the remit and governance of the JHOSC. The terms of reference have recently been amended to reflect legislation and the Guidance and will be agreed by the JHOSC at its meeting in October.

5.6 Should the HASSC agree to the Lead and Deputy Lead members' appointments to the JHOSC, it would need to appoint one final member. The HASSC is therefore asked for nomination(s) for a third representative to be appointed to the JHOSC. If more than one nomination is received, a vote will be conducted to determine the appointment.

Background Papers Used in the Preparation of the Report:

Barking and Dagenham Council Constitution

Local Health Scrutiny Guidance 2014, Department of Health:

List of appendices:

Appendix 1 Joint Health Overview and Scrutiny Committee, draft Terms of Reference
Establishment of the JHOSC

1. The Outer North East London Joint Health Overview and Scrutiny Committee (the JHOSC) is established by the Overview and Scrutiny Committees having health responsibilities of the London Borough Councils of Barking & Dagenham, Havering, Redbridge and Waltham Forest (“the borough OSCs”) in accordance with s.190-191 of the Health and Social Care Act 2012 and consequential amendments and the Local Authority (Overview and Scrutiny Committees Healthy Scrutiny Functions) Regulations 2002.

Membership

2. The JHOSC will consist of three Members appointed of each of the Borough OSCs.

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

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

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

Attendance of Substitute Members

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

Role and Function of the JHOSC

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

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

   a. Request information or to hold direct discussions with appropriate officers from each of the following organisations or their successor bodies:
Appendix 1

Barking and Dagenham Clinical Commissioning Group (CCG)
Havering CCG
Redbridge CCG
Waltham Forest CCG
NHS England
North East London Commissioning Support Unit
Barking, Havering and Redbridge University Hospitals NHS Trust
Barts Health NHS Trust
North East London NHS Foundation Trust
North East London Community Services
London Ambulance Service NHS Trust

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

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

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

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

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

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

Co-optees

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

Formation of Working Groups

10. The JHOSC may form such Working Groups of its membership as it may think fit to consider any aspect or aspects of its work. The role of such Groups will be to consider the matters referred to it in detail with a view to formulating recommendations on them for consideration by the JHOSC. The precise terms of reference and procedural rules of operation of any such Groups (including number of members, chairmanship, frequency of meetings, quorum etc) will be considered by
Appendix 1

the JHOSC at the time of the establishment of each such Group; these may differ in each case if the JHOSC considers it appropriate. The meetings of such Groups should be held in public except to the extent that the Group is considering any item of business from which the press and public could legitimately be excluded under the Access to Information legislation.

Meetings of the JHOSC

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

12. Meeting venues will normally rotate between the four Outer North East London boroughs.

13. Meetings shall be open to the public and press in accordance with the Access to Information requirements. No tape or video recorders, transmitters, microphones, cameras or any other video recording equipment shall be brought into or operated by any person at a meeting of the JHOSC unless the Chair of the meeting gives permission before the meeting (this exclusion will not apply to the taping of the proceedings by officers responsible for producing the minutes). When permission is given, a copy of any tape made must be supplied to the London Borough of Havering, in its role as Administrator.

Attendance at Meetings

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

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

16. The JHOSC and any Working Group formed by the JHOSC may invite other people (including expert witnesses) to address it, to discuss issues of local concern and/or to answer questions. It may for example wish to hear from residents, stakeholders and members and officers in other parts of the public sector and shall invite such people to attend.

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

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

Chair and Vice Chair

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

Agenda items

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

Notice and Summons to Meetings

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

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

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

Reports from the JHOSC

24. Once it has formed recommendations the JHOSC will prepare a formal report and submit it to the relevant bodies. In accordance with the Department of Health Guidance on the Overview and Scrutiny of Health dated July 2003, the JHOSC should aim to produce a report representing a consensus of the views of its members. If consensus is not reached within the JHOSC, minority views will be included in the report.

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

Formal Consultations and Referrals to Secretary of State

26. Under guidance on Local Authority Health Scrutiny issued by the Department of Health in June 2014, only the JHOSC may respond to a formal consultation on substantial variation proposals covering health services in more than one constituent
Appendix 1

Council area. This power also extends to the provision of information or the requirement of relevant NHS officers to attend before the JHOSC in connection with the consultation.

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

Procedure at JHOSC meetings

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

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

Conduct of Meetings

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

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

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

Officer Administration of the JHOSC

32. The London Borough of Havering will be the Lead Authority for clerking and administering the JHOSC. The Clerk of the Committee will be the Principal Committee Officer, London Borough of Havering. Costs of supporting the JHOSC will be shared, in proportion to their representation on the Committee, by the London Boroughs of Barking and Dagenham, Havering, Redbridge, Waltham Forest and by Essex County Council, in cash or in kind.

Voting

33. Members may request a formal vote on any agenda item by informing the Clerk of the Joint Committee at least five working days before a meeting. If it is not possible to give this notice, Members have the right to request a vote at a meeting itself, provided they explain to the meeting why it has not been possible to give the standard notice of this request. The decision on whether to allow a vote, if the standard notice has not been given, will rest with the Chairman of that meeting.
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34. Any matter will be decided by a simple majority of those members voting and present in the room at the time the motion was put. This will be by a show of hands or if no dissent, by the affirmation of the meeting. If there are equal votes for and against, the Chair or other person chairing the meeting will have a second or casting vote. There will be no restriction on how the Chair chooses to exercise a casting vote. Co-opted members will not have a vote.

Public and Press

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

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

Code of Conduct

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

General

38. These terms of reference incorporate and supersede all previous terms of reference pertaining to the JHOSC.
HEALTH AND ADULT SERVICES SELECT COMMITTEE

30 SEPTEMBER 2014

Title: Reflecting on the Francis Report and the implications for Health Scrutiny

Report of the Corporate Director of Adult & Community Services

Open For Information

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Accountable Divisional Director: Fiona Taylor, Head of Legal and Democratic Services

Accountable Director: Graham Farrant, Chief Executive

This Report was provided to the formal meeting of the Health and Adult Services Select Committee (HASSC) on 29 July 2013 where members discussed the report and agreed with the recommendations at section 5.1.

As the HASSC of the municipal year 2014/15 comprises new members, it was considered imperative to re-present the report to the Committee because of the important implications of the Francis Report on health scrutiny.

Members are also provided an update at section 8 on the progress made since the original report went to the HASSC on 29 July 2013.

Summary:

The Francis Inquiry into the failure in care standards at Mid-Staffordshire NHS Foundation Trust uncovered some harrowing stories of poor care, neglect and institutional failure. Whilst primary responsibility rested with the hospital, its management and staff, there were also a number of criticisms levelled at commissioners and those with a responsibility for overseeing and scrutinising the provision of healthcare in the area. This included the local councils’ health overview and scrutiny arrangements.

Robert Francis QC acknowledged that it was difficult for anyone from supervisory, regulatory or scrutiny organisations to truly understand how Mid-Staffordshire NHS Trust was failing or bring to light the negligence taking place within the hospital. However, While the Mid-Staffordshire scrutiny committees were not to blame for any of the suffering that took place at the Trust, their failure to perform their role implicates them in the scandal and reveals some universal weaknesses about the concept of health scrutiny as carried out by elected members.

This report explores the issues raised by Francis and provides an opportunity for members of the Health & Adult Services Select Committee (HASSC) to reflect for themselves on the extent to which local arrangements are robust, and that they are being operated to maximum effect. In particular, it prompts a series of questions about how well the local health scrutiny arrangements hold local NHS (and social care)
agencies to account, and shine a spotlight on poor care and institutional risk. The Francis Report and its recommendations provide an opportunity for HASSC to review its work, and make sure it is upholding local residents’ interests in the provision of health and social care services.

**Recommendation(s)**

The HASSC is asked to:

- Reflect on the findings and recommendations of the Francis Report under the headings described in this report, namely:
  - Operation of the committee, and preparedness of committee members;
  - Support to Members;
  - Relationship of Scrutiny to other accountability mechanisms;
  - Patient voice and proactive scrutiny;
- Assure itself that Scrutiny, as practiced in Barking and Dagenham, is effective and robust;
- Take necessary measures in response to Francis’ recommendations and issues arising from this report (paragraphs 5.2 to 5.6);
- Note the progress made in implementing the recommendations of Francis in Section 8 of the report.
1. Introduction – What is the Francis Report?

“This was a systemic failure of the most shocking kind, and a betrayal of the core values of the health service as set out in the NHS Constitution. We must never allow this to happen again.”

— Rt Hon. Jeremy Hunt MP, Secretary of State for Health

1.1. Between 2005 and 2008 conditions of appalling care were able to flourish in the main hospital serving the people of Stafford and its surrounding area. Eventually, after tireless campaigning from local people, persistent complaints from patients, and interrogation of mortality rates at the hospital, the truth of the failings at Mid-Staffordshire General Hospital NHS Trust was uncovered. Following the scandal the Government launched a full public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid-Staffordshire Foundation NHS Trust. The Inquiry was chaired by Robert Francis QC, the findings (generally known as the Francis Report) were published on 6 February 2013.

1.2. The Francis Report tells a story of unacceptable suffering of many patients within an organisational culture of secrecy and defensiveness. Although the public inquiry was focused on one organisation, it highlights a ‘whole system’ failure: a system which should have had checks and balances in place, and working, to ensure that patients were treated with dignity, and suffered no harm. The 1,782 page report has 290 recommendations which cut across, and have major implications for, all levels of the health service across England.

1.3. In his report, Francis calls for a whole service, patient-centred focus. It is noteworthy that the 290 recommendations do not call for a reorganisation of the system, but for a re-emphasis on what is important, to ensure that the events of mid-Staffordshire do not happen again. Broadly the recommendations of Francis can be distilled into these themes:

- Emphasis on, and commitment to, common values throughout the system by all within it;
- Readily accessible fundamental standards and means of compliance;
- Zero tolerance of non-compliance and the rigorous policing of fundamental standards of care;
- Openness, transparency and candour in all the system’s business;
- Strong leadership in nursing and other professional values;
- Strong support for leadership roles;
- A level playing field for accountability;
- Information accessible and useable by all allowing effective comparison of performance by individuals, services and organisations.

2. What does the Francis Report say about Scrutiny?

2.1. Chapter six of the Francis Report explores the reasons why more concern about the suffering of patients was not raised through patient and public involvement bodies, MPs, LINks, local media outlets and local government scrutiny. Within this chapter Francis looks in-depth at the role of Staffordshire County Council Scrutiny Committee.
and Stafford Borough Council Overview and Scrutiny Committee and draws some important conclusions as to how and why they failed. The particular criticisms and observations of Francis can be summarised into the points below.

- The scrutiny committees got caught up in the Hospital Trust’s Foundation Trust application instead of keeping focus on standards of care and what was happening in the hospital itself.

- The scrutiny forum became bland and meaningless with members passively noting information and receiving reports without asking questions on the content or surrounding issues. The lack of challenge was reflected in the public records of the meetings making it difficult for scrutiny to inform decision-making processes or demonstrate to the public that scrutiny had happened at all.

- The scrutiny committees did not make use of alternative sources of information to challenge the Trust and became wholly reliant on the information supplied by the body it was scrutinising. Complaints data was not made available and nor was it asked for. The scrutiny committees showed a lack of interest in mortality data and took no steps to consider the implications of, or follow, the Health Care Commission’s investigation into the Trust.

- The scrutiny committees did not attempt to engage with or solicit the views of the public and were slow to acknowledge the campaign of Julie Bailey. When Julie Bailey attended the Committee to ask questions directly she was not permitted to speak.

- The scrutiny committees did not escalate or make submissions to any NHS body or the Secretary of State. The Borough Scrutiny Committee did not refer any matters to the County level.

- The scrutiny committees did not prioritise the issues for scrutiny and insufficient significance was given to information coming from the public. The scrutiny committees did not make a connection between the negative experiences of patients that were reported and underlying problems the Trust had in delivering safe and high quality care.

- There was a lack of clarity about roles and responsibilities (this in part relates to scrutiny in two-tier authorities) in terms of who was holding the Trust to account. This was further hazed by Councillors taking the ‘critical friend’ role too literally undermining robust scrutiny/challenge.

- Councillors lacked specific health scrutiny training and had insufficient support and resources at hand to effectively carry out their role.

2.2. Taken together the criticism and failings of the Scrutiny Committees of Staffordshire are significant and damning, opening a Pandora’s Box of issues for health scrutiny functions across the country to confront. Appendix 1 brings together relevant extracts from the Francis Report and testimony to the Inquiry to further elucidate the bullets above.

3. Specific recommendations from the Francis Report

3.1. Emerging from the criticisms and observations (described above) six recommendations are proposed by Francis to empower and strengthen Scrutiny. The implications of taking forward some of these recommendations are discussed in the commentary in section four.
<table>
<thead>
<tr>
<th>#</th>
<th>Recommendation</th>
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<tbody>
<tr>
<td>47</td>
<td>The Care Quality Commission should expand its work with overview and scrutiny committees and Foundation Trust governors as a valuable information resource. For example it should further develop its current “sounding board” events.</td>
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<tr>
<td>119</td>
<td>Overview and Scrutiny Committees and Local Healthwatch should have access to detailed information about complaints although respect needs to be paid in this instance to the requirement for patient confidentiality.</td>
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<tr>
<td>147</td>
<td>Guidance should be given to promote the co-ordination and co-operation between local Healthwatch, Health and Wellbeing Boards and local government scrutiny committees.</td>
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<tr>
<td>149</td>
<td>Scrutiny Committees should be provided with appropriate support to enable them to carry out their scrutiny role including accessible guidance and benchmarks.</td>
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<tr>
<td>150</td>
<td>Scrutiny Committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role or should actively work with those structures to trigger and follow up inspection reports without comment or suggestions for action.</td>
</tr>
<tr>
<td>246</td>
<td>Department of Health / the NHS Commissioning Board / regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations to include a minimum of prescribed information about their compliance with fundamental or other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality Accounts should be required to contain the observations of commissioners, overview and scrutiny and Local Healthwatch.</td>
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4. Exploration of the recommendations

4.1. Upon reading chapter six of the Francis Report we feel the following issues require exploration/consideration by the HASSC as part of the process of reflecting on, and responding to, the findings of Francis.

Operation of the committee, and preparedness of committee members

4.2. One of the main criticisms of Francis about the scrutiny functions of Stafford Borough and Staffordshire County Council was that the committee forums became “pleasant little talking shops” and as such did not offer challenge or pursue issues on behalf of affected residents. Moreover, the Committees did not understand their role or appreciate the responsibility on them to carry out rigorous health scrutiny.
4.3. The passivity which Francis criticises implies the need for Members to arrive at meetings prepared and well-briefed so that precious committee time is well utilised and witnesses are thoroughly interrogated. HASSC may therefore wish to consider:

- Whether briefing materials provided by officers meet their needs and that they fill any gaps in knowledge or background about the issue under scrutiny;
- Whether Members are aware of the purpose of each business item and the key issues that are to be explored at the meeting;
- Whether sufficient time is given by Members to ensuring that they have an understanding of surrounding and related issues under discussion, so that issues are scrutinised taking into account the wider health and social care context of Barking and Dagenham - and whether they are supported to do this by the briefing materials provided to them;
- Whether the Committee prepares lines of enquiry, including supplementary questions, so that questions are directly relevant, succinct, and that the committee takes a co-ordinated approach.

4.4. Further to preparation before committee meetings, Members are recommended to satisfy themselves that they are fully conversant with the legislative standing of health scrutiny, including how to use the range of powers at the disposal of local authorities, and the ways in which the authority can (through the health scrutiny function) escalate matters of concern, when required. Members’ attention is drawn to the work that was undertaken in response to Government proposals to amend the previous Department of Health guidance on health scrutiny from 2003\(^1\). This, taken together with the previous experience of exercising health scrutiny powers (CQC investigation of BHRUT, IRP review of H4NEL proposals), should provide Members with confidence about their awareness of the statutory under-pinning of the HASSC.

4.5. However, Members may wish to consider whether refresher training/briefing on health scrutiny powers is required, especially in light of changes to the HASSC’s membership in recent years. Where there has been lots of structural change to the NHS it might be necessary for the HASSC to look at its place in the new system and the roles and remits of the bodies/organisations (old and new) therein.

4.6. Another criticism of Francis of the Scrutiny Committees of Staffordshire is that they got caught up in the Hospital Trust’s Foundation Trust application instead of keeping focus on standards of care and what was happening in the hospital itself. To avoid losing touch with reality work programmes should maintain balance between review work/policy development and regular more traditional Q&A style ‘holding to account’. The HASSC regularly reviews its work programme either in the committee setting or through agenda planning meetings to ensure that business is topical/relevant. Post-Francis the HASSC might wish to make its topic selection process more open to input from residents and find ways to solicit suggestions to the work programme from the public.

4.7. A key learning point from the Francis Report is that councillors must, by necessity, be reliant on a limited pool of evidence to inform their scrutiny of NHS bodies. It is essential, therefore, that the reports, presentations, and other materials being supplied to Members have the right information at the right level for lay readers to understand and work constructively with. The scrutiny process should therefore try to use a blend

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\(^1\) Overview and Scrutiny of Health: Guidance (Department of Health, July 2003)
of more anecdotal or qualitative sources of evidence alongside ‘harder-edged’
performance data, which can be difficult to analyse or relate back to the patient or
service user experience of using services.

4.8. Recommendation number 119 of the Francis Report calls for Overview and Scrutiny
Committees (and Local Healthwatch) to have access to detailed information about
complaints. In light of this the HASSC should reflect on whether the information it is
supplied with gives it a platform from which to scrutinise performance and detect
problems and consider ways in which information might be presented differently to
make it more user friendly and patient oriented. In this endeavour, they may well wish
to call on the support of Healthwatch to gather and summarise issues of concern that
are being presented to them.

Support to councillors

4.9. Despite being critical of the health scrutiny committees of Staffordshire, Francis
recognises that scrutiny by local councillors is an important part of the framework of
health service accountability, and he stresses that it should be resourced and valued
accordingly.

4.10. Recommendation number 149 calls for Scrutiny Committees to be given the
appropriate level of support to enable them to carry out their role. Reflecting on this
recommendation it is suggested that Barking and Dagenham has a well-resourced
Scrutiny function that draws on skills and expertise from across the directorates to
increase the capacity and capability of Scrutiny (which is further boosted by the
transfer of public health responsibilities to local authorities). Furthermore, the Council
benefits from a having a full-time Member Development Officer to pick up on training
and development needs of members, individually and collectively.

4.11. In view of this we feel that support and resource behind health scrutiny is at a high
level. However, Members should be demanding of these resources, ensure that the
support provided is useful, and be unafraid to ask for further support or to point out
gaps in the support Members receive. While previous Annual Scrutiny Satisfaction
Surveys have indicated Members are happy with the level of support they receive,
officers would welcome current and specific feedback on this from the HASSC.

Relationship of Scrutiny to other accountability mechanisms

4.12. A key lesson to take from Francis is that Scrutiny cannot operate in isolation from the
wider system of checks and balances. Recommendation number 147 calls for
guidance about the co-operation and co-ordination between local government scrutiny
committees, local Healthwatch organisations and health and wellbeing boards.

4.13. In the absence of guidance LBBD has made considerable effort to develop
relationships and define roles and responsibilities. The Shadow Health and Wellbeing
Board worked through scenarios and case studies to establish how various parts of
the system might work together to ensure system-wide leadership and accountability.

4.14. The HASSC has received a report exploring the role and remit of Healthwatch, where
this overlaps with scrutiny, and discussed how the two bodies can use those synergies
for maximum impact. As Healthwatch and the Health and Wellbeing Board continue to
develop within this new system, so will their understanding of each other’s roles.

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2 HASSC, 17 April 2013 – Introducing Healthwatch Barking and Dagenham
Further to the findings of Francis, the HASSC might want to consider how it links up with the regulatory bodies to report concerns, or uses intelligence collected through inspections and auditing to inform local scrutiny activity. Recommendation number 47 of the Francis Report calls for CQC to expand its work with scrutiny committees and Foundation Trust Governors to collect and share information.

The HASSC does have experience of working with CQC. In 2011, following the CQC launching a full investigation into care provided by BHRUT, the HASSC formally gave evidence to the investigation sharing its concerns and the records of scrutiny meetings. The HASSC has also required representatives from BHRUT to answer on performance issues in the formal committee-setting on a number of occasions, following the publication of CQC inspection findings.

Post-Francis the HASSC may wish to further develop its relationship with CQC so that there is more regular dialogue and awareness of local inspection activity. Guidance about how CQC should work with Overview and Scrutiny Committees (OSCs) was released in 2011; it outlined an expectation that OSCs should have contact (phone, e-mail, or meeting) from CQC staff once every 3 months. This regular communication with CQC does not exist locally and is something that the HASSC might wish to address in order that it can obtain oversight of inspection activity and report concerns easily.

The CQC was heavily criticised in the Francis Report and is currently undergoing major reform to change how it inspects health and social care providers and the benchmarks of quality that it will inspect providers against. This overhaul should give the CQC a chance to re-imagine its relationship with local scrutiny committees and give fresh impetus to local CQC teams to be pro-active in nurturing such relationships. The HASSC may wish to seize the opportunity in the wake of the Francis Report to approach the local CQC team (and other regulators/scrutineers) to kick-start this process.

**Patient voice and pro-active scrutiny**

More than anything, the Francis report draws out the absolute necessity of using the experiences and views of local people to hold health service providers and commissioners to account. The Scrutiny Committees of Stafford Borough Council and Staffordshire County Council failed because they became reliant on what representatives from the Hospital Trust were telling them and had no other sources of evidence to inform their opinion or use to challenge the Trust.

In order to be relevant and powerful health scrutiny needs to be in touch with the latest patient views and their experiences of using services (this point is further explored in Paragraph 2.5). It is difficult to draw out the patient experience in the committee forum, even where is regular attendance by members of the public, and cover all the issues that may be topical at any given time. The health agenda is dynamic and transient and as such requires constant monitoring and input from those with a scrutiny role.

For these reasons members must engage with local people whenever they can, even if this means working outside of the formal meeting structure. By being pro-active and responsive members can ensure that the committee is on top of its brief and up-to-date on issues and developments so that in the committee setting members are

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A Guide for Overview and Scrutiny Committees for Health and Social Care: How your committee can work with the Care Quality Commission (September 2011)
informed and equipped to conduct meaningful scrutiny that is reflective of local concern.

4.22. Scrutiny outside of the committee-setting could take many different forms, most, if not all, of which members will be familiar with or have direct experience of. These approaches/techniques include:

- site visits;
- focus groups;
- surveys.

4.23. Following the Francis report the HASSC may wish to consider whether its programme of public engagement and activity outside of the committee-setting is enough and think of utilising a range of approaches that might make scrutiny more dynamic and centred on the experiences of service users.

4.24. One of Francis’s suggestions for OSCs to get closer to the patient experience and find alternative sources of evidence is for them to be granted the power to inspect providers of health and social care services (recommendation number 150). This recommendation is not felt to be entirely practical, since it would require very specific training for councillors and duplicate Healthwatch’s power to conduct ‘Enter and View’ inspections. Also there is a danger that inspections carried out by OSCs could give false assurances about performance to regulators.

5. Summary of recommendations

5.1. From the discussions above, the recommendations for the Health and Adult Services Select Committee to consider to take forward locally in response to the Francis Report can be summarised as the following:

- Ensure that clear information on how the committee works, responsibilities of health scrutiny and sources of information is included in the first meeting of any municipal year where membership changes;
- Request officers to review the forward plan and scrutiny project plans to ensure that the user voice is clearly incorporated. It is recommended that HASSC liaise with Healthwatch in taking this recommendation forward;
- Make contact with the local CQC Team and other regulators and scrutineers to consider how it links up with regulatory bodies to report concerns and use intelligence collected through inspections and auditing to inform local scrutiny activity;
- Reflect on the issues planned for the coming year and identify early where HASSC members may need additional background briefing or technical assistance;
- Consider, in conjunction with the Cabinet Member for Health, how information can be regularly gathered and collated from Ward Councillors regarding the views of their constituents on local health services.

6. Conclusion

6.1. Health scrutiny by elected members is a key part of public accountability of health services and is not a responsibility to be taken lightly. The Francis Report provides a unique opportunity to reflect on the effectiveness of local government health scrutiny and accountability across the health and social care system. Furthermore, the Francis
Report re-focuses members’ minds on what is at the core of health scrutiny and invites members to step back and look objectively at the effectiveness of local scrutiny arrangements.

6.2. Sadly, the events of mid-Staffordshire reveal that no matter how engaged, methodical and conscientious elected members are, inevitably some things are beyond control. A big theme that runs through the Francis Report is ‘duty of candour’ in respect of how NHS professionals were complicit in the scandal through their failure to report what was going on at Mid-Staffordshire. Successful scrutiny depends on the culture and values of those giving evidence, principally openness, transparency and honesty, without which scrutiny councillors face an uphill challenge to perform their role. However, as explored in this report, there are steps and measures members can put in place to ensure scrutiny is as robust as it can be.

7. Implications

7.1. Legal

(Implications completed by: Lucinda Bell, Adult Social Care and Education)

The Health and Social Care Select Committee operates within terms of reference described at Section F, C21 of the Council’s constitution. As such is has responsibility for scrutinising issues falling within its defined remit. The Frances report makes recommendations that include actions that can be taken by the Committee, to enhance its performance.

7.2. Finance

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

Paragraphs 4.9 to 4.11 of the report stress the need for health scrutiny to be given suitable levels of resource and support in order to effective. Further to the points raised in that section, the HASSC should be advised that LBBD has a dedicated Member Development budget which should be able to meet all health related scrutiny training and development needs. Members are able to make requests on this fund through the Member Development Steering Group via the Member Development Officer.

Members should also be reminded that the Scrutiny function has a small discretionary budget to meet the costs of site visits, commissioning independent research or undertaking public engagement activities. Members are free to call on this fund where its use will add value to the scrutiny process. The budget for 2013/14 is £6k and is shared across the five themed select committees; requests of the fund can be made through the Statutory Scrutiny Officer (Democratic Services).
7.3. **Risk Management**

With the well documented performance issues at Barking and Dagenham’s local Hospital Trust (BHRUT) it is important that public accountability through the HASSC is robust, rigorous and demonstrable. In response to the findings and conclusions of Francis several recommendations are offered in the report (see summary in section 5) to strengthen health scrutiny and show learning from the events of mid-Staffordshire.

8. **Summary of Progress since 29 July 2013 HASSC meeting**

8.1 The Health and Wellbeing Board at its meeting on 4 June 2013 established a Task and Finish Group Chaired by Conor Burke Accountable Officer NHS Barking and Dagenham Clinical Commissioning Group to develop a local response to the Francis Report involving all partners on behalf of the Health & Wellbeing Board.

8.2 The Group presented its final report to the Health and Wellbeing Board on 11 February 2014. The Board noted the recommendations and an action plan was developed by the task and finish group, with implementation of the actions across the Barking and Dagenham, Havering and Redbridge social care and health economy.

8.3 Partners have been working to implement the action plan over the last six months, focusing on ensuring that all local NHS Trusts are compliant with the statutory Duty of Candour requirements from October 2014 and all other Providers by April 2015.

**Duty of Candour**

8.4 Medical treatment and care is not risk free. Errors will happen and nearly half of all of these will be due to failures in organisational systems or genuine human errors. The Government expects the NHS to admit to patient safety incidents, apologise to those affected, and ensure that lessons are learnt to prevent them from being repeated. This is the Duty of Candour. There are a number of initiatives, policies and levers in place to encourage openness. Some of these include The Health Act 2009, professional codes for doctors, nurses and NHS managers, and the NHS Litigation Authority. The National Patient Safety Authority published policy guidance in 2009 called ‘Being Open’; this guidance set out the principles of communication and the processes that organisations should follow to ensure mistakes are communicated to patients, relatives and/or carers.

8.5 Since 1 April 2013 it has been a requirement under the NHS Standard Contract 2013/14, that NHS commissioned organisations ensure patients or their next of kin, if the patient has consented to them being informed or does not have capacity, are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and are supported to deal with the consequences (2012-14 NHS Standard Contract, Technical guidance). The culture of ‘Being Open’ should be fundamental in relationships with, and between, patients and/or their carers, the public, staff and other health care organisations.

8.6 The Duty of Candour is the contractual requirement to ensure the ‘Being Open’ process is followed when a patient safety incident results in moderate or severe harm or death. The NHS standard contract outlines the framework that commissioners are expected to adhere to, to gain assurance that providers of services are compliant with the ‘Being Open’ policy and the contractual requirements of the Duty of Candour (it is
noted that further guidance may be published following the conclusions of the public consultation for introducing the Statutory Duty of Candour).

Implementation of Duty of Candour – main provider performance

8.7 **Barking Havering Redbridge University Trust (BHRUT)** – has assured commissioners that they are compliant with the Duty of Candour. The Trust has confirmed that all incidents reported on the Trust incident reporting system must be discussed with the patient or next of kin and that this is now a mandatory field so must be completed by the reporter before the incident can be notified.

8.8 **North East London Foundation Trust (NELFT)** – has confirmed to commissioners that they have had a targeted focus on raising awareness of the requirements of the Duty of Candour with both staff and the public. The Chief Nurse has communicated this to staff in a weekly newsletter, with an entire page dedicated to the new requirements. NELFT has also informed commissioners that the Duty of Candour requirement is a mandatory field on their incident reporting system and therefore must be completed before the incident can be submitted. An internal audit to assure compliance has commenced.

8.9 **Barts Health NHS Trust (BH)** – the implementation process for BH is still under development. Whilst this process is being developed the Nurse Director has been ensuring that the Duty of Candour requirement of informing the patient within 10 days of the incident occurring is being implemented on an individual patient basis for all CCG patients.

8.10 **Partnership of East London Co-operatives (PELC – 111, Out of Hours and Urgent Care Centre)** – The contractual requirements for the Duty of Candour have been communicated to PELC, and a process for implementation is under development. PELC report small numbers of serious incidents, making it straightforward to monitor each of these on an individual basis until the reporting process has been embedded.

8.11 **Independent Sector (Spire, Holly House and the North East London NHS Treatment Centre)** All three organisations rarely have serious incidents occurring on their premises; they are all aware of their contractual responsibilities and have started reporting on the Duty of Candour requirements. These organisations are compliant at the time of writing.

8.12 **Care homes with nursing** - all homes will be having a quality assurance visit during quarter 3 and 4 2014/15. During this visit the requirement to implement the Duty of Candour will be discussed and next steps agree with the provider. The arrangements to monitor compliance are still under development.

List of appendices

APPENDIX 1 Extracts from the Francis Report
Background Papers Used in the Preparation of the Report:

- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volume 1: Analysis of evidence and lessons learned (part 1) Chapter 6, Patient and Public local Involvement and Scrutiny
- The lessons councils must learn from the Francis report (Local Government Chronicle, February 2013)
- Francis criticises council scrutiny ‘failure’ (Local Government Chronicle, February 2013)
- Francis: give councils more scrutiny power (Health Service Journal, February 2013)
- ‘Francis Inquiry is ‘wake-up call’ to refresh culture & improve patient care’ (Centre for Public Scrutiny, Press Release, February 2013)
- Spanning the System: Broader Horizons for Council Scrutiny (Centre for Public Scrutiny, March 2013)
- Minutes and agenda - Health and Wellbeing Board, 4th June 2013
- Minutes and agenda - Health and Adult Services Select Committee, 17 April 2013
- A Guide for Overview and Scrutiny Committees for Health and Social Care: How your committee can work with the Care Quality Commission (September 2011)
- Patients First and Foremost. The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry (March 2013)
- Overview and Scrutiny of Health: Guidance (Department of Health, July 2003)
- Minutes and agenda - Health and Adult Services Select Committee, 29 July 2013
## Extracts from the Francis Report

<table>
<thead>
<tr>
<th>Extract</th>
<th>Chapter/paragraph</th>
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<tr>
<td>It [the health scrutiny committee] made no attempt to solicit the views of the public. It had no procedure which would have encouraged members of the public to come forward with their concerns.</td>
<td>6.350</td>
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<td>The official response of the Borough Council to Julie Bailey’s questions and her letter of 20 February 2008 was quite unacceptably dismissive. Mr Thompson told the Inquiry that the OSC had not detected cause for concern about the issues she raised before because it relied on the public and other bodies to raise such matters, and none had.</td>
<td>6.286</td>
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<td>It should have been quite clear that [the local campaigner] Julie Bailey and her group had raised serious cause for concern about the general standard of service and management at the Trust, albeit understandably based on their own experiences. That is surely the most likely way in which such concerns will come to light. If ever there was an issue on which local politicians were entitled to involve themselves and make demands of the authorities for information and action, this was surely it.</td>
<td>6.287</td>
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<td>It [the scrutiny committee] made little use of other sources of information to which it could have gained access, such as complaints data or even press reports.</td>
<td>6.350</td>
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<td>“the Health Scrutiny Committee can only do so much and though it continues to ask questions, it ultimately has to trust that the picture portrayed of the Hospital by its representatives is honest and accurate unless there is evidence to the contrary. It has no mechanism to make sure the representatives do this nor does it have any authority to investigate the situation at the Hospital itself.”</td>
<td>6.291</td>
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<tr>
<td>“It was just a pleasant little talking shop, and again there are plenty of minutes of that body and those presentations that Julie talked about, that were being swapped with the OSC and the hospital, even as the Healthcare Commission was writing in September 2008 to say: you are a dangerous place, get your A&amp;E sorted out. Meanwhile, the management team is giving a slide show to the OSC saying: it is absolutely fine. The OSC went for lunch at the hospital, were shown round a little bit, asked no questions.”</td>
<td>6.285</td>
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<td>Scrutiny ought to involve more than the passive and unchallenging receipt of reports from the organisations scrutinised…</td>
<td>6.352</td>
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<td>…the power of summoning the leaders of provider trusts to give an account of their actions in public is a</td>
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<td>powerful tool, which, if used properly, proportionately and after preparation, could act as an incentive towards improvement and as a challenge to the public being offered inaccurate or superficial information.</td>
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<td>“The committee … did not get underneath what the representatives from the Hospital were telling it … Chief Executives usually talk up an organisation and put on a positive gloss. If the same happened again, then I would look deeper and ask questions to the people below … e.g. the nurses, doctors and consultants.”</td>
<td>6.280</td>
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<td>THE CHAIRMAN: I mean, would it be fair to categorise what really happened on that day as your committee just rubber stamping the proposal, rather than there being any critical analysis of it?</td>
<td>6.240</td>
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<td>A. I would say that, all right, the PowerPoint presentation was given and at the end of it there would be questions asked. But I can’t recall what questions.</td>
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<td>THE CHAIRMAN: But just as you say that as you had been told of no concerns on other matters, they wouldn’t really be looked into by the committee, you would have had no basis at all to do anything other than accept what was being said to you by the trust which was that this application was, putting it broadly, a good idea; would that be fair?</td>
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<td>A. Yes.</td>
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<td>THE CHAIRMAN: Does that mean that the process of consultation in this particular instance therefore is meaningless?</td>
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<td>A. Yes, I would say that. I would</td>
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<td>“I think there’s going to be very few heroes come out of this Inquiry. We’re certainly not going to be acclaimed with that. So … I think looking back and in hindsight, then clearly, at various times, with the benefit of hindsight we could have done more. And I’m not seeking to argue – argue differently. I think we did in our own way the – you know, what we felt was the most appropriate level of … scrutiny.”</td>
<td>6.278</td>
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<td>Councillors are not and cannot be expected to be experts in healthcare. They can, however, be expected to make themselves aware of, and pursue, the concerns of the public who have elected them.</td>
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<td>“I do not think it was the County Committee’s responsibility to go and find out what the views of people were. In a sense it would have been pointless to do this given the vast and frequently diametrically opposed range of views amongst different views of the public.”</td>
<td>6.306</td>
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<td>“In relation to the criticism that the Committee failed to respond to patient concerns in relation to the Trust, I would have to agree. What became extremely apparent after reading the HCC report is that we, along with”</td>
<td>6.349</td>
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<tr>
<td>Extract</td>
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<td>other agencies, could have been more involved with what was going on at the Trust at the time … I wish that we had dug deeper … there should have been more scepticism of what we were told by the Trust.”</td>
<td>6.290</td>
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<td>As pointed out by several witnesses, scrutiny committees have many areas for scrutiny and have to prioritise between them. There is certainly evidence that insufficient significance was given to information coming from the public. In any event, there may have been a lack of understanding about what scrutiny of an acute hospital actually entailed.</td>
<td>6.290</td>
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<td>Councillor Edgeller could only recall three occasions on which members of the public had raised a concern, and only one of these related to the quality of the service. The OSC was therefore very dependent on the accuracy, completeness and insight of the information conveyed to it by the Trust.</td>
<td>6.204</td>
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<td>The Inquiry has heard considerable evidence about the interaction between patient and public representatives and the Trust. It might have been expected that concerns about the standards of service would have first become apparent through these channels. Such representatives and their organisations were intended to be accessible to patients and the general public and to have the means to identify concerns and communicate to those responsible for the management, oversight and regulation of providers. In practice, alarm bells were not rung by this route, or at least not sufficiently loudly to provoke any effective reaction.</td>
<td>6.1</td>
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HEALTH AND ADULT SERVICES SELECT COMMITTEE

30 SEPTEMBER 2014

Title: Transforming Services Changing Lives Programme

Open Report | For discussion
-------------|------------------
Report Author: Masuma Ahmed, Scrutiny Officer | Contact Details: Tel: 0208 227 2756 E-mail: masuma.ahmed@lbdd.gov.uk

Accountable Director:
Anne Bristow, Corporate Director of Adult and Community Services

Summary:
The Local Clinical Commissioning Groups (CCGs) of Redbridge, Barking and Dagenham, Tower Hamlets, Waltham Forest, and Newham; plus NHS England, Bart’s Health and other local providers, have established a clinical transformation programme called Transforming Services, Changing Lives (TSCL). It will consider how services need to change to provide the best possible health and health care for local residents. It does not, at this stage, outline any recommendations for change.

At Appendix 1 members will find a report from the TSCL Programme outlining the background to the Programme and the 'Interim Case for Change'.

At Appendix 2 members will find a draft response prepared by officers to the Interim Case for Change for review and comment.

Recommendations
The Health and Adult Services Select Committee (HASSC) is recommended to:
(i) Provide comment and feedback to the Programme Team based on their review of the 'Interim Case for Change'.
(ii) Consider and confirm requirements and timings for future updates and presentations about the final Case for Change.
(iii) Review and comment on the draft response prepared by officers to the Interim Case for Change.

Reasons
The HASSC specifically has the role of acting as the statutory consultee where Health Services propose variations in the provision of services. This is an opportunity for HASSC members to provide their comments and put questions to Programme representatives on the Interim case for Change.

List of appendices
Appendix 1 Report of the Transforming Services Changing Lives Programme
Appendix 2 Draft response on the Interim Case for Change
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### Report of the Transforming Services, Changing Lives Programme

<table>
<thead>
<tr>
<th>Report Author: Neil Kennett-Brown, Programme Director</th>
<th>Contact Details: Tel: 020 3688 1222 E-mail: <a href="mailto:neil.kennett-brown@nelcsu.nhs.uk">neil.kennett-brown@nelcsu.nhs.uk</a></th>
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#### Summary:

The Local Clinical Commissioning Groups (CCGs) of Redbridge, Barking and Dagenham, Tower Hamlets, Waltham Forest, and Newham; plus NHS England, Bart’s Health and other local providers, have established a clinical transformation programme called Transforming Services, Changing Lives (TSCL). It will consider how services need to change to provide the best possible health and health care for local residents. **It does not, at this stage, outline any recommendations for change.**

A key element of the programme is to consider how best to ensure safe, effective and sustainable hospital services at Bart’s Health hospitals, set in the context of local plans to further develop and improve primary, community and integrated care services.

The work of the programme, which was launched in February 2014, and is expected to run until autumn 2014, will develop a baseline assessment of the drivers for change in the local health economy and support further discussions about the scope, scale and pace of change needed.

**Key milestones:**

- **9 July**: Interim Case for Change published. Engagement commences to gather feedback to help to inform the final Case for Change and help us determine priorities for the future. This includes events for all Barts Health staff, attendance at public events and a series of patient focus groups.
- **Autumn**: Publication of final Case for Change.
- **After publication of Case for Change**: Explore and agree joint priorities to improve local services. If we think change is required we will work with the public and clinicians to consider a range of potential options to help improve healthcare services.

### 1. Introduction and Background

1.1 The five CCGs involved in Transforming Services, Changing Lives have a duty to promote a comprehensive health service for their populations of around 1.3 million people. Today, local NHS services face the very real challenge of providing care for a rapidly growing local population, whilst continuing to meet the health needs of some of the most deprived areas seen anywhere in the UK.

1.2 The health economy is never static. Change is happening all around the system. In the last year, since the establishment of CCGs, we have seen the introduction of NHS 111, the development of integrated care and soon the launch of personal health budgets. We need to respond to these changes to ensure that benefits are realised and unintended consequences are avoided.
Appendix 1

1.3 However, we also know that some services simply need to improve to meet local needs. We need to address the areas where we are not so good. We know that the quality of care we provide is inconsistent. We need to work better with providers and with social care to address the challenges we face and decide how we can introduce new and different ways of providing care.

1.4 Collectively commissioners have agreed with providers to look at the challenges we face, to ensure we can continue to provide the care our patients need, at the best possible place for them. Organisation boundaries must not and cannot impede the commitment to deliver improvements at scale across the partnership.

1.5 We also need to make sure that any changes in the future happen safely and effectively.

1.6 In developing their case for change, clinicians will be guided by the principles of the Francis Report to ensure delivering first class care for patients and local populations is the driver for change.

2. Proposal and Issues

2.1 Local clinicians have been asked to use their own knowledge of national and international best practice to review the quality and performance of East London health services, highlight areas of good practice that should be maintained and developed, and set out if, why, and in what specialties they think there may be a case for change to ensure the very best care for local residents. They are not, at this stage, setting out any recommendations for change.

2.2 Their work has been published as an ‘Interim Case for Change’, which is available to view at www.transformingservices.org.uk.

2.1 Key milestones:

- **9 July**: Interim Case for Change published. Engagement commences to gather feedback to help to inform the final Case for Change and help us determine priorities for the future. This includes events for all Barts Health staff, attendance at public events and a series of patient focus groups.
- **Autumn**: Publication of final Case for Change.
- **After publication of Case for Change**: Explore and agree joint priorities to improve local services. If we think change is required we will work with the public and clinicians to consider a range of potential options to help improve healthcare services.

3. Options Appraisal

3.1 The TSCL programme does not, at this stage, outline any recommendations for change. Following the publication of the final Case for Change we will explore and agree joint priorities to improve local services. If we think change is required we will work with the public and clinicians to consider a range of potential options to help improve healthcare services.

4. Consultation

4.1 Although TSCL does not, at this stage, set out any recommendations for change, the programme recognises the importance of engaging local stakeholders in our work at an early stage.
This includes, but is not limited to:

- The formation of clinical working groups, made up of clinicians including GPs, doctors, nurses and therapists, who have developed the interim case for change.
- The formation of a public and patient reference to support the development of the interim case for change.
- Two large events in April and July for key stakeholders. Invitations to Health and Wellbeing Board Chairs, as well as other local authority members, such as Directors of Public Health, Directors or Social Care, Chairs of Overview and Scrutiny Committees etc
- Barking & Dagenham Healthwatch team has been invited to sit on the Transforming Services, Changing Lives Public and Patient Reference Group in order to help shape the Case for Change. They have acknowledged the invitation and have received ongoing, regular email updates about the programme.
- A series of large engagement events for Barts Health staff
- A range of public events, including attendance at the Barking and Dagenham CCG Patient Engagement Forum and stands at hospital sites
- Presentations at the August Barking & Dagenham Local Medical Committee, September Health and Wellbeing Board and Joint Executive Committee meetings
- A series of patient focus groups

4.2 In order to analyse the feedback and report back to the commissioners, and to be fair to respondents, we had to provide a date by which people should respond. Official engagement on the interim Case for Change ends on Sunday 21st September.

4.3 However, we will incorporate into the final report any feedback received up until Friday 26 September 2014.

4.4 We are keen to continue talking to stakeholders about the TSCL programme. After this date if we are able to incorporate feedback into the final report we will do so, or we can update commissioners verbally.

4.5 We see this as a continuing dialogue and so welcome comments at any time.

5. Implications

There are no financial implications arising from this report. Any costs associated with London Borough of Barking and Dagenham representation on the TSCL Programme Board are met through existing budgetary provision. There are no legal implications arising from this report.

Background Papers Used in the Preparation of the Report:

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Appendix 2: Proposed response to the Transforming Services, Changing Lives Consultation to be submitted to the Chair of the Health and Adult Services Select Committee on behalf of the Council

Thank you for asking the Barking and Dagenham Health and Adult Services Select Committee to respond to the consultation on the Transforming Services, Changing Lives Programme. We support the Programme’s aim of improving people’s health and healthcare in East London and feel that your Case for Change has some general applications across the Barking and Dagenham, Havering and Redbridge health economy. However we would like to put forward the following comments in response to the consultation, also taking into consideration the comments made by the Health and Wellbeing Board in response to the presentation made at their 9 September meeting.

Ensuring that local services do meet local needs

One of the key areas for change within Transforming Services, Changing Lives (TSCL) is ‘Ensuring local services meet local needs’. Barking and Dagenham is only cited a handful of times in your Case for Change document. It is therefore not clear how the Programme is taking Barking and Dagenham residents directly into account, nor how the key areas for change will benefit our residents. We understand that the Programme is focused primarily on Newham, Tower Hamlets and Waltham Forest, however Barking and Dagenham forms part of East London and a number of our residents use services commissioned from the acute and community trusts discussed in the document. It would be useful for future Programme documentation to profile the Borough, the needs of our residents and service usage and state explicitly how the Change Programme will bring improved services and health outcomes for our residents.

Whilst we understand why you wish to adopt common outcomes and clinical principles, this cannot necessarily translate into a common service delivery model or vehicle. We say this because we do not believe that a ‘one size fits all’ approach will work in this Programme. As we are sure that your analysis shows, every Borough’s health needs and demographic pressures are different and the TSCL Programme needs to ensure that this is reflected to ensure that local services truly meet local needs. The Borough has seen transformative programmes before, namely the Health for North East London (H4NEL) programme, and the lessons from these previous consultations do not appear to have been learned. H4NEL did not take into account the individual Borough needs nor the practicalities of accessing services from the point of view of residents (such as the availability of transport routes and the length of travel times), and the Programme needs to ensure that these important issues are being addressed when any changes are being made to services.
Focus on integration

Although the focus of this consultation is to improve healthcare and health outcomes, it is disappointing that the TSCL Programme does not give credit to the important integrated working that is taking place between health and social care across East London. Within Barking and Dagenham our integrated cluster teams (teams of social workers, GPs and other health professionals) work together to improve outcomes for some of our most vulnerable residents which has prevented the need for health services further down the line. Additionally, our Joint Assessment and Discharge service with Havering and Redbridge is ensuring that patients are discharged in a timely manner and leave hospital with appropriate support within their own home or in the community where possible, rather than in hospital or residential settings. Our Borough’s focus is on integrating more with health services, and with key legislation and policy such as the Better Care Fund, Care Act, Children and Families Act, and the most recent Baker Commission report recognising the importance and the benefits of integration, we feel that the TSCL Programme needs to both acknowledge the integration agenda, and think about how joint working and commissioning can facilitate and drive health improvements in East London.

Parity of esteem

Finally, we wish to ensure that the TSCL Programme is taking both physical and mental health needs into account when designing improved services. Parity of esteem has been a significant topic of discussion at our Health and Wellbeing Board and mental health sub-group meetings and we are currently auditing our own mental health services to ensure that our service provision is robust, effective and addressing the 25 priority areas outlined in the Department of Health’s ‘Closing the Gap’ report. This Committee would like to be reassured that the TSCL programme will address both the physical and mental health inequalities and needs within our populations and see mental health given an equal footing with other health services in East London.

We look forward to seeing the future development of the Transforming Services, Changing Lives programme and seeing our comments included within future documents. We will ensure that you are invited to a future Health and Adult Services Select Committee meeting once the vision and priorities for change have been worked up following the consultation.
HEALTH AND ADULT SERVICES SELECT COMMITTEE

30 SEPTEMBER 2014

Title: Intermediate Care Consultation

Report of the Divisional Director of Adult Social Care

Open Report

Report Author: Bruce Morris
Divisional Director Adult Social Care

Contact Details:
Tel: 020 227 2749
E-mail: bruce.morris@lbld.gov.uk

For Information

Accountable Divisional Director: Bruce Morris, Divisional Director, Adult Social Care

Accountable Director: Anne Bristow, Corporate Director, Adult and Community Services

Summary:
The Clinical Commissioning Group (CCG) are consulting on proposals to change the way NHS rehabilitation services are provided across Havering, Barking & Dagenham, and Redbridge. The three separate CCGs have come together to agree these proposals across the three local authorities concerned and the consultation is going through the other scrutiny processes simultaneously.

This report sets out information about the consultation process and the issues around the proposals. Sharon Morrow, the Chief Operating Officer from Barking and Dagenham CCG will attend the Health and Adult Services Select Committee to present the proposals.

It should be noted that the deadline for the Intermediate Care Consultation has now been extended from Wednesday 1 October to 5.00pm on Wednesday 15 October 2014.

Recommendations

The Health and Adult Services Select Committee is recommended to:

(i) Consider the proposals presented by the CCG

(ii) Discuss and comment on the attached issues (Section 3) which will form the response to the Intermediate Care Consultation from the Health and Adult Services Select Committee (HASSC)

(iii) Agree for the Chair of HASSC, Councillor Keller, to finalise the response and send it on behalf of HASSC to the CCG.

Reasons

The Intermediate Care Consultation has ramifications for the Council’s second priority, ‘enabling social responsibility’, and in particular the objective, ‘ensure everyone can
access good quality healthcare when they need it’. There are concerns that the proposals put forward in the Intermediate Care Consultation regarding the placement of inpatient beds at King George Hospital will have an impact upon the accessibility of the site for both patients and visitors. Additionally, there are concerns about how stroke rehabilitation and services at Grays Court will be affected by the proposals in the consultation.

1. **Introduction and Background**

1.1 The CCG are consulting on proposals to change the way NHS rehabilitation services are provided across Havering, Barking & Dagenham, and Redbridge. The 3 separate CCGs have come together to agree these proposals across the 3 local authorities concerned and the consultation is going through the other scrutiny processes simultaneously.

1.2 The proposal is to reduce the number of inpatient beds provided across the 3 boroughs in the specialist community hospitals and provide more treatment in people’s own homes.

1.3 The inpatient beds are currently provided at specialist NHS facilities at Grays Court in Barking & Dagenham, King George Hospital (following the closure of Havering inpatient beds at St George’s Hospital), and Heronwood and Galleon in Redbridge. They are referred to in the consultation as “Community beds”.

1.4 The proposal is that in future a reduced total number of inpatient beds would be provided at King George Hospital for all 3 boroughs, with a dedicated cross-borough service, IRS (the Intensive Rehabilitation Service), providing therapy services in people’s own homes. The IRS is a team of physiotherapists, occupational therapists, healthcare assistants and others offering intensive physiotherapy and other therapy in a patient’s own home, with up to four visits a day depending on the patient’s needs. The service operates from 8am - 8pm, seven days a week.

1.5 The proposals also refer to another cross-borough service to support people in their own homes, the CTT (Community Treatment Team). The CTT is a team of doctors, nurses, physiotherapists, social workers and others who together care for people having a health or social care crisis at home so that they either do not need to go into hospital or return home from hospital sooner. This service is intended to provide an urgent response to people who may otherwise need to go to the Accident & Emergency departments because they need intensive treatment at home over and above the service that could be provided by standard primary care teams (GPs and district nurses). As the CTT works extended hours (till 10.00 pm) 7 days per week, the rationale is this service would, by working with the IRS, provide wrap around cover for patients in their own homes.

1.6 The CCG have been trialling an expanded CTT and the new IRS in Barking and Dagenham since November 2013. Both services have been well-utilised during the trial and have performed well. The CCG have reported improved patient outcome scores and that patients are able to access community beds more quickly than they could before the advent of the trial.
2. The Consultation Process

2.1 The consultation was launched on 9 July 2014 and is due to run until Wednesday 15 October.

2.2 The CCG had an informal meeting with Members on Thursday 31 July 2014 to brief them on the proposals and provide clarification on a number of issues including the scope of the proposals. The Health & Wellbeing Board considered the proposals on 9 September 2014 and this has informed the concerns as outlined in Section 3 of this report. Members may wish to ask questions of the Chair of the Health and Wellbeing Board and/or officers to help form a view on the proposals and suggested areas for questioning have been outlined below.

2.3 The Health and Wellbeing Board considered the Intermediate Care Consultation at their 9 September meeting. Although there was broad support for the clinical model and the overarching principles, there remain a number of detailed considerations for local residents and the Council and these are highlighted below.

2.4 Following the discussion at HASSC, the issues will form the basis for the response to the consultation which will be sent from Councillor Keller, Chair of the Health and Adult Services Select Committee to the CCG.

3. Issues

Local Need

3.1 Members have previously expressed concerns about organising services to cover the disparate populations and needs of Havering, Redbridge and Barking and Dagenham with a “one size fits all” approach. The characteristics of the different local authority areas in terms of poverty and wealth, housing, demographics, and health needs is well understood.

3.2 It would be useful to ask the CCG to describe how the proposals will affect local residents in particular, and to ask for details of the number of Barking and Dagenham residents who are expected to use these services, and the expected future demand.

Grays Court

3.3 Grays Court is owned by the Council and on a long lease to the NHS. The proposals do not cover the alternative use of Grays Court. Members have been advised informally by the CCG that there are 17 “stroke beds” at Grays Court and they are not subject to this consultation. There are also a range of specialist outpatient services and clinics on the ground floor at Grays Court and it is currently unclear whether these are included in the scope of the consultation.

3.4 With proposals in their current form there is every possibility of a half empty, or empty building in the middle of the borough. Officers have worked hard with the CCG to consider alternative uses for the building by Council services but none of these ideas will be feasible if there are still NHS inpatient beds in the building.
3.5 If members were minded to give in principle support to the proposals this would need to be subject to a written agreement about the future use of Grays Court and financial and other legal matters would need to be resolved.

3.6 Grays Court is near to another NHS facility, Broad Street Walk-in centre, that was recently closed despite considerable opposition from the Council, voluntary sector and local residents. It is generally considered that, in view of the health needs of the local population, Barking & Dagenham requires more local investment to cater for both those with long term health conditions, and a growing younger population. Taken together with the well documented problems in the acute hospital, BHRUT, there must be a risk that these proposals will put further stress on a health and social care system that is already stretched.

3.7 Residents are likely to perceive these proposals as a further reduction in NHS services in the borough, and in light of earlier comments in the report they need to be considered in the context of other changes. It should also be noted that at the Health and Wellbeing Board it was stated that the closure of two services in Barking and Dagenham (Grays Court and Broad Street Walk in Centre) feels disproportionate to closures in the other two Boroughs. Whilst the clinical rationale for Grays Court is understood, it has still raised concern that the centralisation of services is happening out of Borough.

3.8 Members may wish to explore this issue with the CCG and require assurances that there will be no further closures of local services.

Medical Cover

3.9 At the Health and Wellbeing Board meeting on 9 September, a clinician stated that at times he did not have full reassurance that patients were receiving the appropriate level of care and support overnight. Members may wish to seek assurance from the CCG about levels of medical cover and patient safety overnight in the current inpatient services,

3.10 With the ongoing recruitment problems of consultants at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), the consultation poses questions as to whether King George Hospital will be given appropriate levels of medical cover. Members may wish to seek assurance that appropriate medical cover will be given to this unit, particularly overnight, and what plans are being put in place to ensure that this is achieved considering the recruitment problems at BHRUT.

Location and Travel Times

3.11 The CCG have argued that travel times to King George Hospital will be less of an issue as more people will be treated in their own homes. While this is true it is also the case that some residents will require inpatient treatment and their family and friends will be reliant on public transport to King George to visit them. Although the hospital is a 20 minute walk from Goodmayes station and is connected by local bus routes, residents could face significant travel times in getting to King George. For example, Transport for London Journey Planner results to King George Hospital list approximate minimum journey times as:
3.12 In light of these concerns, Members may wish to consider requesting an impact assessment covering alternative travel plans comparing Grays Court and King George Hospital, to better understand how local residents will be affected.

3.13 Members may wish to explore what feedback the CCG have received from patients and residents about this issue. Given that HASSC is meeting with the CCG quite late in the consultation process, Members may wish to ask about the consultation responses that they have received from members of the public and local organisations so far, particularly from the consultation event held at Barking Learning Centre on Thursday 11 September.

**Stroke Rehabilitation**

3.14 The scope of the proposals do not cover the full range of services that would usually be considered as NHS Intermediate Care services.

3.15 Stroke rehabilitation is specifically excluded from the consultation remit as this is referred to as being part of a different care pathway. Furthermore there is growing evidence of small numbers of people ready to leave hospital having their discharge delayed because they are not considered suitable or ready for rehabilitation, and other people with very specialist needs who are delayed waiting for specialised long-term rehabilitation. It is suggested the proposals need to either include services for this group of people, or at the very least deal with the impact of these proposals on those groups of patients, and the services that are provided to them.

3.16 In light of these concerns, Members may wish to explore the following in their discussion and questioning to the CCG:

- What was the rationale for excluding stroke rehabilitation from the remit of the Intermediate Care Consultation?
- How are the CCG going to ensure that changes to Intermediate Care services are not going to adversely impact patients who have suffered a stroke and are awaiting rehabilitation?
- How is the CCG reviewing the stroke care pathway and ensuring that it is fit for purpose?

4. **Financial Implications**

4.1 The impact of any changes to intermediate care services on local authority care services will be closely monitored to ensure these remain within planned levels. Further consideration will be given to the use of Grays Court when CCG requirements have been clarified.

Implications completed by: Roger Hampson, Group Manager Finance (Adult and Community Services).
5. Legal Implications

5.1 Section 3 of the Care Act 2014 places a duty on local authorities to carry out their care and support functions with the aim of integrating services with those provided by the NHS or other health-related services. Local authorities should prioritise integration activity in areas where there is evidence that effective integration of services materially improves people’s wellbeing. Issues have been raised during consultation about the proposed changes as detailed in section 3 of the report and are subject to further discussion and decision-making.

Implications completed by: Chris Pickering, Principal Solicitor, Employment & Litigation, Legal and Democratic Services

Background Papers Used in the Preparation of the Report:

BDCCG, Making Intermediate Care Better (Consultation paper)
Available at: www.barkingdagenhamccg.nhs.uk/Get-involved/consultations.htm

List of appendices:

None.
REPORT OF SCRUTINY

Report Author: Masuma Ahmed, Scrutiny Officer
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Email: masuma.ahmed@lbld.gov.uk

Accountable Divisional Director: Fiona Taylor, Head of Legal and Democratic Services

Accountable Director: Graham Farrant, Chief Executive

Summary:

Each of the Council's scrutiny select committees has a 'work programme' which is a timetable of the matters the Committee wishes to consider in the current municipal year. This report aims to assist the Health and Adult Services Select Committee (HASSC) members to produce its Work Programme for 2014/15.

Earlier in the municipal year, the Scrutiny Team asked for suggestions on areas the HASSC could potentially scrutinise from members of the public, select committee members, partners and Council officers. This resulted in a list of seven suggested topics.

Prior to the formal meeting of the HASSC on 30 September 2015, the Committee shall have a work programming meeting to undertake preliminary discussions on which topics would form good subject matter for a scrutiny review.

At the formal meeting, the Lead Member will update those in attendance on the views arising from the former, preliminary meeting and provide an opportunity for members of the public present to feed their views into the work programme.

The following are appended to this report:

A. The Committee's remit as described in the Council's Constitution
B. The Draft Work Programme with dates of meetings and standard items
C. The topics put forward by partners, officers, members and the public for the Committee's consideration.

Recommendations

The HASSC is recommended to agree the topic which will form the basis of its Scrutiny Review and other items to be placed on its Work Programme 2014/15.
1. Scrutiny Work Programmes

1.1 Work Programmes generally consist of two types of scrutiny:

1.1.1 Scrutiny Reviews

Usually, as part of their annual work programme, the select committees aim to complete at least one investigation into an area of member and/or public concern to make recommendations in order to improve services. These investigations are referred to as 'scrutiny reviews'. A scrutiny review usually involves a number of different stages including:

1. Agreeing the subject matter of the review according to given criteria
2. Drafting the terms of reference for the review (these are a set of questions/ specific areas the Committee wishes to consider, with a view to making recommendations for improvement in those areas)
3. Scoping the review (scoping refers to a detailed project plan outlining the suggested methods for gathering evidence including potential participants/ contributors to the review. It is a timetable designed to deliver what is set out in the terms of reference and includes the estimated date for the completion of the review, in accordance with internal scrutiny procedures and protocols)
4. Carrying out the review in accordance with the agreed scope
5. Agreeing the contents of the scrutiny review report including the recommendations
6. Sharing the report with those involved with the review and finalising the report
7. Publicising the report
8. Monitoring the impact of the review.

Further information about the scrutiny review process is on pages 15 to 16 of the Scrutiny Handbook for members.

1.1.2 'One-off' Items

Select Committees may also use the Work Programme to consider issues on a 'one-off' basis by, for example, asking representatives of a service to attend a meeting to have a discussion with members, or undertaking a site visit to a facility.

2. Matters to Consider before deciding items to scrutinise

2.1 When deciding what matters should be scrutinised, whether they will be scrutinised via a review or as a one-off item, it is good practice to reflect upon the following matters:

2.1.2 The Committee's Remit

First and foremost the selected topics must be ones which fall under the Committee’s remit, which is provided in Appendix A.

Members will note that the HASSC specifically has the role of acting as the statutory consultee where Health Services propose substantial variations in the provision of services. Therefore if substantial variations are proposed during the course of the year the HASSC may wish to invite representatives of the Health Service making the proposal to a meeting to undertake scrutiny of the proposals.
Also specific to the HASSC is the statutory power of HealthWatch to refer matters to
the HASSC. Although at the time of writing this report, no such matters have been
brought to the attention of the Scrutiny Officer, Members are asked to note that
HealthWatch may ask to refer items during the course of the year.

Members will note furthermore, that the HASSC’s remit includes holding the Health
and Wellbeing Board to account for its decisions. The Health and Wellbeing Board,
which is chaired by the Cabinet Member for Health, takes executive decisions.
These include approving the Joint Strategic Needs Assessment and the Health and
Wellbeing Strategy. Further information about the role of the Health and Wellbeing
Board can be found in the Council Constitution.

2.1.3 The ’PAPER‘ Criteria

When deciding which topic to select for review, best practice is to select topics that
meet the following criteria:

— Public interest (be of importance to local residents)
— Ability to change (be within the Council and its partners’ power to change or
  influence)
— Performance (areas where scrutiny can add value are ones which require
  improvement)
— Extent of issue (priority should be given to issues that are relevant to a
  significant part of the Borough)
— Replication (avoid duplicating the work of other committees, bodies or
  organisations)

Factors to take into account when considering the Work Programme for 2014/15

2.1.4 Resources

The Scrutiny Team in 2014 consists of one full time Scrutiny Officer (supporting the
HASSC, the Children’s Services Select Committee, and the Children’s Trust), one
part-time Scrutiny Officer (supporting the Safer and Stronger Community Select
Committee and the Living and Working Select Committee). The Public Accounts
and Audit Select Committee is currently supported by the Group Manager of
Democratic Services. Scrutiny line management responsibilities have transferred to
Alan Dawson, who continues to manage committee staff.

2.1.5 The number of formal meetings

Select committees typically meet formally six or seven times a year; however,
scrutiny meetings and the Council Calendar generally this year have been planned
to fit around the local elections in May 2014, the member induction period in June/
July, the August recess, and the ‘purdah’ period prior to the parliamentary elections
in 2015. This means there are only four formal HASSC meetings this municipal
year.
2.1.6 The Work Programme

There are standard items on the Work Programme the Committee will consider including:

- Budget Scrutiny: each select committee will use one of its formal public meetings to review savings proposals for Council services that fall under its remit.
- Updates from meetings of the Joint Health Overview and Scrutiny Committee

Furthermore, members are asked to note that there may be additions to the Work Programme later on in the year if:

- the Committee agrees to carry out pre-decision scrutiny (including scrutiny of proposed substantial variations to health services)
- decisions made by the Cabinet or the Health and Wellbeing Board that are relevant to the Committee’s remit are ‘called-in’
- there are public petitions which fall under the Committee’s remit.

3. Potential areas to scrutinise

3.1 Appended to this report are a list of suggested topics put forward for the HASSC’s consideration.

3.2 Topics which are not selected to form the subject matter of a scrutiny review may be put forward to be considered at a meeting as ‘one-off’ items (as well as other topics of interest to members). When deciding the number of items to place on the Work Programme, members are reminded that the HASSC may wish to undertake pre-decision scrutiny and may need to consider call-ins, public petitions and proposals for substantial variations.

3.3 Members are asked to indicate what their preferred method of information gathering will be for these items (for example, members may wish for officers to deliver a presentation, carry-out a site visit or ask for key individuals to attend a HASSC meeting).

4. Next steps

4.1 Once members have selected a topic for Scrutiny Review, officers will further develop the scope of the Review with key milestones and date of completion, which will be shared with the Committee. Information about scoping is provided at section 5 below.

4.2 With regards to any ‘one-off’ items agreed upon by Members, the Scrutiny Officer will place them on the draft Work Programme and inform the relevant Senior Officer of the items, who will commission reports or presentations, for example.

5. Information about Scoping

5.1 Scoping is also known as methodology. It refers to the different methods that may be used to gather evidence for a scrutiny review and achieve what is set out in its terms of reference, including:
— Desktop-based analysis and research
— Commissioning reports or presentations from council departments, partner organisations, or external bodies to be considered at formal meetings or informal meetings
— Organising themed workshops with stakeholders
— Surveys, site visits, walkabouts, or ‘mystery shopping’ exercises
— Inviting experts, officers, partners, those who are affected by the issue or other relevant persons or organisations to give oral or written evidence to a Select Committee meeting.

5.2 Due to the limited number of formal HASSC meetings this municipal year and in order to carry out a more in-depth scrutiny review on the topic selected, members whilst scoping the review may wish to consider using part of the 2015/16 municipal year to conclude the review. Members may seek advice from officers at the meeting as to what such a scope would look like.

Background Papers Used in the Preparation of the Report:

The Council Constitution:

http://www.lbld.gov.uk/CouncilandDemocracy/EthicalGovernance/Pages/CouncilConstitution.aspx

List of appendices:

Appendix A  The Committee's remit as described in the Council's Constitution
Appendix B  The Draft Work Programme with dates of meetings and standard items
Appendix C  The topics put forward by partners, officers, members and the public
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Appendix A

The HASSC’s remit as stated in the Council’s Constitution

SECTION F – THE HEALTH AND ADULT SERVICES SELECT COMMITTEE

1. Scrutinising any matter relating to the planning, provision and operation of the health service in the borough or accessed by Barking and Dagenham residents.

2. Requesting information from NHS bodies and any health service provider. Exempt from this power are requests for information that are confidential (i.e., information that identifies a living person or is prohibited under any enactment) or relate to NHS Trusts in special administration.

3. Requesting attendance from any member or employee of a relevant NHS body or health service provider to attend before it to answer any questions; provided those questions do not relate to confidential information or information that they would be entitled to refuse to provide in a court of law. The request for attendance may also be refused if reasonable notice has not been given.

4. Acting, on behalf of the Authority, as the statutory consultee where NHS bodies propose substantial developments or variations in the provision of services and thus have a duty to consult with the local authority before taking a decision. When being consulted with, the HASSC must notify the relevant NHS body of its response to the consultation and any intention to refer the matter to the Secretary of State within the timescales agreed by both parties.

5. Exercising, on behalf of the Authority, the Council’s right of referral to the Secretary of State on substantial variations to local health services. The HASSC will have regard to the criteria and process for making a referral to the Secretary of State which are prescribed in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

6. Receiving referrals from the local Healthwatch on matters relating to the planning, provision, and operation of health services in the borough, acknowledging receipt within five working days. Further to the regulations, Healthwatch can expect a referral to be discussed at the next formal meeting of HASSC, or at a formal meeting within three months (whichever is most timely). In accordance with the regulations the HASSC is obligated to keep the referrer informed of any action taken in relation to the matter.

7. Holding to account the Health and Wellbeing Board for the delivery of its functions, and in doing so, having particular regard to the robustness of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy as effective documents to ensure commissioning of health and social care services is reflective of local need.

8. Presenting recommendations arising from scrutiny investigations in accordance with the Council’s agreed processes, submitting recommendations to the relevant decision-maker as determined by Council’s Scheme of Delegation. Where recommendations or reports are issued to NHS bodies/health service providers, that body or provider must, if requested to do so, respond to the HASSC within 28 days.
1. Monitoring progress of implementation of recommendations in accordance with the Council's agreed processes, ensuring that decision-makers have due regard to findings and recommendations arising from scrutiny investigations.

2. Addressing any Call-ins as allocated by the Statutory Scrutiny Officer in accordance with Article 6A. On occasions where the decision called-in is owned by the Health and Wellbeing Board the HASSC will by default be the receiving Select Committee of that Call-in regardless of the subject of the decision.

3. Addressing any Councillor Calls for Action as allocated by the Statutory Scrutiny Officer in accordance with Article 6B.

4. Considering petitions in accordance with the Council's Petition Scheme which can be found on the Council's website:
   
   http://www.lbld.gov.uk/CouncilandDemocracy/Information/Pages/Petitions.aspx

5. Representing local people and bringing local concerns and feedback about health and social care services to the attention of leaders within the local health and social care economy, formally advising the Health & Wellbeing Board of any such concerns in the process.

Section F, Part C, Council Constitution
## Draft Work Programme 2014/15

### Health and Adult Services Select Committee

<table>
<thead>
<tr>
<th>Meeting (Civic Centre)</th>
<th>Agenda Items</th>
<th>Presenter/Officer responsible</th>
<th>Deadline for Papers</th>
<th>Pre-meeting date with Lead and Deputy Lead</th>
<th>Agenda circulation</th>
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<td>Deadline for circulation via Members' post</td>
<td>Statutory deadline for publication of agenda</td>
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<td>19 Nov 18:00</td>
<td>Budget Scrutiny</td>
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<td>24 Oct</td>
<td>7 Nov</td>
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<td>Cllr Keller</td>
<td>12 Dec</td>
<td>16 Jan</td>
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Appendix C

Topics put forward by partners, officers, members and the public for the Committee’s consideration.

Options 1 - 5 completed by Adult and Community Services

Option 1: Falls

<table>
<thead>
<tr>
<th>Overview</th>
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<tbody>
<tr>
<td>At least a third of people over 65 years of age living in the community fall each year, with significant implications for their health and utilization of health services. Injury and mortality caused by falls is significant as are the consequences of a fear of falling.</td>
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</table>

Falls are a major cause of disability and the leading cause of mortality resulting from injury in people aged over 75 in the UK.

Over 400,000 older people in England attend Accident and Emergency following an accident and up to 14,000 die annually in the UK as a result of an osteoporotic hip fracture. 20% of older people who sustain a hip fracture die within 4 months and 30% within a year.

Hip fractures also result in an annual cost to the NHS of £1.7b for England. Of this 45% of the cost is for acute care, 50% for social care and long term hospitalization and 5% for drugs and follow up.

It is clear that Falls are a significant issue for older people, with increased risks as people age. Older People are likely to have a range of conditions associated with ageing which make them vulnerable and more likely to enter acute hospital care. The effects of falling are exacerbated by problems with bone strength which can mean that older people are more likely to suffer a hip fracture following a fall. This can have a significant impact on mobility and the likelihood of requiring significant care and support, including a risk of needing residential or nursing care. In addition, even minor falls affect self confidence and the ability to remain independent and self caring, particularly where this is combined with other poor health and or long term conditions.

Recovering full functioning following a hip fracture is a lengthy process and many people will require significant rehabilitation and sometimes long term care, either at home or in residential or nursing care. For older people there is a significant risk of further fractures or complications.

Barking and Dagenham as an area has additional risk factors such as those of deprivation with the Borough being in the top 7% most deprived Boroughs within England and 46th in terms of income deprivation (JSNA 2012/13).

Barking and Dagenham was also highlighted as being one of only two boroughs in London that was significantly worse than the

Low levels of physical activity are a significant risk factor for ill health, contribute to health inequality, and are linked to Falls. For example, regular physical activity reduces the risk of falls and accidents (especially in older people) by improving bone health and maintaining strength, co-ordination, cognitive functioning and balance (JSNA 2012/13). A number of services such as exercise on prescription and active aging can positive reduce risk alongside practical interventions such as addressing trip hazards and improving vision.

For women in particular, it is important to recognize potential problems with bone density in middle age, 50, as there is evidence that treatment given early on can go some way to preventing problems in later life. Early diagnosis, before the problem becomes apparent is key.

As well as providing early diagnosis and effective treatment and rehabilitation for the consequences of frailty, treatment of hip fractures, there is also some evidence that other initiatives aimed at prevention can have an impact in the numbers of people who may require treatment and care. For example encouraging people to remain active, and engage in some form of physical exercise means they are less likely to suffer from problems associated with frailty, where conversely people who have experienced a fall are more likely to stay indoors because they are fearful of another fall.

Prevention can usefully focus on making sure the home environment is well lit and uncluttered. In addition a number of services such as ‘exercise on prescription’ and ‘active ageing’ can positively reduce risk alongside practical interventions such as addressing trip hazards and improving vision. One of the micro providers locally has developed a service “Whole Body Therapy” The therapy service incorporating deep tissue massage, holistic massage, strengthening and stretching techniques, postural assessments and advice on health and wellbeing for older people predominantly either in the home or community settings.

Work is currently underway to better understand the range of services that are involved with dealing with Falls.

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<th>Performance/Evidence</th>
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<tr>
<td>Falls are a significant reason for admission to hospital and are therefore significant in our shared attempts to better manage acute admissions to and capacity of. As well as being painful and requiring major surgery, hip fractures are devastating as one third of people die within a year and a high proportion (41%) never return to their own home. (JSNA 2012/13). Specific falls prevention services which improve balance and strength can decrease falls by more than half (55%) if at least all fragility fractures were prevented in the Borough this would save £270,000 (JSNA 201/13).</td>
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In BHR in 2011/12 4442 admissions to hospital were as a result of falls across Barking and Dagenham, Havering and Redbridge. In terms of usage of non acute beds 48% of reasons for admission were identified as falls. In non-acute beds 66% of admissions due to falls were women with an average age for women of 87 and 83 for men. 87% were previously living in their own homes. Alongside people living in their own homes it is important that we take steps to reduce admissions to acute care from care homes which from recent audit activity undertaken by the hospital, remains a significant issue. (BHRUT 2012).

<table>
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<th>Policy and legislation issues</th>
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| Frail Older people are a key group in their projected increase in numbers nationally and their usage of Health and Social Care Services. Developments such as the Care Act broaden responsibilities to Carers, enhanced provision of information and advice, personalization and market shaping and new funding reforms- engaging with people at an earlier point in their support journey.  

The delivery of the Better Care Fund has nationally placed additional emphasis upon local areas steps to reduce admissions to hospital – this being the only area of performance to which performance related funding is now attached. NHS England have been clear that a 3.5% reduction in current admission rates will be expected in plans due to be re-submitted on the 19th September. Reducing levels of falls locally will therefore play its part in achieving this target. |

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<th>Areas of potential enquiry</th>
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| As referred to above there is already a significant work programme established to review and improve services for older people under the umbrella of “Frailty”, of which Falls is a key priority and there is a significant amount of data available.  

Areas of potential enquiry by the Committee could be to:  
- Enquire about the extent to which primary care, GPs, are successful in diagnosing and treating people in middle age with bone density problems  
- Hear evidence from local surgeons about the success rate of treatment for hip fractures, particularly in older people  
- Ask about the extent to which physiotherapy and other services are available for people to help them regain functioning  
- Ask patients about their experiences of recovering from a hip fracture  
- Enquire about the range of initiatives to help people avoid falls around their home, sloppy slippers, lighting etc. |
- Enquire about the range of aids and adaptations available to help people remain independent in their own home if they have lost some mobility or functioning.

### Option 2: Sight loss

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<th>Overview</th>
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<td><strong>Overview</strong></td>
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| We know that visual impairment is a normal effect of ageing with the majority of the population wearing glasses by the age of 55. However more serious implications of sight loss increase with age: 
  - one quarter of over 65s state that the quality of their vision restricts their daily routine. 
  - the prevalence of severe eye conditions increases with age and the majority of people with serious visual impairment are over 65 with a steep increase in over 75s. 
  - Conditions such as diabetes and high blood pressure can further lead to sight problems and are associated with obesity and a lack of physical exercise. 

We know that people living in the Borough are more likely to experience health conditions that can lead to sight loss than is the case in most other areas of the country and that predictions about the numbers of people with low vision underestimate the level of local need.

Given the level of need it seems likely that the take up of some eye care services is not as high as it could be e.g. only 16% of the predicted population of people with severe sight loss access low vision services whereas the proportion in other areas is higher- with neighbouring authorities achieving 21%.

For people with a visual impairment the importance of the built environment – such as the provision of audible crossings and accessible communications is key – if they are to be able to take part in the community as active citizens and access facilities and services.

There are a number of national organisations and also active local groups run by and involving service users who can inform our perspective on visual impairment and with whom the Committee might engage, these include:

- Macular Disease Society
- SeeAbility
- VIPERS
- Vision Strategy Group

- In addition there are officers and clinicians in the local
CCG responsible for commissioning low vision services in the borough.
- Specialist Council staff in the Adult Social Care Division responsible for providing rehabilitation services and advising on specialist equipment.
- Consultant ophthalmologists providing specialist diagnosis and treatment
- An active local Optometry committee involving local opticians.

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<th>Performance / Evidence</th>
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| There appears to be a significant under diagnosis in Barking and Dagenham with only 1,220 people registered with slight 'sight impairment' (partially sighted) or severe sight impairment (blind) which is only 0.73% of the population. The vast majority are over 75 and 32% also have an additional physical disability or long term condition. (JSNA).

We have a low proportion of people with severe sight difficulties reaching the Councils register and this indicates that large numbers of visually impaired people are failing to access specialist services.

This is compounded because people from BAME groups (projected to increase as a proportion of our population) are less likely to have their eyes examined and receive services that can improve their ability to carry on life as normal, or provide early diagnosis of other more serious conditions..

Poor or deteriorating eyesight is a significant contributor to falls which can result in admission to hospital, injury and a deterioration in an individuals ability to self care. On the spectrum of eye care a number of such incidences could have been avoided through having the right glasses and in other cases by more serious eye conditions.

People who are over the age of 75 are recommended to have their sight tested every two years. We know that a fear of having to buy glasses has a detrimental effect on having an eye test, particularly for poorer people. The Atlas of variation also shows that the number of primary eye care professionals is lower in Barking and Dagenham than for Redbridge and Havering. This may be because of the relationship between optometrists and spectacle sales.

The holistic Impaired Vision project that was jointly commissioned by the Council and NHS and was used by 48 people has now drawn to a close.

Nationally, there is no evidence of the effectiveness of rehabilitation and low vision services generally in improving sight but these do deliver other benefits such as improved independence, confidence and well-being.

| Policy and Accessibility and Equalities legislation and policies relating |
legislation
issues

Potential areas for enquiry might include: Engagement with local groups and individuals, alongside commissioners, high street opticians and public health who can inform the Committee’s review of sight loss within the Borough. This would further help to establish:

- Why don’t more residents get their eyes tested, which would also help to identify other health problems which require treatment, such as diabetes.
- Are there potential problems with the growth in the number of people purchasing cheap reading glasses, rather than having glasses prescribed following an eye test?
- Are there a suitable range of appropriate eye care and support services (including psychological support) across the spectrum of need, within the Borough?
- How we might promote improved take up of services within the Borough by people affected by sight impairment and by those most vulnerable groups?
- Do we enable or disable those with sight conditions (through insufficient priority to communications, buildings and transport)?

### Option 3: HIV Prevention

#### Overview

HIV (Human Immunodeficiency Virus) attacks the immune system and weakens a person’s ability to fight infections and disease. AIDS (Acquired Immune Deficiency Syndrome) is the final stage of HIV infection (when the body can no longer fight life-threatening infections).

HIV is found in the body fluids of an infected person, which includes blood, semen and breast milk. HIV infection can be passed on:

- Through unprotected sex,
- Using/sharing a contaminated needle, syringe or other injecting equipment,
- Transmission from mother to baby (before or during birth, or by breastfeeding).
- Through blood or blood products.

Although there is no cure for HIV, early detection and treatment enable people with the infection to live a long and healthy life with normal life expectancy. This means a person diagnosed early with HIV and receiving antiretroviral
treatment can expect to live as long as someone without the infection. Identifying HIV early also minimises costs due to hospital admissions and care in the community. In the first year after diagnosis, it costs the health economy twice as much if the person is diagnosed late (National Institute for Health and Care Excellence, NICE).

Performance/Evidence

Within London, 30 out of 33 boroughs have a high HIV prevalence rate (i.e. a rate greater than 2 HIV positive people per 1000 population, is considered high prevalence). Currently, Barking and Dagenham’s HIV prevalence is 5.47/1000. This means that for every 1,000 people living in Barking and Dagenham, at least 5 will be diagnosed with HIV.

As of 2011, within Barking and Dagenham:

- There are 660 people living with HIV (prevalence of 5.47 / 1000)
- 62% of these are female.
- 86% were infected through heterosexual transmission, 8% through MSM (Men who have sex with men).
- From 2007 to 2011, there was a 44% increase in reported HIV cases.

The borough has a very diverse population, some with their origins in countries with high HIV prevalence. This is also significant in the context of increasingly frequent global travel for leisure and ‘health tourism’ purposes.

As of 2011, 58% of HIV positive residents in Barking and Dagenham were diagnosed late, the 3rd highest late diagnosis rate in London.

In 2011, nationally, the proportion of late diagnoses was lowest among MSM and highest among heterosexual men (table 1). These figures suggest that MSM access testing services more effectively than the heterosexual population and the challenge is to target and encourage heterosexual women and men to be tested for HIV. This is relevant because of the nature of diagnosis and transmission in the borough.

Table 1: stage of HIV diagnosis by probable exposure category.
<table>
<thead>
<tr>
<th></th>
<th>count below 350 cells/mm³ within 91 days of diagnosis</th>
<th>200 cells/mm³ within 91 days of diagnosis</th>
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<tbody>
<tr>
<td>Men who have sex with men</td>
<td>34%</td>
<td>16%</td>
</tr>
<tr>
<td>Heterosexual women</td>
<td>57%</td>
<td>34%</td>
</tr>
<tr>
<td>Heterosexual men</td>
<td>65%</td>
<td>42%</td>
</tr>
<tr>
<td>Overall</td>
<td>47%</td>
<td>26%</td>
</tr>
</tbody>
</table>

(See more at National Aids Trust (NAT): http://www.nat.org.uk/HIV-Facts/Statistics/Latest-UK-statistics/Late-diagnosis.aspx#sthash.gty7xDMI.dpuf)

**London Borough of Barking and Dagenham currently provides the following services -**

- HIV testing as part of sexually transmitted infections (STI) testing as part of the Integrated Sexual Health service provided at Outpatients East (Barking Hospital), Vicarage Field and Oxlow Lane. This service is provided by Barking Havering Redbridge University Hospitals NHS Trust (BHRUT) and is jointly commissioned by the London Boroughs of Barking and Dagenham, Havering and Redbridge. This provision is currently being reviewed and a new service commissioned to start in October 2015.

The following services are contracted to the end of March 2015 and are being reviewed with the view to developing a more local service -

- Positive East provide HIV rapid testing and counseling support (Widows and Orphans are subcontracted for counseling provision)
- Terrace Higgins Trust provide HIV rapid testing
- From September 2014 four GP practices will provide HIV testing as opt out for all (estimated to test over 6000 residents)

Barking and Dagenham also contribute to the Pan London HIV service lead by the London Borough of Lambeth. This service includes outreach and condom distribution for MSM.

**Policy and legislation issues**

It is mandatory for HIV testing to be provided by Local Authorities. As of April 2013, the Local Authority became responsible for commissioning STI (including HIV) testing as well as HIV prevention and sexual health promotion work.

NHS England is responsible for commissioning HIV
treatment and care, including post-exposure prophylaxis after sexual exposure.

The number of people presenting with HIV at a late stage of diagnosis is measured through the Public Health Outcomes Framework (PHOF) and published nationally (indicator 3.04).

| Areas of potential enquiry | HIV services are currently being re-commissioned as part of a pan-London exercise. Discussions are underway with current providers of services to develop new specifications for the services we need here in Barking & Dagenham and across London. In the circumstances this might be a difficult area for scrutiny to explore as an in depth topic and a one-off report could be requested from officers responsible for commissioning services, which would facilitate a discussion of the relevant issues. |

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**Option 4: Carers including children as carers**

**Overview**

Carers (meaning family members or friends who provide informal care to those who need it) are an enormously significant part of the social care system. CarersUK estimate nationally that, every day, another 6,000 people take on a caring responsibility: over 2 million people each year. Of those, it is estimated that 625,000 people suffer mental and physical ill health as a direct consequence of the stress and physical demands of caring. In a cash-strapped health and social care economy, the estimates are of £119bn being saved through the work of informal carers.

The carers’ support system is about to undergo huge change as a result of the Care Act 2014, increasing the right to assessment and services for carers in their own right.

A joint (with the NHS) Carers strategy is currently being developed which will be discussed at the Health & Well-Being Board. This is intended to include changes outlined in the Care Act.

| Demography and prevalence | In the 2011 Census, 16,201 people in Barking & Dagenham identified that they provided some degree of informal care for someone. Of those, over 7,500 provided 20 or more hours per week. Carers of Barking & Dagenham estimate regular contact with approximately 3,500 people (through their newsletter and the provision of other services). 2,580 people are in receipt of carers’ allowance from the Department for |
Work & Pensions. During 2013/14, 745 people were assessed or reviewed by the Council (or Carers of Barking & Dagenham under contract to the Council) for their need for support as a carer.

For young carers, Census figures estimate 623 people under age 18 as carers, with 97 receiving an assessment (JSNA 2013).

Policy and legislation issues

The Care Act 2014, which comes into effect on 1 April 2015, will provide a right for all carers to an assessment, and to the services identified as needed. This is potentially a significant expansion of the support provided to carers, as is evidenced by the data above. During the period of any potential review a lot of work will be being undertaken to plan for the changes. This includes the agreement of a new Carers’ Strategy and the retender of carers’ support services to a specification which is currently under development by CarersUK.

Under the Children & Families Act 2014, the Council is expected to try and identify young carers so they can be offered support, and both adult and children’s social services will need to work together on helping young carers.

Areas of potential enquiry

Given the legislative and policy changes over the next 12 – 18 months, a scrutiny in this area might be a more useful area of focus in 2 years time. At that point it could usefully look at:

- examining how the changes had impacted on carers,
- how the Council was meeting its new responsibilities,
- and, if there were any gaps in policy, strategy or services available.

Option 5: Dementia

Overview

The term ‘dementia’ describes a set of symptoms which include loss of memory, mood changes, and problems with communication and reasoning. These symptoms occur when the brain is damaged by certain diseases, the most common being Alzheimer's disease, but also there can be similar symptoms from damage caused by a series of small strokes. There is a much smaller group suffering a discrete condition called Lewy bodies, a deteriorating brain disorder.

Alzheimer’s disease is progressive, which means the symptoms will gradually get worse. How fast the dementia
progresses will depend on a number of different factors. Each person will experience dementia in an individual way and the symptoms can be extremely distressing, sometimes being associated with behavioural changes where people can become aggressive.

### Performance/Evidence

Findings from a dementia needs assessment (April 2014) –

- In 2013, an estimated 1537 people in Barking and Dagenham had dementia, of these, 669 were diagnosed and recorded on GP registers.

- It is expected that the number of people with dementia in Barking and Dagenham will rise by approximately 10% over the coming decade; however, this increase is much steeper in the 90+ age group, with the number of people with dementia in this age group increasing by nearly 50% in this time.

- Barking and Dagenham’s poor general health and high levels of risk factors for vascular dementia, such as heart disease, diabetes and smoking rates, may result in a more rapid increase in dementia prevalence than is predicted in the figures above.

- Diagnosis rates of dementia have improved in the borough (currently standing at an estimated 43%-46%) but further work is needed to reach the 60% target. Combined with the expected prevalence increase, if diagnosis rates are successfully increased to this level by 2023, over 1,000 people in the borough will be diagnosed with dementia (compared to a current 669), increasing service demand.

- It is important to take into account the specific needs of people with dementia who live on their own, as more than a third of people aged 65+ in Barking and Dagenham currently live alone.

- The ethnic diversity of the dementia population in Barking and Dagenham is expected to increase substantially over the coming years, services and awareness raising programmes will need to adapt to the different needs of these groups.

Key feedback about services in Barking and Dagenham is summarised as follows:

- The integrated cluster team approach is working well and the borough has made good progress in taking forward the personalisation agenda.

- The Memory Service plays a central role in supporting
people through assessment, diagnosis and treatment of dementia. Memory Service capacity needs to be monitored. The Memory Service contributes to service improvement such as by providing feedback on inappropriate referrals and visiting care homes to improve the way they manage challenging behaviour and use medicines.

- The recruitment of a Dementia Advisor from the Alzheimer’s Society was welcomed by stakeholders because it has helped to introduce good practice and ways of working into the borough. ‘Carers of Barking and Dagenham’ play a central role in delivering a range of services and support for people with dementia and their carers.

- Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) have placed a greater emphasis on training. Commissioning for Quality and Innovation (CQUIN) framework has led to dementia screening for all over 65s admitted into hospital A buddy system at meal times is proposed to promote improved nutrition and fluid intake.

- There is growing awareness of dementia in the borough and this means that more people are being assessed and diagnosed in the early stages. This is giving service users greater scope to exercise choice and control over their lives and future care.

### Policy and legislation issues

#### National developments

2009 The Department of Health launched the first ever National Dementia Strategy for England. 17 recommendations across three key areas –

- Raising awareness and understanding
- Early diagnosis and support
- Living well with dementia

The Dementia Challenge was launched in March 2012 by Prime Minister David Cameron. Central to the PM’s challenge is to improve diagnosis (currently only 42% of people with dementia have a formal diagnosis) and improve care in hospitals (where ¼ of all beds are occupied with someone with dementia). Other parts of the PM’s challenge gives a commitment to more than double the investment in research to £66 million, and to establish at least 20 recognised dementia friendly communities by 2015. Three ‘champion groups’ are working to deliver the 14 commitments by 2015; progress is being reported through a series of annual reports – the first of which was published in May 2013.

#### Local developments

HASSC completed a review into local dementia services in
March 2010 which recommended –

- Awareness raising
- Single point of access for assessment
- Workforce development
- Keeping people with dementia in the community
- Changed system for out of hours/weekends
- Publicising respite for carers

Following another scrutiny by the Living and Working Select Committee (which also completed in 2010) into supported housing for older people, elected members recommended the re-development of Fews Lodge to change from sheltered housing to extra care for dementia. The new Fews Lodge opened in January 2014 and has 13 self-contained flats to support independent living and maintain quality of life. When more intensive support is needed, a resident of Fews Lodge can easily transfer to Kallar Lodge, the borough’s specialist dementia care home.

Office of Public Management (OPM) were commissioned by LBBD to complete a Dementia Needs Assessment to better understand the local picture. An action plan has been developed by Public Health LBBD and Barking and Dagenham CCG based on the recommendations.

| Areas of potential enquiry | As a scrutiny review on dementia was undertaken in 2009/10 and it remains to be seen whether there is more to be gained from a specific review into this area. However if the Committee wanted to review this area it might be useful to ask for a one-off item from officers reporting back on the action plan developed following the previous scrutiny. |
Option 6

Suggestion from Quaker Social Action: Funeral Poverty

*Quaker Social Action sent the following briefing*

**Briefing on Funeral Poverty**

**What is funeral poverty?**

Funeral poverty, where people are unable to cover the costs of a funeral for a person close to them, is on the increase. Sunlife report that now almost one in five people are unable to cover the cost of a funeral when someone close to them dies. For the bereaved, funeral poverty means spiralling debt and ongoing financial burdens, as well as the shame of not being able to provide a meaningful funeral for a loved one at a time when they’re at their most vulnerable.

**How big a problem is funeral poverty?**

- Cost of dying up 7.1% since 2012 with a significant postcode lottery
- Funeral cost up 80% since 2004 – average funeral now £3,456
- Sun Life Direct projects the average cost of a funeral will rise to over £4,300 by 2018
- This year, over 100,000 people will struggle to pay for a funeral. With the average shortfall experienced £1,277, it has been estimated that across the country funeral poverty now stands at £131million, over 50% higher than the £85million estimated 3 years ago.

This data is from the *Sunlife Cost of Dying* report 2013.

**Focus on Barking and Dagenham**

Given that funeral poverty follows other poverty indicators such as low income, debt, and low pay, the London Borough of Barking and Dagenham (LBBD) is likely to have a particular issue with funeral poverty given it has some of the highest poverty across London.

The LBBD has:

- The highest proportion of people with long term health problems of all London boroughs (14%)
- The 2nd highest proportion of residents who are low paid (25%)
- The 2nd highest level of Local Housing Allowance claims - 43% of private renting households in Barking and Dagenham need housing benefit to cover their costs.

Statistics from the *London Poverty Profile 2013*.

**Support for those in funeral poverty**

Quaker Social Action are a charity that run a direct support service (Down to Earth) supporting people in funeral poverty, trying to help the bereaved find a funeral that is both...
meaningful and affordable. We have a history providing practical support to people on low incomes in the boroughs of East London. Down to Earth’s direct delivery supports 200 people annually in the boroughs of East London (Redbridge, Hackney, Havering, Newham, Tower Hamlets, Barking and Dagenham and Waltham Forest). But given capacity our service can only support a limited number of people so only reaches the ‘tip of the iceberg’.

Statutory safety net?

It’s often assumed that the state will provide for people who can’t afford to pay for a funeral. This is not the case. Although people on benefits can apply to the Social Fund Funeral Payment, the maximum amount they’ll be awarded is around £1,200, not nearly enough to cover even the most basic funeral. The maximum amount a person can apply for has not risen since the inception of the Funeral Payment 10 years ago. Rejections to the Funeral Payment are up and now stand at fifty percent.

The role of the funeral industry

Government support for people in funeral has been eroded at the same time as funerals have got much more expensive. In 2003 Citizen’s Advice Bureau produced a report which stated, 'Much of our evidence refers to the extra distress caused by lack of information and ensuing debt that comes from a necessary purchase for a deceased and loved person. We feel strongly that buyers need to be better protected at this very difficult time.'

Funeral Directors vary greatly but there is evidence to suggest there is a growing commercialisation of funerals and many within the industry are not doing all they could to offer straightforward information on affordable funerals. There are huge differences in what funeral directors charge. There is also a lack of transparent information available to the bereaved about prices. Although members of trade association are supposed to offer people on low incomes affordable options, there’s a lot of anecdotal evidence to suggest this isn’t always happening.

A problem set to get much worse

The long term decline in death rates is about to reverse, with a projected rise by around 15-20% in the next two decades. Therefore it is imperative that the public, private and charity sectors work together to support the ageing population – and the generations behind them - to prepare for the costs associated with death.

Increase in public health funerals

When a family member can’t pay for a funeral, the deceased will be given what’s termed a ‘public health funeral’ paid for by the local authority. In 2010/11 there were 2,900 public health funerals in the UK, costing local authorities £2.1 million. This figure does not include staff or administrative costs. In a survey by the Local Government Association in 2011, 52% of local authorities indicated that they had “observed an increase in the number of family or friends unable to contribute to the costs of a funeral over the last three years”

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Suggested terms of reference

1. Examine the 'costs of dying' across the borough (e.g. the price of a funeral, burial/cremation, state administration) and the increasing demand for local authority funerals.
2. Investigate the quality and scope of support/provision available from the Council for those on low income unable to afford to cover costs on their own.
3. Examine advice available for residents on registering deaths, funerals and burials to ensure clarity and cultural sensitivity.
4. Investigate the development of online information resources to support local people experiencing funeral poverty.
5. Examine ways to improve information to residents about funerals and affordability.
6. Examine the efficacy of multi-agency working between the Council and local partners in the funeral industry.
7. Investigate examples of best practice from other boroughs and third sector organisations.
8. Investigate how the Council can encourage a culture of saving for death.
9. Examine the council's own use of funeral directors and whether these are a member of a national trade body.
10. Examine other low cost steps to become a 'best practice' council on funeral poverty.

Option 7

Suggestion from member of public: provision for children and young people with mental health problems

The member of the public sent a link with their suggestion to the following BBC article:

Mental health services cuts 'affecting children'

By Jeremy Cooke UK affairs correspondent

20 June 2014 Last updated at 17:01

Cuts in mental health services for children in England amount to a national crisis with tragic consequences, a charity has said.

More than half of councils have cut or frozen budgets for child and adolescent mental health, according to official figures obtained by Young Minds.

Experts believe early care is better for patients and value for money.

But budget reductions meant tough decisions were necessary, according to the Local Government Association.
Provision of mental health services for young people varies widely across England, with entry-level care largely funded by local authorities, which are trying to slash spending.

**NHS 'responsibility'**
Research has found young people who do not receive help in the early stages of their illness can suffer serious consequences, often needing time in hospital or remaining ill during adulthood.

Young Minds submitted a Freedom of Information request about funding of child and adolescent mental health services for 2014-15 and the previous four financial years.

**Annie's story**

Like hundreds of thousands of young people, 17-year-old Annie Hart carries the burden of mental illness.

Annie was diagnosed with bipolar disorder last year. Her condition led to her feeling very low. She self-harmed and spent time in hospital.

"On a bad day, you wake up in the morning and you have this feeling that nothing is good, that everything is black, and that if you step out of bed you will fall into a black hole," she says.

In Annie's area, West Sussex, there was a long waiting list.

Her father Jeremy says she "would have had eight months thinking about it and not knowing what was happening to her".

"For us that was just unacceptable," he adds.

In the end her family decided to pay. Once in the system, Annie's condition improved and she continues to have treatment.

Professional help is "really good", she says, but long waiting lists and patchy service provision can put young people at risk.

"It's a deadly illness - some people take their lives because of it. And that's not them taking their lives; that's the illness taking their lives."

It had responses from 99 out of the 151 councils it contacted.

More than half had made cuts over the last five years, while nine councils had kept funding at the same level.

The biggest reduction was at Birmingham City Council, from just above £2.3m in 2010-11 to £125,000 in 2014-15, a drop of 94%.

A spokesman for the authority said government funding had ended in 2010 and after a public consultation, it was decided to stop paying for a service that was primarily an "NHS responsibility".
The council preferred to "prioritise those services for which it was responsible" at a time when significant savings were required.

"We are very much committed to ensuring that children and young people in Birmingham have access to the mental health services that they need," the spokesman added, adding other services were provided for vulnerable children by the council, the NHS and the voluntary sector.

However, some local authorities have increased spending, such as Worcestershire County Council, where the budget went from £678,523 in 2010/11 to £4.9m for 2014/15.

Overall the figures were "deeply distressing", said Sarah Brennan, chief executive of Young Minds.

"Children and young people's mental health services have been chronically underfunded for decades.

"The latest round of cuts will add to the devastation of local services and compound the struggles of young children and their families."

'No justification'

There is no justification for disadvantaging mental health as against physical health
Norman Lamb, Care minister

Ministers continue to stress their commitment make young people's mental healthcare as good as their physical healthcare.

"The government has legislated for it," said care minister Norman Lamb. "We now have to get every area of the country to do what is clearly the right thing.

"There is no justification for disadvantaging mental health as against physical health."

Mr Lamb said the government backed the introduction of waiting time for mental health services, to bring them into line with NHS physical health care.

David Simmonds, chairman of the Local Government Association's children and young people's board, said councils had "worked hard" to protect services to vulnerable children but this had become "increasingly challenging" in the current financial climate.

"Local authorities have serious concerns about mental health funding for children, and want a complete overhaul of the fragmented and complex system they currently face each day when trying to access services delivered by the NHS and other partners."

Councils were "committed to change" and were "already playing their part", he stressed.