Present: Cllr Eileen Keller (Chair), Cllr Sade Bright and Cllr Edna Fergus

Apologies: Cllr Danielle Lawrence, Cllr Syed Ahammad, Cllr Sanchia Alasia, Cllr Abdul Aziz, Cllr Peter Chand and Cllr Faruk Choudhury

13. Declaration of Members' Interests

There were no declarations of interest.

14. Minutes - To confirm as correct the minutes of the meetings held on 30 September and 19 November 2014

The minutes were agreed.

15. Scoping Report

The Group Manager for Intensive Support (GMIS) stated that on 30 September 2014 an options paper was presented to the Committee asking members to discuss and agree which topic they wished to undertake a scrutiny review on in 2014/15. Members agreed to undertake a scrutiny review on local eye care services.

The GMIS then presented the report which outlined the proposed methodology and terms of reference for the review, which were:

- Whether there are gaps or obstacles in current service and pathways
- How supply and take-up of Optometry (Opticians) and other eye service compares with other London boroughs and the national average
- Whether local low vision services for Blind and Partially Sighted people are fit for purpose and whether take-up is appropriate
- CCG plans regarding eye care services
- The role of GPs
- Emotional and other support for people newly diagnosed
- How well local services for blind and partially sighted people rate when benchmarked against the national “seeing it my way” charter

The terms of reference and the methodology proposed in the report were agreed.

16. Scene Setting

Peter Corbett, Chief Executive of the Thomas Pocklington Trust (the Trust) thanked the Committee for inviting him and his colleague Phil Ambler, Director of Policy, to discuss the national context of eye care health as part of the Committee’s scrutiny review.
Mr Corbett explained his background and the circumstances in which he started working for the Trust, a large endowed charity offering support to people who are blind or sight impaired. He had been Chief Executive of the Trust since 2011 when he made it his priority to understand what people with sight loss conditions really needed.

The Trust looked at the UK Vision Strategy and saw a lot of merit in it but they found that a lot of the content did not seem to have been translated into local action. They investigated whether all of London's 32 boroughs had a local vision strategy and found that Barking and Dagenham Council was the only one that did, which it was to be congratulated on. The Trust had spent about three years working on ensuring that all boroughs have a vision strategy, which was implemented locally.

Mr Ambler and Mr Corbett then delivered a presentation on the national context of living with sight loss. The following information was noted by the HASSC.

There was a big disparity between the number of people living with sight loss and the number of people registered as blind or partially sighted. There were a range of reasons for this including:

- People not presenting themselves to health services; for example, it was recognised that certain ethnic minority groups were less likely to present themselves to health services in relation to their eye health. Also, in people with learning disabilities the sight condition may not be picked up because certain symptoms were attributed to their disability.
- People may not realise that their sight was deteriorating as they were getting older.
- People may not notice that they have a refractive error which needs correction with spectacles or lenses, or that they were wearing the wrong prescription spectacles or lenses.

The Royal National Institute for the Blind estimated that around 3910 people were living with sight loss in Barking and Dagenham but only 870 people were registered.

There was a general lack of awareness about eye health; for example, many people held the belief that glasses would be unaffordable and therefore avoided visiting their local optometrist. Many people were also unaware that in addition to refractive error, optometrists could pick up serious diseases such as glaucoma and sometimes even stroke.

The emotional impact on individuals who had lost their sight could be very strong due to the effects on their employment, social life and independence. About 66% of those living with sight loss of working age were unemployed. The vast majority of people living with sight loss did want to work but faced barriers. They were flung into a new world and faced the struggle of having to learn new skills very quickly. Accessing information and services such as leisure, housing and transport could become a huge challenge. It is important that people suffering from eye loss receive rehabilitation to teach them key skills such as learning how to access information using a computer to increase mobility and employability, for example.

People living with sight loss had an increased risk of having a fall, and faced
communication barriers. For example, GPs sometimes asked people with sight loss whether they could ask a friend to read their own very private medical information to them, which was not always what the person was comfortable with.

Mr Corbett stated that the key difference he had seen in the quality of life of people living with sight loss, as a result of good support, was the confidence to use public transport. Some Transport for London services were excellent in making transport more accessible; however, to get to the services, people suffering from sight loss had to have the motivation to get up, get dressed and get out of their home. To get to that stage, they needed the right support and to build up their confidence.

Nowadays it was very common to hear about ‘person centred care’; however, people suffering with eye conditions were very often not put at the centre. It was very rare that people affected by sight loss received the right level of attention from key parts of the pathway and there was also fragmentation in geographical areas which could be better linked-up. Primary and secondary health services, the local authority and the voluntary sector all needed to join-up and put the person at the centre to provide excellent care all the way along. An example of projects working to make services more joined up was East London Vision (ELVis) a cluster for seven east London boroughs, which included Barking and Dagenham.

Professionals in public health, ophthalmologists, GPs and rehabilitation workers were doing a lot of work to support people with sight loss. However, in spite of this a lot of people were not meeting all the professionals they needed to, leading to poor overall care. Sight loss should not be looked at in isolation; rather, all the health pathways for the individual should be looked at and joined up where necessary to provide better care; for example, people should be incentivised to stop smoking not only because it was a risk factor for cancer but also because it was a risk factor for certain sight complications.

The Trust was highly in favour of every eye clinic having an Eye Clinic Liaison Officer to signpost people to relevant services. At the moment only half of eye clinics had this post.

Older people were most affected by sight problems. Rehabilitation often meant that a lower level of care could be provided. Some people suffering from sight loss were at an increased risk of injury from accidents because they were being cared for by unpaid carers who could not provide the right level of care.

Even where people did receive rehabilitation the time lag was often too long which meant that people deteriorated emotionally and their financial situation could worsen quickly too. There was a major opportunity in the sector to demonstrate that joined up work could provide very effective and cost effective models of giving people what they need. A key question was how could the voluntary sector join up with the local authority to provide low-cost rehabilitation support?

It was recognised that there was a limit to resources. Local committees whose remit included sight loss also had to deal with many other competing issues. The voluntary sector has to make sure it plays its part in enabling people to have less reliance on paid for support. Sight loss was an issue struggling for profile.

Proper investment in early intervention was crucial in providing good care and cost effectiveness as it would ensure more people with sight loss were in employment
and reduce the care needs of older people. 50% of sight loss conditions were avoidable. If a person has a family history of diseases that affect the eye, the sooner it is investigated, the sooner it can be addressed. Smoking, obesity and hypertension were considered risk factors for certain eye conditions.

The Divisional Director, Adult Social Care (DDASC) asked what could be done about lower level eye health issues, such as not enough people going to optometrists for an eye test. Mr Corbett stated in response that there was evidence that underprivileged communities in particular had fewer practices in their locality and that there was a variation amongst different ethnic groups when it came to visits to optometrists. People needed to be made aware that they could shop around for cheaper glasses and did not have to purchase the ones suggested by their local optometrist or optician. Whilst optometrists were business people interested in how they could run their businesses better, they could collectively think of ways to address these problems. Mr Corbett strongly recommended that the Council undertake a mapping exercise of optometrists in the Borough. The other possible area to explore was the offer of domiciliary tests in care homes, for example.

Mr Ambler stated that various studies have been done, for example, one had been undertaken in Leeds which found that the distance to an optometrist’s is a major factor when it came to people deciding whether they were going to go for an eye test. A lot more could be done on raising public awareness on eye health. For example, there was a project in Sheffield whereby the voluntary sector, local optometrists and the police worked together to encourage people to have eye tests. The police would ask members of the public at a supermarket car park whether they could read the number plate of a car from a certain distance. If the person said no, the police would advise that the person visit an optometrist.

The Director of Public Health stated that the figures given during the presentation on how many people were suffering from sight loss were predictions only; the real prevalence was not known. He also raised the question of corrective surgery and measuring how many people were doing this privately. Finally, he highlighted that eye sight could be affected by passive smoking as well as direct smoking. Mr Corbett stated that whilst it was correct that the actual prevalence of sight loss was not known, a lot of data that people relied upon such as GDP and inflation were estimates, and it was important to work with the information available.

The GMIS stated that the epidemiology of eye care suggested that most estimates probably underestimated the actual number. The health of Barking and Dagenham's general population was lower than average, therefore it was likely that their eye health was poorer than average too.

In response to questions the Corporate Director of Adult and Community Services stated that the scrutiny review would be carried out by members of the Committee who would be engaging with local stakeholders and undertaking visits. The GMIS and the Scrutiny Officer would write up the Committee's findings and recommendations, and officers supporting this Committee would oversee the process of implementing the recommendations.

17. Interactive session

The GMIS handed out ‘simulation spectacles’ for members to try on to gain a
greater appreciation of what it was potentially like to live with the following eye conditions:

- Cataracts
- Macular degeneration
- Tunnel vision (from glaucoma, for example)
- Tunnel vision and low visual acuity (loss of peripheral and central vision from retinitis pigmentosa, for example)
- Hemianopia (caused by damage to the visual centres in the brain from a stroke or head injury, for example)
- Diabetic retinopathy

18. The Local Account

The Group Manager, Integrated Care (GMIC) provided an outline of the report on the Local Account, the Council’s statement to the local community and service users about the quality of social care services in Barking and Dagenham. He described the background to the Local Account, the structure of the 2013/14 version, its highlights and the consultation that had been undertaken locally with various groups before it was finalised.

The GMIC then covered some of the areas of work the Department would focus on this year including:

- Getting ready for the implementation of the Care Act 2014 for 1 April 2015, which will bring major change to how social care services are delivered. The Department will be rolling out a Care Act training programme as well as releasing publicity materials on changes brought about by the Act soon.
- The launch of the Joint Assessment and Discharge team, which brings hospital, community health and social care teams into one so that people coming out of hospital get a better service.
- Improving systems for responding to Deprivation of Liberty Safeguard applications (where people are prevented from doing something for their own protection) to meet rising demand.
- Continuing work to make sure that residents, service users and staff all know how to raise safeguarding alerts when they are concerned about someone’s safety or wellbeing in social care services.
- Launching the first Market Position Statement, that sets out how local services need to develop in order to meet the demands of people using services.
- Improving processes for ensuring the quality of local services, focusing attention on those that are a concern, and working closely with the Care Quality Commission.
- Developing a new Carers’ Strategy, with input from local carers and their support organisations, and work out new ways to deliver services for carers in the future.
- Working with HealthWatch to strengthen the voice of social care users, carers, patients and the public, and to make sure their voice gets heard at the Health & Wellbeing Board.

The GMIC stated that consideration was being given to changing the format of future local accounts to make it more engaging for service-users and the
community. One of the ideas put forward was presenting the local account in video format. The GMIC asked members for their thoughts on this.

Members expressed enthusiasm for the suggestion of a video format as it could be played in places like GPs surgeries, dentist surgeries and the reception areas of other local services, which would be a good way to make it accessible to a lot of people. Suggestions were made on engaging younger users and tailoring the format for different groups as well as presenting the account as a podcast.

19. Joint Health Overview & Scrutiny Committee (JHOSC)- update

The DDASC provided an update on the discussions around the agenda items of the last two Joint Health Overview and Scrutiny Committee meetings as follows:

- 14 Oct 2014:
  - Urgent Care Procurement - the Chief Operating Officer of Havering Clinical Commissioning Group (CCG) explained that there were a large number of different providers of urgent care across the four boroughs and outlined the four local CCGs plans to improve this via a procurement exercise. The procurement exercise would cover services including NHS 111 and the GP out of hours service. All walk-in centres in NHS London would also be included with the exception of that at Barking Community Hospital where a new contract had recently been put in place. Members asked about what type of organisations could bid for contracts and whether this process would involve an element of privatisation of NHS services. The Chief Operating Officer stated that all sorts of organisations could bid for contracts including ones who were currently providing the services.
  - Intermediate Care Consultation - the four boroughs shared their positions on the proposals.
  - GP List Sizes and Contract Arrangements - a representative provided an update on the position.

- 13 Jan 2015:
  - There was no Barking and Dagenham member representation at this meeting; however, he and the Scrutiny Officer were in attendance.
  - Pharmacy Arrangements - a Redbridge local pharmacist briefed the JHOSC on a communication template he had created to communicate with GPs regarding patients’ treatment, which he believed would lead to better care and cost effectiveness for the NHS in the long run if taken up by pharmacies to be used in a standardised way.
  - Great Ormond Street Hospital – the Hospital’s Director Of Planning & Information delivered a presentation on the services provided, provision for the four boroughs’ residents and challenges ahead.
  - Maternity Services - officers from Barts and BHRUT provided an update on maternity services at local hospitals. The DDASC asked the about the future commissioning of services at Barking Community Hospital but the representative was not able to provide details at that stage. Havering’s HealthWatch outlined findings of their April 2014 enter and view of Queen’s Maternity Services.
  - NHS 111 - a representative of the NHS 111 service provider
summarised the key features of the Service in Outer North East London.
- Urgent Care Procurement – the Chief Operating Officer provided an update on the Programme.

In relation to maternity services, members discussed the currently inequitable breast feeding support service for the Barking and Dagenham mothers as compared to the other boroughs. The Director of Public Health stated that he was aware of BHRUT’s plans to provide a generic service for women across all the boroughs going forward. Members stated that this was something the HASSC may potentially need to visit in the next municipal year.

20. Work Programme

It was noted that there would be workshops on 4 March 2015 before the Committee’s formal meeting to give members the opportunity to engage with local stakeholders as part of the eye care services scrutiny review.

It was agreed that the provisional item for the meeting on 4 March 2015 on the re-inspection by the Care Quality Commission of BHRUT be rescheduled for the meeting in June 2015 as it had been announced that the re-inspection would be taking place in early March 2015.