Notice of Meeting

HEALTH AND ADULT SERVICES SELECT COMMITTEE

Tuesday, 16 June 2015 - 6:00 pm
Committee Rooms 1 & 2, Civic Centre, Dagenham

Members: Cllr Eileen Keller (Lead Member), Cllr Peter Chand (Deputy Lead Member), Cllr Sanchia Alasia, Cllr Abdul Aziz, Cllr Edna Fergus, Cllr Adegboyega Oluwole and Cllr Hardial Singh Rai (two vacancies)

Date of publication: 5 June 2015

Chris Naylor
Chief Executive

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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 confirm as correct the minutes of the meeting held on 4 March 2015 (Pages 3 - 8)
4. Timing of meetings (Page 9)
5. Joint Health Overview & Scrutiny Committee (Pages 11 - 20)
6. BHRUT update on the Care Quality Commission's Re-inspection (Pages 21 - 32)
7. Primary Care in Barking and Dagenham (Pages 33 - 35)
8. Together First's Primary Care Appointments Service (Pages 37 - 50)
9. Scrutiny Review of Local Eye Care Services - results of staff survey (Pages 51 - 73)
10. Intermediate Care Proposals - update (Pages 75 - 95)
11. HASSC Work Programme 2015/16 (Pages 97 - 109)

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
Our Vision for Barking and Dagenham

One borough; one community; London’s growth opportunity

Encouraging civic pride

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

Enabling social responsibility

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

Growing the borough

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

Wednesday, 4 March 2015
(6:00 - 8:35 pm)

Present: Cllr Eileen Keller (Chair), Cllr Abdul Aziz, Cllr Sade Bright, Cllr Edna Fergus and Cllr Adegboyega Oluwole

Also Present: Cllr Maureen Worby

Apologies: Cllr Danielle Lawrence, Cllr Sanchia Alasia and Cllr Peter Chand

21. Declaration of Members’ Interests

There were no declarations of interest.

22. Minutes - To confirm as correct the minutes of the meeting held on 20 January 2015

The minutes of the meeting held on 20 January 2015 were confirmed as correct.

23. Presentation on the 'local picture'

The Director of Public Health (DPH) delivered a presentation to provide the Committee with the ‘local picture’ of eye health, as part of the Health and Adult Services Select Committee’s (HASSC) scrutiny review on local eye care services. The presentation covered:

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

The Committee particularly noted the following issues raised in the presentation as possible areas for further consideration as part of its Review:

- The England average number of children having eye sight tests was 25,167 in every 100,000 children whilst the Borough average was equivalent to 20,761 in every 100,000 children.
- 870 local people were registered as sight impaired whereas the estimated number of people living with sight impairment was 3910, which meant that only about 22.3% of those with sight impairments were registered as blind. This meant that there was possible a large number of people who were not getting the services they needed.
- Blindness caused by diabetes can be prevented.
- The biggest cause of preventable blindness in England is diabetes.
- People who are of BME origin are more likely to suffer from diabetes.
- Fear of having to buy glasses is well known to be an obstacle to visiting an optician, especially in less affluent neighbourhoods.
- Eye tests are free for many people and there was a need to raise more awareness of this.
• Access to an optician is good for people in the majority of the Borough; however, there were areas with no optician service such as Mayesbrook, Parsloes, Heath and Eastbrook.
• Those aged over 40 years and have a first-degree relative with glaucoma, or are over 60 years old, are eligible for a free glaucoma screen at their local optician; however, there was no information on the take-up of this offer.

Members thanked the DPH for his presentation.

24. Workshop

The Lead Member stated that this part of the meeting would involve a workshop between members and stakeholders of the HASSC’s Scrutiny Review on local eye care services. She encouraged members to engage with those who had been invited to the workshop, including service-user groups and professionals, to find out what the current challenges were in meeting the Borough’s eye health needs. She asked attendees to move to committee rooms 1 and 2 to take part in the workshop and to return to the chamber in 45 minutes for the continuation of the meeting.

25. Verbal feedback from the Workshop

The Lead Member invited members and other participants to provide their feedback from the workshop, which would potentially help contribute to the Committee’s Review on local eye care services.

A member of the HASSC stated that one of his constituent’s GP had told them that they could only go to a certain local service for their eye problem whereas the constituent wished to go to another local service. The member asked why this was the case. Local ophthalmologists stated that there were many local eye care providers and it seemed to be the case that GPs did not have all the information they required about them, which could get in the way of patient choice. It was important for the Committee to look at this and the commissioning of eye care services as part of its Review and consider how pathways could be improved to achieve better outcomes for local people.

The Chair of the Local Optical Committee stated that the way commissioning was designed at the moment meant that local optometrists were not being utilised for their expertise, which sometimes lead to a pathway which was not entirely efficient for the patient. She stated, for example, that until recently, local optometrists had a cataract referral system which meant that if they suspected a cataract, they could invite the patient back to discuss the condition and talk about the patient’s treatment options. This was no longer the case; primary care was not being utilised effectively which was likely to mean costs more in the long run.

The Lead Member asked members to note the comments made and stated that the Committee would consider delving further into the issues raised as part of its Review.

The Corporate Director, Adult & Community Services (CDACS) stated that over the next few months the Committee would continue to find out more about local eye care services during this Review with a view to making recommendations to
improve the way services work. Towards the end of the Review a report would get written up with the Committee’s findings and recommendations which would be presented to the Health and Well Being Board (HWBB) and shared with local stakeholders.

The Lead Member thanked those who gave up their time to present information about local eye care services as part of the workshop.

26. Intermediate Care Proposals- Redbridge Health Scrutiny Committee’s referral to the Secretary of State

The Divisional Director, Adult Social Care (DDASC), presented the report updating the Committee on the developments relating to the Intermediate Care Consultation which involved proposals made by the Clinical Commissioning Groups (CCGs) of Barking and Dagenham, Havering and Redbridge. The proposals were to change the way NHS rehabilitation services were provided across the three boroughs by reducing the number of inpatient beds and providing more treatment in people’s own homes via an Intensive Rehabilitation Service and a Community Treatment Team. After the consultation period the three CCGs made the decision to:

- permanently establish the home-based services
- reduce the number of community rehabilitation beds to 40 - 61 for the three boroughs and
- locate these beds on one site at King George Hospital in Redbridge.

Following the announcement of the CCGs’ decision, Redbridge’s Health Scrutiny Committee agreed to refer its concerns relating to the proposals and the consultation to the Secretary of State for Health.

Members noted the written update from the Barking and Dagenham CCG (BDCCG) on the potential implications of Redbridge’s referral, which was appended to the report.

The Cabinet Member for Adult Social Care & Health (ASCH) stated that the HASSC and the HWBB had had robust discussions with the CCGs during the consultation regarding the Local Authority’s concerns relating to the proposals, as noted in the HASSC’s formal response to the consultation. One of the key concerns was that there was a lack of clarity around the impact the proposals would have on other services in Gray’s Court, including stroke beds. It was very disappointing that the CCG’s response to this point was to state that there would be a separate ‘stroke consultation’ which would deal with those concerns. She stated that she wished to express support for Redbridge’s referral to the Secretary of State as she also felt that the basis of the bed modelling in the proposals was not robust.

HASSC members echoed the Cabinet Member’s comments and agreed to support the referral made by Redbridge’s Health Scrutiny Committee and delegated the responsibility to write to the Secretary of State for Health on behalf of the HASSC to the Lead Member.

27. Urgent care 'surge' appointments in primary care - verbal update

The Scrutiny Officer circulated a briefing from the BDCCG which provided
information on the provision of urgent GP appointments in the Borough. The briefing stated that a GP-led service had opened in the Borough for patients with urgent needs, to improve care and help ease pressure on local A&E departments. The practice “hub” opened on Monday 19 January 2015 and was based at Barking Community Hospital in Upney Lane. It was being run by Together First, an organisation set up by local GPs to provide the new service, with initial funding provided from the Prime Minister’s Challenge Fund.

The Cabinet Member for ASCH stated that it would be helpful for members to see data on how many people the Hub had served since opening in January 2015. She expressed disappointment that Together First did not show a commitment in the briefing to working with the Local Authority, in addition to working with HealthWatch, on the best location for opening a second hub. The CDACS stated that she would be interested to know why the boroughs of Redbridge and Havering already had two hubs, when Barking and Dagenham was the first of the three boroughs to have a hub. Members stated that in their collective experience, GP practices overall were not referring patients to the Hub when they were unable to offer an urgent appointment.

Sarah D’Souza, Senior Locality Lead for the BDCCG, stated that representatives of Together First could attend the Committee’s meeting in June 2015 to answer the above questions and provide more in-depth information on the service, which the Committee agreed to. The CDACS suggested that NHS England and CCG representatives be present at the June meeting if it was the case that commissioning decisions in relation to the hubs were made by these parties.

28. Implementation of the Care Act 2014

The HASSC noted the report informing the Committee on the progress made on implementing The Care Act 2014. The Care Act Programme Lead (CAPL) delivered a presentation which covered the reporting structure in place to ensure implementation and the risks and challenges associated with this, such as the short time period in which to deliver a large and complex programme, pressure on the Local Authority’s budgets, additional demands and expectations from residents, and the IT changes required.

Members thanked the CAPL for his report and presentation.

29. Barking & Dagenham HealthWatch’s Enter and View of Fern Ward, King George Hospital

Manisha Modhvadia, Barking and Dagenham HealthWatch Officer, presented a report by HealthWatch on an ‘enter and view’ it carried out of Fern Ward at King George Hospital on 8 October 2014. Specific areas for observation during the visit were nutrition, personal hygiene and interaction between staff and patients. Whilst HealthWatch found that the patients they talked to were satisfied overall with their care, there were some areas for improvement, which were outlined in the report.

Members asked whether Ms Modhvadia felt that HealthWatch’s findings were potentially a reflection of other wards at King George Hospital. Ms Modhvadia stated that it was difficult to say without having visited other wards; however, HealthWatch did intend to carry out ‘enter and views’ of other wards in the near future, and if it did find cross-cutting issues, it would raise this via the appropriate
The DDASC stated that many of the patients of Fern Ward and their relatives were often very vulnerable and it was positive that HealthWatch had given them a voice through this report. Whilst the issues identified by HealthWatch did not require large scale changes, they were important in ensuring the comfort and safety of patients. He asked whether HealthWatch was pleased with BHRUT’s response to its recommendations. Ms Modhvadia stated that HealthWatch was pleased with the response; however, it would have liked to have seen, in addition, BHRUT explore the possibility of offering a befriending service for parents, perhaps through the use of volunteers.

Members praised HealthWatch for their report and were particularly pleased that the Senior Nurse at Fern Ward had been identified as responsible for implementing the recommended actions arising from the enter and view.

BDCCG stated that the work of HealthWatch was very valuable as it provided a good snapshot of the quality of services and helped the CCG accumulate information about services and identify trends.

Ms Modhvadia asked what the best way would be to keep the HASSC up-to-date on HealthWatch’s enter and view visits going forward. The Committee agreed that HealthWatch should keep the Scrutiny Officer up-to-date on its visits, who would, in liaison with the Lead Member and senior officers, come to a view on which of the enter and view reports should be presented to the HASSC.


Gill Mills, Integrated Care Director at North East London Foundation Trust (NELFT) presented the final update on the Scrutiny Review on the Potential Impact of the Recession and Welfare Reforms on Mental Health 2013/14, which was noted by the HASSC.

Ms Gills stated that in order to ensure that the issues raised by this Review continued to receive priority, they had been incorporated into a wider piece of work on a full Mental Health Needs Assessment which was led by Public Health. This work incorporated the Borough’s response to Closing the Gap and the Mental Health Crisis Concordat, produced by the Department of Health. Two service user and carer engagement events had taken place since September 2014 to gather information and feedback to inform the Mental Health Needs Assessment. Following these events the membership of the Mental Health Sub Group had widened to include a service user and a carer.

Members commended the effort to implement the recommendations and continue to ensure mental health remained a priority by incorporating the issues raised by the Review into wider work.

In response to a question Ms Mills stated that ‘Mental Health First Aid’ training had been delivered to hundreds of professionals including GPs. The CDACS stated that this training was open to members also and was listed in the Member Development Programme.
The DDASC stated that one of the key findings of the Review was that too often anti-depressants appeared to be the first treatment offered in the depression pathway and asked if this was still the case. Gemma Hughes, Senior Locality at BDCCG, stated that the BDCCG had been working hard with GPs to ensure that the usual first port of call for depression and anxiety was talking therapies. There were national targets for CCGs to ensure psychotherapy services were available and BDCCG was targeting GPs with low referrals to talking therapies to improve. Ms Gills stated that NELFT were promoting the Improving Access to Psychological Therapy (IAPT) Service through which people could refer themselves for talking therapies.

Members commended the initiative to allow people to self-refer to talking therapies for problems like anxiety and depression, particularly with current challenges in GP appointment waiting times.
HEALTH AND ADULT SERVICES SELECT COMMITTEE

16 June 2015

Timing of Future Meetings

Report of the Monitoring Officer

Report Author: Masuma Ahmed, Democratic Services Officer, Legal and Democratic Services

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

Accountable Director: Chris Naylor, Chief Executive

Summary

At the Assembly on 25 February 2015 (minute 58 refers), it was agreed that the default start time for evening meetings should be 7.00pm, unless alternative arrangements are agreed by the majority of the members of the Committee.

Health and Adult Services Select Committee (HASSC) meetings in 2014/15 had a start time of 6.00pm.

Recommendation

The HASSC is asked to agree the start time of its meetings for the remainder of 2015/16 municipal year.

Reason(s)

To accord with the Council’s Constitution.

Public Background Papers Used in the Preparation of the Report: None

List of appendices: None
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**HEALTH AND ADULT SERVICES SELECT COMMITTEE**

**16 June 2015**

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<th>Title: Joint Health Overview and Scrutiny Committee</th>
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**Report of the Chief Executive**

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<tr>
<th>Open Report</th>
<th>For Decision</th>
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| **Report Author:** Masuma Ahmed, Scrutiny Officer | **Contact Details:**  
Tel: 020 8227 2756  
E-mail: masuma.ahmed@lbbd.gov.uk |
| **Accountable Divisional Director:** Fiona Taylor, Head of Legal and Democratic Services |
| **Accountable Director:** Chris Naylor, Chief Executive |

**Summary:**

This report is to:

1. Inform the Health and Adults Services Select Committee (HASSC) of the local arrangements for joint health scrutiny and
2. Ask the Committee to appoint three HASSC members to the Joint Health Overview and Scrutiny Committee (JHOSC) for the 2015/16 municipal year.

This report and the appended 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 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 of the HASSC have been put forward to fill two of the three vacancies.

**Recommendations**

The HASSC is recommended to:

(i) Note the 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. **Powers of Health Scrutiny in general**

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." 

3.2 The London Borough of Barking and Dagenham's Constitution 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 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 considered to be 'substantial variations' in local health services to form a 'joint health overview and scrutiny committee' to consider those changes.

5. **Further information regarding the JHOSC and Appointment of Members**

5.1 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 his support in proportion to the number of members they may appoint to the Committee.

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3 Department of Health, p17
5.2 There was a JHOSC meeting hosted by Waltham Forest on 14 April 2015. The following matters were discussed at this meeting:

- Barts Health - Response to Whipps Cross Hospital Care Quality Commission’s (CQC) Inspection
- CQC Hospital Inspection Process
- Clinical Commissioning Group/ NHS England and Co-Commissioning
- Urgent Care Re-procurement

5.3 Four JHOSC meetings have been scheduled for the 2015/16 municipal year as follows:

- Tuesday 21 July 2015, 2.00pm - Civic Centre, Dagenham
- Tuesday 13 October 2015, 2.00pm, Havering
- Tuesday 12 January 2016, 2.00pm, Redbridge
- Tuesday 19 April 2016, 2.00pm, Waltham Forest

5.4 The appended Terms of Reference describe the remit and governance of the JHOSC.

5.5 In previous years the HASSC has agreed to appoint its Lead and Deputy Lead members to fill two of the three vacancies and if the HASSC agrees to do the same at its meeting on 16 June 2015, it would need to appoint one further member. If more than three nominations are received, a vote will be conducted to determine the appointments.

Financial Implications

There are no financial implications arising directly from this report.

Legal Implications

There are no legal implications arising directly from this report.

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’s 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
Appendix 1

JHOSC will have the right to respond in its own right to all consultations on such matters, both formal and informal.

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

   a. Request information or to hold direct discussions with appropriate officers from each of the following organisations or their successor bodies:
      
      Barking and Dagenham Clinical Commissioning Group (CCG)
      Havering CCG
      Redbridge CCG
      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
Appendix 1

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 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.

**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 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.

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

16 June 2015

The Care Quality Commission’s Re-inspection of Barking, Havering, Redbridge University hospitals Trust

Report of the Corporate Director, Adult and Community Services

Open Report  For Information

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

Accountable Divisional Director: Bruce Morris, Adult Social Care

Accountable Director: Anne Bristow, Adult & Community Services

Summary:

In December 2013, following inspection, the Care Quality Commission (CQC) placed Barking, Havering, and Redbridge University hospitals Trust (BHRUT) in ‘special measures’. As a result, the Trust published its improvement plan, ‘Unlocking our Potential’ in June 2014, as well as monthly reports describing progress against its improvement plan. In March 2015 the CQC re-inspected the Trust.

The Chief Executive of the Trust, Matthew Hopkins, has been invited to the Health & Adult Services Select Committee (HASSC) meeting to update the Committee on the progress made by BHRUT since it was placed in special measures.

Whilst the CQC report arising from the re-inspection in March is not expected to be published by the time of the HASSC meeting on 16 June, Mr Hopkins will outline the scope of the re-inspection, the inspection process and next steps, including the expected date of the Quality Summit and publication of the report.

A Quality Summit is a part of the post-inspection process and involves a meeting with the CQC, the inspected organisation and other local partners to inform them about the findings of the inspection and to focus on the next steps required to improve.

During an inspection CQC inspectors use their professional judgement, supported by objective measures and evidence, to assess services against five key questions:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people’s needs
- Are they well-led?

Inspectors also rate services to help enable people to compare services. The ratings are:

- Outstanding
- Good
• Requires improvement or
  • Inadequate.

The NHS Trust Development Authority (TDA) or Monitor will only take a trust out of special measures following a recommendation from the Chief Inspector. NHS TDA or Monitor will usually make such a recommendation after a trust has been re-inspected, is no longer rated as 'inadequate' in the 'well-led' domain and has made progress across the other four domains. NHS TDA or Monitor must also be confident that improvements will be sustained.

Recommendation(s)

The HASSC is recommended to note this report, the presentation by Matthew Hopkins at the meeting and the expected date of publication of the CQC re-inspection report.

Reason(s)

This report relates to the Council’s priority to ‘enable social responsibility’ and under it, the objective to ‘ensure everyone can access good quality healthcare when they need it’.

Financial Implications

There are no financial implications arising directly from this report.

Legal Implications

There are no legal implications arising directly from this report.

Background Reading Papers:

5 February 2014 report to HASSC following initial CQC inspection

CQC’s inspection report on BHRUT (December 2013)

BHRUT’s Improvement Plan, ‘Unlocking Our Potential’ and monthly progress reports
http://www.bhrhospitals.nhs.uk/about-us/our-improvement-plan_2.htm

BHRUT’s Issue Brief on the March 2015 CQC re-inspection

A Guide to Special Measures:

List of appendices:

Appendix 1 BHRUT’s presentation slides for HASSC meeting on 16 June 2015
Unlocking our Potential

Barking and Dagenham Overview and Scrutiny Committee

16 June 2015
Unlocking our Potential

**Dec 2013:** placed in special measures following Chief Inspector of Hospitals review

**Jun 2014:** published *Unlocking our Potential*, our improvement plan to address issues

**Mar 2015:** re-inspection by Care Quality Commission to review progress

**Unlocking our Potential**

Five workstreams with an Executive lead:

- Leadership and Organisational Development
- Outpatients
- Patient Care and Clinical Governance
- Patient Flow and Emergency Pathway
- Workforce

---

**Our vision:**
To provide outstanding healthcare to our community, delivered with PRIDE

**Our mission:**
Great care to every patient every day

**Taking PRIDE:**
Achieve the above through our living our values:

- Passion
- Responsibility
- Innovation
- Drive
- Empowerment
Leadership and Organisational Development

To give great care to every patient every day we need to structure ourselves for success

Leading the way

• New Trust Board; recruiting for Chief Nurse
• Board development programme – build relationships; effective team work
• Phase one of organisational restructure – six clinical divisions each with:
  – Divisional Director
  – Divisional Manager
  – Divisional Nurse
• Phase two – implementation underway

Taking PRIDE in our care

• Embed and expand our PRIDE brand – emphasise external partnerships *Taking PRIDE in Your Care Together*
• Reward and recognise – Terrific Tickets
• Staff engagement strategy being developed
Outpatients

Call Centre improvements
• Call demand and capacity analysis – better allocate resource
• Pre-pilot mid-July 2014 – answer rate approx. 48 per cent
• Since November 2014 – regular answer rates of 95 per cent

Short notice clinic cancellations
• Reduced by 87 per cent
• Led to huge reduction in multiple appointment changes since April 2014

Patient Experience
• Patient pagers – don’t need to wait in clinics
• Rolled out Friends and Family Test to Queen’s Hospital
• Planned refurbishment and uniforms
• GP Liaison Service launched
Patient Care and Clinical Governance

Listening to our patients; supporting our staff

Patient Experience

- **Spot it, Treat it, Beat it sepsis campaign** – best practice tool; more than 3,000 staff trained; redesigned observation charts
- **New nursing documentation** – streamlined; more time with patients
- **Improving accessibility** – easy-read and child-friendly patient surveys; deaf awareness training
- **Listening and responding** – listening events; You said, we did boards; Mystery Shoppers
- **Dementia wards** - colour coded bays; time and date clocks; Rempod; Tommy on Tour
- **Nutrition** – menu choices; feeding buddies; ward champions

Governance

- Getting our structures and processes right
- Focus on Serious Incidents
- Learning Lessons campaign
- Good Governance Institute
- Guardian Service
Patient Flow and Emergency Pathway

Strong focus on partnership working

Discharges
• ‘It’s Everyone’s Responsibility’ campaign – started with 10 x 10; 20 x 12 model
• Now focus on pre-8am discharges
• Discharging on average 24 per cent patients before 12pm
• Joint Assessment and Discharge Service (JAD)

Front door
• Majors Lite
• Urgent Care Centre

Frailty pathway
• Extended Frail Older Persons’ Advisory Service to King George Hospital
• Extended Elders Receiving Unit at Queen’s Hospital to 30 beds
• Community Treatment Teams out with London Ambulance crews
• Ambulatory care pathway – access acute services without admission
Four hour emergency access target


Graph showing A&E waiting times from April 2014 to May 2015.
Workforce

Working with partners and staff to recruit and retain high calibre colleagues

- New values-based recruitment approach – right skills; right attitude
- Working with partners on recruitment strategy
- Working with our accommodation contractors to provide better facilities
- Reduced time to hire – now 43.3 days from 55.3 days; target 40 days
- Filled 95 per cent of our Healthcare Assistant positions for inpatient areas
- Establishment, Retention and Recruitment (ERR) groups for Emergency Department and Acute Medicine
- Focus on reduction of agency staff – increased In House Bank rates; weekly star chamber
Care Quality Commission

Our re-inspection

• March 2015: re-inspected by CQC

• Announced and unannounced visits

• Four possible ratings across five domains

What’s next?

• Quality Summit planned for 17 June 2015

• Report expected to be published 18 or 19 June 2015

• Continue on our journey to improve care for our patients
Today we are here

Special measures

Up to 2014

2014/2015

2015/2016

2016/17

Year 1

Unlocking our potential

Stability

Year 2

Delivering our potential

Resilience

Year 3

New models of delivery

Sustainable

Cycle of regime change and inconsistency
The Health & Adult Services Select Committee (HASSC) and other members have recently received a number of notifications from NHS England with regards to the relocation of several GP surgeries in the Borough. These include:

- the relocation of Highgrove surgery, Malborough Road, Dagenham to Barking Community Hospital.
- the relocation of Dr Pervez’ surgery in Third Avenue, Dagenham to 219 High Street, Hornchurch and
- the merger of the Lawns Medical Care (in Marks Gate Health Centre) and the North Street Medical Care practices (in Chadwell Heath).

These re-locations have prompted some questions regarding the provision of primary care in the Borough and whether it is adequate for the local population.

GP commissioning responsibilities for the Borough have recently been delegated to the Clinical Commissioning Group (CCG) from NHS England. The CCG’s Director of Primary Care Transformation has been invited to attend the HASSC meeting and asked to provide assurance on the following areas:

- whether there is benchmark data on the numbers of practices across London, to allow comparison with Barking & Dagenham
- information on practice sizes in the Borough
- whether there are issues or challenges that relate to GPs retiring and requiring replacement and
- whether there is an estates strategy, as the reasons practices have given for moving include lack of available accommodation.

As GP commissioning responsibilities have now been delegated to the CCG, the HASSC may also wish to seek assurance from the CCG that the process for notifying HASSC and ward members of future potential GP relocations allows members to express their concerns as far in advance as possible, particularly given that NHS England had notified
members only days before the Dr Pervez and Lawns Medical Care practices relocated.

Furthermore, members are asked to note that the CCG is currently working on developing a Primary Care Strategy with plans to engage with local stakeholders on it from June to August 2015. Appendix 1 of this report provides further details.

<table>
<thead>
<tr>
<th>Recommendation(s)</th>
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<tbody>
<tr>
<td>The HASSC is recommended to seek assurance from the CCG that there is adequate GP provision to meet the Borough’s residents’ needs currently and in the long term and that processes for providing members early notification of potential GP relocations have been established.</td>
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<table>
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<tr>
<th>Reason(s)</th>
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<tr>
<td>This report relates to the Council’s priority to ‘enable social responsibility’ and under it, the objective to ‘ensure everyone can access good quality healthcare when they need it’.</td>
</tr>
</tbody>
</table>

Financial Implications

There are no financial implications arising directly from this report.

Legal Implications

There are no legal implications arising directly from this report.

Background Papers Used in the Preparation of the Report:

None.

List of appendices:

Appendix 1
Briefing note: Developing a Primary Care Strategy in Barking and Dagenham

28 May 2015

Background and Context
Barking and Dagenham CCG are responding to delivering primary care services within a complex and changing context. At a national and London level there have been key policy announcements about how primary care is commissioned and delivered to address some of the challenges around accessible, proactive and coordinated care. At a local level some of the key challenges for Barking and Dagenham include an increase in the demand on local primary care services, limited amounts of funding and resource and the need for better succession planning for retiring GPs.

The strategic landscape for primary care services is central to how Barking and Dagenham CCG address these challenges and opportunities, and work is already underway to tackle some of these areas. Examples include the CCGs new role as delegated commissioners, the development of federations and the implementation of primary care extended access hubs.

Barking and Dagenham CCG are now working towards bringing this together into a clear, coherent and realistic strategy for primary care transformation through the development of a primary care transformation strategy. The strategy will outline the vision for primary care services within Barking and Dagenham over the next five years taking into consideration the wider primary care landscape and other transformational change initiatives relevant to the delivery of services. The final strategy will be published in the autumn/winter.

Key milestones:
- **April to June:** Establish the current state position for primary care services in Barking and Dagenham.
- **June to August:** Engagement to gather feedback on primary care services to help to shape the final strategy and key priorities for the future. This includes attending key meetings across the patch. Events will also be scheduled for all practice staff, GPs and broader stakeholders across the local healthcare economy.
- **Early Autumn:** engagement on the draft strategy
- **Winter:** Publication of final Barking and Dagenham Primary Care Strategy

Engaging with stakeholders to shape and influence the strategy
Stakeholder engagement is being planned throughout the spring and summer and will aim to seek feedback from key stakeholders (including local primary care staff, local voluntary and community organisations, patients, local authorities and social care organisations). The feedback captured will then be used to shape the final strategy winter. Feedback will be sought at key meetings, stakeholder events and through an online survey.

The aim of engagement is to:
- raise awareness of the development of a primary care strategy for Barking and Dagenham
- seek feedback on local primary care services from a broad range of stakeholders and the public.
- learn more about the current context of primary care, including the opportunities and the challenges.
- understand in more detail what is working well in primary care and what can be improved.
- ensure that the development of the Barking and Dagenham Primary Care strategy is shaped and influenced by local stakeholders.
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HEALTH AND ADULT SERVICES SELECT COMMITTEE

16 June 2015

Together First, GP Federation and the GP appointments hub service

Report of the Corporate Director, Adult & Community Services

Open Report

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

Accountable Divisional Director: Bruce Morris, Adult Social Care

Accountable Director: Anne Bristow, Adult & Community Services

Summary:

The Health & Adult Services Select Committee (HASSC) received a briefing in March 2015 from the Barking & Dagenham Clinical Commissioning Group (BDCCG) which provided information on the provision of urgent GP appointments in the Borough. Members noted that a GP-led service had opened in the Borough for patients with urgent needs, to improve care and help ease pressure on local A&E departments. The practice “hub” opened on Monday 19 January 2015 and was based at Barking Community Hospital in Upney Lane. It was being run by Together First, an organisation set up by local GPs to provide the new service, with initial funding provided from the Prime Minister’s Challenge Fund. Members also noted that there were plans to open a second hub in Dagenham. The briefing is provided as Appendix 1 to this report for members’ information.

In response to the briefing members stated that it would be helpful to see data on how many people the Hub had served since opening in January 2015. Furthermore, with regards to the opening of a second hub in Dagenham, members expressed disappointment that Together First did not show a commitment in the briefing to working with the Local Authority, in addition to working with HealthWatch, on the best location for opening a second hub. Members stated that in their collective experience they felt that GP practices overall were not referring patients to the Hub when they were unable to offer an urgent appointment.

On 3 June 2015 Together First held an event to which councillors and other local stakeholders were invited to discuss the criteria for the location of the second hub.

Representatives of Together First have been invited to the HASSC meeting on 16 June 2015 to deliver a presentation on the service (at Appendix 2), as well as update members on developments around the location of the second hub.

Recommendation(s)

The HASSC is recommended to note the March briefing, the presentation from Together First and the progress made in identifying the best location for the second hub.

Reason(s)

This report relates to the Council’s priority to ‘enable social responsibility’ and under it, the objective to ‘ensure everyone can access good quality healthcare when they need it’.
Background Papers Used in the Preparation of the Report:

None.

List of appendices:

Appendix 1  BDCCG’s March 2015 briefing for HASSC
Appendix 2  Together First’s presentation for the HASSC meeting on 16 June 2015

Financial Implications

There are no financial implications arising directly from this report.

Legal Implications

There are no legal implications arising directly from this report.
To: Barking and Dagenham Health and Adult Services Scrutiny Committee

From: Dr Arun Sharma, Together First

Date: 4 March 2015

Subject: Update on urgent GP appointments

Executive summary

This paper provides the committee with an update regarding provision of urgent GP appointments in Barking and Dagenham. A verbal update will follow at the HASSC meeting in June 2015.

Recommendations

The committee is asked note and consider the contents of this report.
Expanded GP opening hours in Barking and Dagenham

A GP-led service has opened in Barking and Dagenham for patients with urgent needs, to improve care and help ease pressure on local A&E departments. The practice “hub” opened on Monday 19 January 2015 and is based at Barking Community Hospital in Upney Lane. It is being run by Together First, an organisation set up by local GPs to provide the new service, with initial funding provided from the Prime Minister’s Challenge Fund (PMCF).

Patients calling the NHS 111 service can now be given an appointment to see a GP that same evening. The appointments are available between 6.30pm and 10pm for patients registered with a GP in Barking and Dagenham. Patients have to be booked in by their GP practice or by NHS 111 - they cannot simply turn up at an evening surgery or book appointments themselves. Phone lines are now open from 2pm-10pm to allow bookings from GP practices, and the hub is taking referrals from A&E, walk-in services and urgent care centres. After seeing the evening GP, details of the consultation and any medicines prescribed will be sent to the patient’s own GP by 9am the next morning, so the family doctor knows what has happened and what - if any - treatment has been provided.

From mid-March, the hub will be open on Thursdays from 2pm-10pm to support half-day closure for GP practices. The hub will be getting up to speed over the next few months – we are looking to begin weekend opening hours in the spring, and are hoping to open a second hub in Dagenham. We are working with Healthwatch to identify the best location for the second hub.

Communications

Together First sent information about the new service to GP practices in Barking and Dagenham and to Barking, Havering and Redbridge University Hospitals Trust (BHRUT) when the new hub opened. A media release about the service has gone out to the local media.

Background

Many people going to A&E or urgent care centres outside normal hours could get the care they need from a GP appointment. By making these appointments available, GPs are not only giving local people more appropriate care, but potentially saving them from a long wait in hospital.

Barking and Dagenham’s ‘urgent primary care surge scheme’ was commissioned during 2013/14 to support winter pressures on the healthcare system. This is a pilot scheme designed to provide system support during the development of the new GP-led federation, Together First. The surge scheme provides additional urgent appointments at a patient’s registered practice, within normal opening hours. The scheme was designed to reduce the need for patients to attend other urgent care services and improve patient satisfaction levels with general practice. Of the 41 Barking and Dagenham practices, 34 are currently contracted to deliver surge appointments, and these contracts expire on 31 March 2015.

Together First is a federation of Barking and Dagenham GP practices, set up to collectively operate services to benefit primary care.
Contents

- Together First Structure.

- Together First Business Activity.

- Barking Hub Structure and Data.

- Data Sharing Agreement.
Queens and Kings see’s approximately 100,000 patients across B&D, Redbridge and Havering

Barking Hub to provide approximately 15,000 appointments

- Patients Seen By GP’s
- Seen at an appointed time
- More Patient Satisfaction
- Less pressure on A&E
- Dagenham Hub will help further
Patients or Surgery can call to book appointment on 0203 770 1888

Telephone Lines Open
Monday-Friday - 14:00-21:00
Saturday, Sunday and Bank Holidays - 09.00 – 17:00

Call Center Staff
4 Call Operators
1 Site Supervisor

Hub Site Staff
1 Receptionist
2/3 Doctors

B&D Patients
Havering Patients
Redbridge Patients

Chadwell Heath Call Center

Barking Hospital
North Street Hub
Rosewood Hub
Fulwell Cross Hub
Newbury Group Hub
Appointments Offered, Booked and DNA at Barking Hub

Appointments offered, Patients Booked and DNA's by RM and IG Postcode (19.01.2015 – 30.04.2015)

- **Appointments Offered**: 3044
- **Total Booked**: 1613
- **RM Postcode**
  - Patients Booked: 897
  - DNA’s: 68
- **IG Postcode**
  - Patients Booked: 716
  - DNA’s: 83

Patients Booked | DNA’s
Patients Age Profile Barking Hub

Percentage Breakdown Age Group of Patients Seen at Barking Hub Between 19.01.2015 - 31.04.2015

Under 14 accounts for 42% of all patients seen

- 0-4: 22.2%
- 5-9: 13.7%
- 10-14: 6.0%
- 15-19: 6.0%
- 20-24: 6.2%
- 25-29: 8.1%
- 30-34: 6.9%
- 35-39: 5.9%
- 40-44: 5.6%
- 45-49: 5.0%
- 50-54: 4.7%
- 55-59: 2.4%
- 60-64: 2.5%
- 65-69: 2.0%
- 70-74: 0.9%
- 75-79: 0.7%
- 80-84: 0.7%
- 85-89: 0.6%
- 90-94: 0.2%
- 95-99: 0.1%
Patient Satisfaction Barking Hub

FFT B&D Hub Site 19.01.2015 – 30.04.2015

- Extremely likely to recommend
- Likely to recommend
- Neither likely or unlikely to recommend
- Unlikely to recommend
- Extremely unlikely to recommend
- Don't know
# Health and Adult Services Select Committee

## 16 June 2015

### Eye Health Survey Results

**Report of the Corporate Director, Adult & Community Services**

<table>
<thead>
<tr>
<th>Open Report</th>
<th>For Information</th>
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<tbody>
<tr>
<td><strong>Report Author:</strong> Sue Lloyd, Public Health Consultant</td>
<td><strong>Contact Details:</strong> Tel: 020 8227 2799 E-mail: <a href="mailto:sue.lloyd@lbby.gov.uk">sue.lloyd@lbby.gov.uk</a></td>
</tr>
<tr>
<td><strong>Accountable Divisional Director:</strong> Matthew Cole, Director of Public Health</td>
<td></td>
</tr>
<tr>
<td><strong>Accountable Director:</strong> Anne, Bristow, Adult &amp; Community Services</td>
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#### Summary:

In September 2014 the Health & Adult Services Select Committee (HASSC) agreed to undertake an in-depth scrutiny review on local eye care services. In January 2015, HASSC members agreed the scope of this Review which included a survey to help guide the Committee on potential patterns around awareness and usage of primary eye care services.

The Director of Public Health will deliver a presentation to the HASSC outlining the findings of an internal staff survey undertaken for this purpose in May 2015.

#### Recommendation(s)

The HASSC is recommended to note the presentation and discuss with officers the impact of the survey findings on the scrutiny review report arising from the Review.

#### Reason(s)

This report relates to the HASSC’s scrutiny review on local eye care services, which relates to the Council’s priority to ‘enable social responsibility’ and under it, the objective to ‘ensure everyone can access good quality healthcare when they need it’.

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

None.

### List of appendices:

- **Appendix 1**  
  Eye Health Staff Survey Presentation for the HASSC on 16 June 2015
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Appendix 1

One borough; one community; London’s growth opportunity

Enabling social responsibility

Growing the borough

For more information visit lbbd.gov.uk/visionandpriorities
LBBD Staff - Eye Health Survey Results
May 2015

Name: Matthew Cole
Job title: Director of Public Health
Date: May 2015
Eye Health Survey

What did we do?
We asked council employees about their eye health

How did we ask council employees?
- We surveyed LBBD staff in April-May 2015
- We used an online questionnaire sent in CMT briefing, via Yammer and via email

Who responded?
- 88 people completed the questionnaire
Use the information as a guide

There are limitations to the data

- All people who answered are employed
- All people were employed by LBBD
Ages are 20 – 69 years

86 people answered this question
More females than males answered

86 people answered this question
The balance of people who answered were white

85 people answered this question

- White: 87.1%
- Afro-Caribbean: 7.1%
- Asian: 3.5%
- Mixed: 2.4%
When was your last sight test?

- 2 years ago or less: 75
- 3 years ago or less: 10
- Other: 3
- I've never had a sight test: 0

All 88 people answered this question.
How often do you think you should have your eyes tested?

Correct answer: Every 2 years

87 people answered this question
For most people, it is recommended that you should have your eyes tested every 2 years. We asked - If you have not had your eyes tested in the last 2 years, please tell us why.

- I am worried I may be pressured into buying glasses or lenses
- I have not got the time - it's an inconvenience
- I don’t think I need an eye test
- I did not know how often I should have my eyes tested

17 people answered this question
Are there other reasons why you have not been to an optician?

- My eyes don't hurt
- I don't know where to go
- Not had time
- I can see OK
- Other

16 people answered this question
Do you have a close relative who has glaucoma?

- Yes (25.6%)
- No (9.3%)
- Don't know (65.1%)

86 people answered this question
Do you have diabetes?

86 people answered this question

Don't Know (91.9%)  
No (2.3%)  
Yes (5.8%)
Do you know if you are entitled to a free NHS sight test?

Well; Tesco, Specsavers, Boots ... will do the same!

No - I don't know if I am entitled

Yes - I know I am not entitled

Yes - I know I am entitled

86 people answered this question
Do you know if you are entitled to financial help towards the cost of spectacles or contact lenses (NHS optical voucher)?

No - I don't know if I am entitled or not

Yes - I know I am not entitled

Yes - I know I am entitled

86 people answered this question
Do you know if you are entitled to an eye examination paid for by your employer?

Here to help!

85 people answered question
Are you registered as visually impaired?

86 people answered this question
Do you receive any of these benefits?

Only 3 people reported receiving Tax Credits
No-one received any other benefits

86 people answered this question
Other comments

...it had been 7 years due to the cost involved

really can't afford to buy new glasses

spectacle lenses so expensive in this country

I have always claimed support through the Council scheme and I think it is very helpful towards costs.
What does this mean for residents in Barking and Dagenham?

- **There was an awareness of the importance of eye health**
  Most people who responded had had an eye test in the past 2 years

- **Not all people knew how often their eyes should be tested**
  Only half of the respondents knew to get their eyes tested every 2 years

- **People felt a pressure to spend money**
  People were sometimes not aware of free tests
  People were sometimes not aware if they or close relative had glaucoma / diabetes this means they were not accessing free tests
Questions – Discussion
# HEALTH AND ADULT SERVICES SELECT COMMITTEE

16 June 2015

## Intermediate Care Proposals – update on Redbridge Health Scrutiny Committee’s referral to the Secretary of State for Health

### Report of the Corporate Director of Adult & Community Services

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<th>Open Report</th>
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**Accountable Divisional Director:** Bruce Morris, Adult Social Care

**Accountable Director:** Anne Bristow, Adult & Community Services

### Summary:

The Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (CCGs) consulted on their proposals to change the way NHS rehabilitation services are provided across the three boroughs by reducing the number of inpatient beds across the three boroughs and providing more treatment in people’s own homes. The three separate CCGs came together to agree these proposals across the local authorities concerned and the consultation went through the three boroughs’ scrutiny processes simultaneously. The consultation was undertaken from 9 July to 15 October 2014 and was referred to formally as the consultation on the ‘Intermediate Care Proposals’. At its meeting on 26 January 2015 the London Borough of Redbridge’s Health Scrutiny Committee (LBRHSC) resolved to refer its concerns regarding the proposals to the Secretary of State for Health.

On 3 March 2015 the Health & Adult Services Select Committee (HASSC):
- Noted Redbridge’s referral letter (at Appendix 3)
- Noted an update report from Barking and Dagenham CCG on the potential implications of the referral (at Appendix 4) and
- Agreed to indicate support for Redbridge’s referral by writing to the Secretary of State for Health.

Subsequently the LBRHSC received a letter from the Secretary of State responding to its referral stating that the referral did not meet legislative requirements to constitute a legitimate referral and requesting further evidence in relation to the provisions laid out in relevant regulations. On 13 May 2015 the LBRHSC convened a special meeting to agree upon its next steps.

This Report provides background to the Intermediate Care Consultation and provides the Secretary of State’s response to the referral for members’ information at Appendix 5.

### Recommendation(s)

The HASSC is recommended to note this report.
Reason(s)
The Intermediate Care Proposals and the consequent referral by Redbridge relate to the HASSC’s function to scrutinise any matter relating to the planning, provision and operation of the health service in the borough or accessed by Barking and Dagenham residents. This report also relates to the Council’s priority to ‘enable social responsibility’ and under it, the objective to ‘ensure everyone can access good quality healthcare when they need it’.

1. Introduction and Background

1.1 The Intermediate Care proposals involved reducing the number of inpatient beds provided across the three boroughs in the specialist community hospitals and provide more treatment in people’s own homes. 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.

1.2 If implemented, the proposal would see a reduction in the total number of inpatient beds across the three boroughs. The beds would be provided at King George Hospital for the residents of all three boroughs, with dedicated cross-borough services, the Intensive Rehabilitation Service (IRS) and the Community Treatment Team (CTT), providing therapy and urgent response services in people’s own homes.

2. Summary of key consultation with Barking & Dagenham members and the three boroughs’ responses

2.1 In addition to other forms of consultation, representatives of the CCG attended:

- A (closed) meeting of the HASSC on 31 July 2014 to present the proposals to HASSC members and the Cabinet Member for Adult Social Care and Health
- A public meeting of the Health & Wellbeing Board on 9 September 2014 and
- A public meeting of the HASSC on 30 September 2014.

2.2 At these meetings the HASSC and the Cabinet Member for Health and Adult Social Care, expressed a number of concerns with regards to the potential local impact of the proposals, including issues around local need, clarity around the possible alternative use of Grays Court and the potential impact on other health services there, medical cover, location and travel times and stroke rehabilitation.

2.3 The HASSC’s formal response to the consultation, dated 15 October 2014, is provided at Appendix 1 and the CCG’s response to this, dated 18 November 2014 is attached at Appendix 2.

2.4 Whilst Havering’s Health Overview and Scrutiny Committee was in support of the proposals overall, the LBRHSC expressed significant concerns around the proposals relating to the adequacy of the content of the consultation and whether the proposals would be in the best interest of the health service in their area.
3. The CCGs’ decision following the consultation period

3.1 Following the end of the consultation period on 15 October 2014, on 11 December 2014, the governing bodies of the three CCGs agreed to:

- permanently establish the home-based services, the CTT and IRS
- reduce the number of community rehabilitation beds to 40-61 for the three boroughs
- locate these beds on one site at King George Hospital in Redbridge.

4. Referral by London Borough of Redbridge’s Health Scrutiny Committee to Secretary of State for Health

4.1 Following the announcement of the CCGs’ decision, at its meeting on 26 January 2015, the LBRHSC resolved to refer its concerns regarding the proposals to the Secretary of State for Health under provisions of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. The referral letter is provided at Appendix 3.

4.2 Following the referral to the Secretary of State by the LBRHSC, the CCG provided an update on the potential implications of the referral for the HASSC as part of an update report for the 3 March 2015 meeting. This is attached at Appendix 4.

4.3 At its meeting on 3 March 2015, the HASSC agreed to delegate responsibility to write to the Secretary of State for Health to the Lead Member, Councillor Keller, in support of Redbridge’s referral.

4.4 However, subsequently to the 3 March 2015 HASSC meeting, Redbridge published the Secretary of State’s response to the referral (at Appendix 5) which stated that the referral did not meet the legislative requirements to constitute a legitimate referral and requested further evidence in relation to the provisions laid out in The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 in order for the request to be reconsidered. The Lead Member of HASSC therefore decided not to write to the Secretary of State in support of Redbridge’s referral at this stage and requested that officers to seek clarification from Redbridge as to the LBRHSC’s next steps.

4.5 On 13 May 2015 the LBRHSC met to discuss its next steps with regards to the response from the Secretary of State to its referral. Details of the developments at that meeting are yet to be published. Once they are made public, the HASSC will receive an update report.

5. Financial Implications

Implications completed by Roger Hampson, Group Manager, Finance (Adults and Community Services)

5.1 There are no financial implications directly arising from this Report.
6. **Legal Implications**

Implications completed by Dawn Pelle, Adult Care Lawyer, Legal and Democratic Services

6.1 Whilst there are no direct legal implications of this Report, should the London Borough of Redbridge choose, at a later date, to pursue its referral to the Secretary of State, the way intermediate care health services are delivered in the Borough may potentially be affected, depending on the course of action taken by the Secretary of State in response.

6.2 The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 sets out the courses of action the Secretary of State may take upon receiving a referral from a local authority on proposals to substantially vary a health service in the authority’s area.

6.3 Where a local authority has reported to the Secretary of State because it is not satisfied that the consultation on a proposal has been adequate in relation to content or time allowed, and/ or because the authority considers that the proposal would not be in the interests of the health service in its area (as Redbridge has done), the regulations state that the Secretary of State may make a decision in relation to the subject matter of the referral, make a final decision on the proposal, or give directions to the National Health Service Commissioning Board to require the CCG to:

   a) to consult (or consult further) with the authority in relation to the proposal;
   b) to determine the matter in a particular way;
   c) to take, or not to take, any other steps in relation to the matter.

6.4 Before coming to a decision on the referral made by Redbridge, the Secretary of State may request the Independent Reconfiguration Panel (a non-departmental public body and independent expert on NHS service change) to review the proposals, in an advisory capacity.

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


**List of appendices:**

Appendix 1 HASSC’s response letter to the Intermediate Care Consultation

Appendix 2 CCG’s response to HASSC’s letter

Appendix 3 LBRHSC’s referral to the Secretary of State for Health

Appendix 4 Update on the Intermediate Care Consultation from the BDCCG

Appendix 5 Secretary of State for Health’s response to LBRHSC’s referral
Dear Dr Jagan John

Intermediate Care Consultation

Thank you for asking the Barking and Dagenham Health and Adult Services Select Committee (HASSC) to respond to the consultation on the Intermediate Care proposals relating to how NHS rehabilitation services are provided across Havering, Barking & Dagenham, and Redbridge. I write to you on behalf of the Committee in my capacity as Lead Member to outline members' concerns regarding the potential local impact of the proposals raised at a meeting with the HASSC on 31 July 2014, a meeting of the Health and Wellbeing Board on 9 September 2014 and a formal meeting of the HASSC on 30 September 2014.

Local Need

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. We were disappointed in that regard not to hear more from CCG representatives about the potential impacts of the proposals on Barking and Dagenham residents from the outset.

Grays Court

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. We have been advised 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 unclear whether these are included in the scope of the consultation.

We are concerned that with the proposals in their current form there is every possibility of a half empty, or empty building in the middle of the borough. Whilst we are aware that alternative uses for the building by Council services have been considered, we do not feel that these ideas will be feasible if there are still NHS inpatient beds in the building. Therefore before we are able to support the proposals in principle, we would like to see a
written agreement about the future use of Grays Court and also, financial and other legal matters would need to be resolved.

Grays Court is near to another NHS facility, Broad Street Walk-in Centre, which 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, we are concerned that there will be a risk that these proposals will put further stress on a health and social care system that is already stretched.

I attended the Health and Wellbeing Board on 9 September 2014 where the CCG delivered a presentation on the proposals. The Board 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. It was reiterated at the HASSC meeting on 30 September that residents are likely to perceive these proposals as a further reduction in NHS services in the borough. Whilst the clinical rationale for Grays Court is understood, it has still raised concern that the centralisation of services is happening out of Borough. We ask for assurances that there will be no further closures of local services.

Medical Cover

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

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. We 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

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:
Appendix 1

The London Borough of Barking and Dagenham

- 40 minutes from Barking Town Centre (Barking Town Hall)
- 50 minutes from Dagenham Heathway (Shopping Centre)
- 1 hour and 5 minutes from Thames View

In light of these concerns, we request an impact assessment covering alternative travel plans comparing Grays Court and King George Hospital, to better understand how local residents will be affected.

**Stroke Rehabilitation**

The scope of the proposals do not cover the full range of services that would usually be considered as NHS Intermediate Care services. Stroke rehabilitation is specifically excluded from the consultation remit as this is referred to as being part of a different care pathway.

Given the current proposals would effectively leave half of the beds at Grays Court empty, it is highly likely this will put the viability of this element of the service at Grays Court at risk and we see the future of the two elements of the service delivered from Grays Court as intrinsically linked. We would therefore like to see forthcoming proposals for changes in Stroke services delivered from Grays Court before coming to a conclusion about the Intermediate Care Consultation.

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. We suggest 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.

In conclusion, whilst we understand the clinical rationale behind the proposals and support services that enable more people to be treated in their own homes, we are concerned about the impact the proposals will have locally, particularly what the alternative use of Grays Court will be, and the impact on residents travelling to King George Hospital to visit their family, relatives or friends using impatient services.

We ask that the CCG continue to work with our officers to address these particular impacts, and take into account our other concerns before implementing the proposals.

Yours sincerely

Councillor Eileen Keller
Chair, Health and Adult Services Select Committee
CC
Councillor Maureen Worby, Cabinet Member for Adult Social Care and Health
Anne Bristow, Corporate Director, Adult and Community Services
Bruce Morris, Divisional Director, Adult Social Care
Dear Councillor Keller

Thank you for your letter of 14 October 2014 regarding the Intermediate Care Consultation. I am pleased that you are supportive of the need to provide care in people’s home as far as possible and that you recognise the clinical rationale for the proposals. You have raised some concerns about the potential local impact of the proposals and the CCG welcomes the opportunity to work with officers to address the issues you raise in your letter.

I make an initial response to the main issues you raise in your letter below

**Impact on Barking and Dagenham residents.**

You raise concerns about a “one size fits all” approach across Barking and Dagenham, Havering and Redbridge (BHR) as this does not take into account the specific and different needs of the residents in our borough, compared with our neighbouring boroughs. I understand these concerns however I believe that we have considered the individual needs of residents in developing the new model.

The model of care that we have developed is based on assessing an individual’s needs and providing care to meet those needs in the best place for them, which for many people is in their own home, where they prefer to be. This is a great improvement on the previous model of care which had a much more standardised approach to providing bed-based intermediate care without the option of providing rehabilitation at home. This individualised approach means that Barking and Dagenham residents will, like other boroughs’ residents, get support tailored to their needs rather than having to go through the same rehabilitation process for all patients discharged from hospital.
We know that although Barking and Dagenham’s older population is not projected to grow as rapidly as other boroughs, it will see changes in, for example, the needs of the oldest old. The particular needs of these people will be much better met by the new model than the previous system of intermediate care.

I understand that you are concerned about the impact on Dagenham in particular given that another service has recently closed there and the perception of local residents that NHS services are being reduced in the borough. We would maintain that the new model has increased access to intermediate care services for residents in Barking and Dagenham. Based on current utilisation we are forecasting that 3140 Barking and Dagenham residents will receive intermediate care support in 2014/15 compared to 2499 in 2013/14, an increase of 26%.

The HASSC also expressed concern that the proposal could put further stress on the health and social care system. Through the trial, it has been demonstrated that the new model has supported people being discharged home earlier with support and the home based services have prevented hospital admissions. Intermediate care is one of the schemes that will be jointly commissioned by the CCG and LBBD through the Better Care Fund, which has been approved by the Health and Wellbeing Board. This will ensure a continued focus on the effective use of both health and social care resources.

Grays Court and stroke services

The HASSC has expressed concerns about the potential impact of the proposals on Grays Court and on other services provided from the estate. There are no service changes planned for the specialist outpatient services and clinics provided from the ground floor at Grays Court and these are not included in the consultation.

The consultation is on a new model of intermediate care, as defined in the BHR integrated Care Strategy, which may have an impact on the 26 intermediate care beds in Grays Court. Specialist stroke rehabilitation services, including the 17 stroke beds at Grays Court for Barking and Dagenham and Havering residents, are not part of the consultation and are subject to a separate review that will be starting in December 2014. This review will need to take into account the impact of the CCG decision on the new intermediate care model which will be made in December. The HASSC will be consulted on any service changes arising from this review.

It is unfortunate that the timescales for the two business cases were not aligned and the CCG acknowledges the potential risks if intermediate care beds are relocated and stroke beds remain on-site. We will work with Council Officers to agree how the estate risks can be mitigated through the Finance and Estates Group which is led by the CCG Deputy Chief Officer.

Medical cover at Grays Court

Patients are admitted to a community intermediate care bed following hospital discharge when they have been assessed as being medically fit. The treatment goals during their stay are focused on rehabilitation with support provided primarily from therapists and nurses.

There is 24/7 medical support which is accessed by the senior nurse on call either via the consultant on call or a middle grade doctor depending on time and urgency of the call.
If a patient deteriorates beyond the medical plan in place staff will call an ambulance in an emergency situation if required. I am satisfied that the medical cover is adequate for rehabilitation patients who are admitted to the unit.

**Travel times to King George’s Hospital**

The following factors need to be borne in mind when considering changes to travel times if inpatient beds are centralised at King George Hospital:

As you note, many more people will be cared for in their own homes so will have no travel to do whereas currently they, and their families and friends will need to travel to one of the intermediate care inpatient services in BHR e.g. Grays Court.

Patients who are admitted to an in-patient bed will have shorter lengths of stay than previously so the burden of travel will be reduced as the number of journeys family and friends will need to take will decrease for shorter stays.

Our analysis shows that whilst the travel times to King George Hospital from some locations is longer than to Grays Court the travel route is often more direct with fewer transport changes. We will undertake a fuller assessment of this in the development of the final business case.

**Delayed discharge from hospital**

The trial of the new model for intermediate care has demonstrated that delayed transfers of care have reduced for general rehabilitation patients. The CCG is working with NHS England to support the discharge of patients with very specialist needs who are not part if this review.

In conclusion, given that you are supportive of the clinical rationale of the proposals we have made regarding intermediate care, I am confident that we will be able to work together to address your concerns about the potential impact of implementation of these proposals. I therefore propose that we engage with your officers to develop a joint implementation plan that will resolve the concerns about Grays Court in particular.

Yours sincerely,

[Signature]

**Dr Jagan John**

Clinical Director Barking and Dagenham CCG

cc: Anne Bristow, Corporate Director Adult & Community Services, LBBD

Bruce Morris, Divisional Director of Adult Social Care, LBBD

Zoe Anderson, Senior Public Affairs and Consultation Manager, NELCSU
This page is intentionally left blank
The Rt. Hon. Jeremy Hunt, MP
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Director of Adult Social Services
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Please ask for: John Powell

Your ref:
My Ref: JPJM/SR/dash15/SoS/lt04.02.15

4th February 2015

Dear Secretary of State,

INTERMEDIATE CARE PROPOSALS AFFECTING REDBRIDGE RESIDENTS
REFFERAL TO THE SECRETARY OF STATE

On 26th January 2015, the Health Scrutiny Committee for Redbridge resolved to refer a decision, made by Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups on 11th December 2014 regarding the future of local intermediate care services, to the Secretary of State. This referral is made pursuant to Regulation 23(9) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

The referral is made following the Committee’s initial response to the consultation, which outlined the following concerns:

1. Inadequate time for the consultation – the Committee recommended that the consultation be extended by a month but it was only extended by 2 weeks following the intervention of Jane Ellison, MP, and not as a direct result of the Committee’s request.

2. Dissatisfaction with the adequacy of the content of the consultation – in particular, that consultation questions were leading.

3. Concern that the proposals would not be in the best interests of the health service in the area or to Redbridge residents – the Committee highlighted that bed modelling was not robust and the ‘National Audit of Intermediate Care Report 2013’, albeit an audit, suggested the mean number of commissioned intermediate care beds per 100,000 of the population was 26.3 beds and this would suggest that the number of beds required by Redbridge, Barking & Dagenham and Havering would be 184, not 40-61 as proposed by the CCGs.

Roger Hampson – Chief Executive
At its meetings on 24th July 2014, 23rd September 2014 and 26th January 2015, the Committee heard from a number of local public speakers and representatives from third sector groups, such as Age UK Redbridge; Redbridge Carers Support Service; Wanstead and Snaresbrook Residents’ Alliance and Redbridge Healthwatch, and the Committee was also informed about a petition by Save the Wanstead Hospital, which has in excess of 3000 signatories.

Whilst some support was expressed at these meetings about the benefits of the proposed enhanced intermediate care services, there are continuing concerns, including whether nine months was a sufficient enough period for the CCGs to undertake the pilot on which the proposals are based; and also that the proposed new service should not be introduced at the cost of losing the existing service, i.e. the beds based at the Heronwood and Galleon Unit in Wanstead.

A summary of the key concerns outlined at the Committee’s recent meeting on 26th January, attended by representatives from Redbridge CCG and the provider organisation, North East London Foundation Trust, is set out below:

- Inadequate consultation process – that there was a lack of awareness about the consultation due to an initially insufficient consultation period and insufficient circulation of consultation documents and that the consultation questions were leading; in addition, it was noted by the Committee that a public speaker commented that GPs were not consulted during the formal consultation.

- Insufficient bed modelling regarding the proposed number of intermediate care beds for the Redbridge population – a public speaker suggested to the Committee that the Business Case that supported the decision by the CCGs made no reference to the bed base need.

- A lack of consideration for the views of the Redbridge public regarding the impact on carers, and in particular the views expressed via Redbridge Healthwatch.

The Committee’s referral is based on a majority cross-party decision.

I look forward to hearing from you.

Yours sincerely

John Powell
Director of Adult Social Services and Housing

Councillor Stuart Bellwood
Vice Chair, Health Scrutiny Committee
(in the chair on 26th January 2015)

Roger Hampson – Chief Executive
To:       Barking and Dagenham Health and Adult Services Select Committee

From: Jagan John, Clinical Director Integrated Care
Sharon Morrow, Chief Operating Officer

Date:  4 March 2015

Subject:  Update on the Intermediate Care Consultation

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**Executive summary**

This paper provides the committee with an update regarding potential implications of the Redbridge Health Scrutiny Committee's decision to ask the Secretary of State to refer the consultation to the Independent Reconfiguration Panel for its consideration.

It will also update regarding progress of the stroke rehabilitation review and discussions regarding Grays Court estate in Dagenham.

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**Recommendations**

The committee is asked note and consider the contents of this report.
1.0 Purpose of the Report

1.1 To provide the committee with an update regarding potential implications of the Redbridge Health Scrutiny Committee’s decision to ask the Secretary of State for Health to refer the intermediate care consultation to the Independent Reconfiguration Panel for its consideration.

1.2 It will also update regarding Grays Court in Dagenham.

2.0 Background/Introduction

2.1 Barking and Dagenham CCG, Redbridge CCG and Havering CCG have been trialling a new model of intermediate care since November 2013. The outcomes of the trial have been reported to the CCG Governing Body and the Health and Wellbeing Board. A pre-consultation business case proposing a new home-based model of intermediate care was approved the CCG Governing Body in June 2014. A 14 week public consultation ran from 7 July to 15 October 2014. This involved extensive engagement with community and voluntary groups.

2.2 The CCG attended a closed HASSC meeting on 31 July 2014 and a public meeting of the HASSC on 30 September 2014 to present the proposals. A written response to the HASSC’s formal response to the consultation was provided on 18 November 2015 (attached).

2.3 On 11 December 2014, Redbridge Barking and Dagenham CCG’s governing body agreed the future model of intermediate care as:

- Permanently establish the new home-based services—Community Treatment Team and Intensive Rehabilitation Service
- Reduce the community bed base in line with the community bed modelling i.e. flex between 40-61 beds (average 50)
- To locate these beds on one site at King George Hospital.

2.4 The governing bodies also agreed that implementation of the changes would require the following specific actions to be taken:

- 2015/16 activity trajectories for CTT and IRS to be revised in line with actual delivery 2014/15.
- Commissioning intentions for 2015/16 include a requirement for improved seven day access/admission to community beds.
- Ongoing monitoring and scrutiny via contract performance review processes.
- Barking and Dagenham CCG will work with the London Borough of Barking and Dagenham to agree an implementation plan that will take account of their concerns about the future use of Grays Court and the impact of this change in Dagenham, and taking account the review of the stroke services that is currently underway.

2.5 The evidence considered by the CCGs’ governing bodies is contained within the decision-making business case (157 pages) which is available online:


This includes evidence as follows:

- updated service performance information and patient and clinical outcomes
- details the public consultation process undertaken following governing body agreement in June 2014 and the outcome of this process
- provides detail of the equalities impact assessment completed to support the consultation process
- outlines the intermediate care consultation steering group’s recommended proposal for governing body decision and detailed supporting information
provides detail of implementation timescales subject to governing body agreement.

An analysis of the impact on travel as a result of the proposed changes was also included in the DMBC following a specific request from this committee.

2.6 The governing bodies also reviewed consultation responses and members of the public and other stakeholders were also able to make representations at the beginning of the governing body and their comments were also considered during decision making.

21% of respondents to the consultation were from Barking and Dagenham. The response to the consultation from Barking and Dagenham residents was as follows:

<table>
<thead>
<tr>
<th>Support % Higher (↑) or lower (↓) than overall results</th>
<th>Opposition % Higher (↑) or lower (↓) than overall results</th>
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<tbody>
<tr>
<td>The NHS should permanently run the new home-based services that have been trialled (the community treatment teams and the intensive rehabilitation service) because they help people to get better more quickly and to stay independent.</td>
<td>90% ↑ 9% ↓</td>
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<tr>
<td>The NHS should reduce the numbers of community rehabilitation beds if it can be shown that they are not used and are not needed.</td>
<td>73% ↑ 21% ↓</td>
</tr>
<tr>
<td>The NHS should reduce the number of community rehabilitation units if it can be shown that this is the best way to provide high quality, safe care.</td>
<td>64% ↑ 25% ↓</td>
</tr>
<tr>
<td>Option five – home-based services where possible and one community rehabilitation unit on the King George Hospital site, with 40-61 beds – is the best way to organise intermediate care services in the future.</td>
<td>72% ↑ 22% ↓</td>
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- Barking and Dagenham respondents were in favour of each of the proposals.
- Barking and Dagenham respondents were more positive about all the proposals than respondents overall.
- Barking and Dagenham respondents showed most support for permanently running the new home-based services, with 9 out of 10 people in favour.
- Barking and Dagenham respondents showed least support for reducing the number of community rehabilitation beds, but almost 2/3 were in favour.
- Almost 3/4 of Barking and Dagenham respondents were in favour of the preferred option.
3.0 Impact on Grays Court

3.1 The CCG has agreed to work with the London Borough of Barking and Dagenham to agree an implementation plan that will take account of their concerns about the future use of Grays Court.

3.2 A stroke rehabilitation pathway review is currently taking place and the committee will be updated on this as it progresses.

3.3 The timescale for the relocation of community rehabilitation beds to King George Hospital was agreed by governing bodies for autumn 2015.

The implementation plan will be overseen by the BHR Finance and Estates Group (which includes representation from BHRUT, NELFT and CCGs) with local authority representation.

3.3 There are no planned changes to services provided from the outpatient unit at Grays Court.

4.0 Risk

4.1 On 26 January 2015, Redbridge Health Scrutiny Committee decided to write to the Secretary of State asking him to refer the consultation to the independent reconfiguration panel. The majority of respondents within Redbridge (56%) supported the CCGs’ preferred option and the Redbridge Health Scrutiny Committee’s own response includes the following:

‘The Committee and all of the stakeholders welcome the opportunity to enhance and improve the Intermediate Care Services for Redbridge Residents and can see that the proposal is to locate services in King George Hospital which is welcomed...’.

4.2 The CCG has written to the Secretary of State for Health outlining why we do not agree with the grounds on which Redbridge Health Scrutiny Committee is requesting the proposals be referred. We are yet to receive a formal response from the Secretary of State regarding this, however will provide regular updates to the committee as this progresses.

4.3 This decision may result in a delay to implementation which could have consequences for patients’ care locally. Through the course of the trial, more than 10,000 patients have been cared for by the community treatment team and intensive rehabilitation service in the past year with improved outcomes and patient experience. Only 1300 would have been cared for in the old bed-based system alone—a difference of 8,700 patients in a year.

4.4 These successful services have also proved very popular with patients and carers who have constantly rated them at more than nine out of ten. Without these services in place, many more patients would have ended up in our already overstretched A&E departments and required more help from their family and/or carers.

Community rehab bed occupancy levels currently identify that 49% of community beds across the BHR economy are sitting unused as a result of more people receiving care at home. This is not sustainable or an acceptable use of valuable NHS resources.

4.5 The implementation of a new model for intermediate care is one of the key schemes in the Better Care Fund plan which was approved by the Health and Wellbeing Board in September 2014. Savings generated from the relocation of beds to King George Hospital would be used to manage...
financial pressures in the Barking and Dagenham CCG/ London Borough of Barking and Dagenham pooled budget. The CCG has identified non-recurrent funding in 2015/16 to manage cost pressures arising from the Care Act implementation. Recurrent funding would need to be found from savings within this pooled budget.

**Attachments:**
1. Barking and Dagenham CCG response to HASSC letter of 15 October 2014

**Author:** Gemma Hughes/Sarah D’Souza  
Deputy Chief Operating Officer, Barking and Dagenham CCG

Tara-Lee Baohm  
Deputy Director of Strategic Delivery

**Date:** 18 February 2015
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Dear Mr Powell and Cllr Bellwood,

Thank you for your letter of 4 February 2015 about Redbridge Intermediate Care proposals.

I understand that Redbridge Health Scrutiny Committee intends to refer the case of the Redbridge Intermediate Care services as a contested proposal for service change. Unfortunately, the letter you have provided does not meet the legislative requirements that constitute a legitimate referral.

As you will know, referrals about contested service change must comply with specific requirements set out in Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. It would be helpful if the Committee could provide further evidence, referring specifically to the provisions as laid out in the Regulations, in order for the request to be appropriately considered.
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HEALTH AND ADULT SERVICES SELECT COMMITTEE

16 June 2015

Scrutiny Work Programme 2015/16

Report of the Chief Executive

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: Chris Naylor, 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 2015/16.

At the start of the 2014/15 municipal year members of the HASSC were given a range of potential topic areas to consider for in-depth scrutiny. The HASSC agreed that it would undertake an in-depth scrutiny review on local eye care services in 2014/15 and allow part of the 2015/16 municipal year to complete the review and the end report containing the recommendations for service-improvement and take-up. At this time members were also interested in ‘Falls’ as an area to scrutinise and agreed that this could potentially be considered for in-depth scrutiny over the course of the 2015/16 municipal year, after the conclusion of the eye care services review.

The following are appended to this report:

A. The Draft Work Programme with dates of meetings, standard items and potential areas for (one-off) scrutiny at committee meetings
B. The Committee’s remit as described in the Council’s Constitution
C. An overview of the issues that would be involved in undertaking an in-depth scrutiny into ‘Falls’ and
D. A template for members who wish to suggest alternative topics for consideration by HASSC on areas other than ‘Falls’.

Recommendations

The HASSC is recommended to:

i. Discuss and agree whether to undertake an in-depth review into ‘Falls’ in 2015/16 after the conclusion of the eye care services review.

ii. Agree the other areas for scrutiny at HASSC meetings in 2015/16 as part of the Work Programme.
1. Scrutiny Work Programmes

Work Programmes generally consist of two types of scrutiny:

(i) 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 and 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. Sharing the report with the body or individuals responsible for making decisions on whether to implement the decisions or not. For HASSC these could be the Health and Wellbeing Board or the Clinical Commissioning group, for example.
8. Publicising the report.
9. Monitoring the impact of the review and recommendations to evaluate the effectiveness of the review.

In September 2014, at a work programming meeting, the HASSC took the view that ‘Falls’ would be a good area to scrutinise in 2015/16. Appendix C provides an overview of the issues a scrutiny review on ‘Falls’ would involve. Members may put forward alternative areas for in-depth scrutiny for discussion by the HASSC and may use the template provided at Appendix D to help do this.

(ii) 'One-off' Items

Select Committees may also use their Work Programmes 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. The Work Programme at Appendix A lists some suggestions for such items. Officers will be at hand to advise members on the particular details of these items and why it was considered necessary for HASSC to scrutinise them.

Members may also put forward the areas they believe would be effective areas to scrutinise on a one-off basis in 2015/16 for discussion and agreement by the HASSC.

2. Matters to Consider before deciding items to scrutinise

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:
(i) 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 B.

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 Committee. In 2014/15 it was agreed that HealthWatch would inform the Scrutiny Officer of reports and other matters it wishes to refer to the HASSC, who would then liaise with the HASSC’s Lead Member as to which meeting agenda the matter should be scheduled for.

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, has a duty to promote integration between services and takes executive decisions. These include approving the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy. Further information about the Health and Wellbeing Board can be found in the Council’s Constitution.

(ii) 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 proportion of the Borough’s residents)
- Replication (avoid duplicating the work of other committees, bodies or organisations)

(iii) Other potential items

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

- the Committee agrees to carryout 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' or
- there are public petitions which fall under the Committee's remit.
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<table>
<thead>
<tr>
<th>Meeting date</th>
<th>Agenda item</th>
<th>Presenter</th>
<th>Draft Papers deadline</th>
<th>Pre-meeting with Lead &amp; Deputy Lead</th>
<th>Final Papers deadline</th>
<th>Members Friday post circulation</th>
<th>Deadline for statutory publication of agenda</th>
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</table>
| 21 Sep 2015 | - Stroke Consultation – t.b.c.  
- Scrutiny review report on local eye care services – final report  
- JHOSC update  
- Scrutiny Review - Falls (t.b.c): Scoping report  
- Intermediate Care update  
- HealthWatch report on Speech and Language Therapy services | BDCCG Chair & CDACS Chair  
ACS officer  
DDASC HealthWatch | Mon 24 Aug | Fri 28 Aug | Wed 9 Sept | Fri 11 Sept | Fri 11 Sept |
| 4 Nov 2015  | - JHOSC update                                                             | Chair           | Mon 5 Oct             | Fri 9 Oct                           | Wed 21 Oct            | Fri 23 Oct                    | Tue 27 Oct                                 |
## Notes

HealthWatch reports may be added to the Work Programme at the discretion of the Lead Member

| Date         | Item                                                                 | Committee | Meeting Dates         | | | | |
|--------------|----------------------------------------------------------------------|-----------|-----------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| 12 Dec 2015  | - Personal budgets: monitoring the impact of budget reduction       | DDASC     | Mon 16 Nov            | Fri 20 Nov       | Wed 2 Dec       | Fri 4 Dec       | Fri 4 Dec       |                 |                 |                 |                 |                 |                 |
| 10 Feb 2016  | - JHOSC update                                                     | Chair     | Mon 11 Jan            | Fri 15 Jan       | Wed 27 Jan      | Fri 29 Jan      | Tue 2 Feb       |                 |                 |                 |                 |                 |                 |
| 13 April 2016| - Six month progress report on implementation of eye care scrutiny recommendations – t.b.c. | t.b.c.    | Mon 14 Mar            | Fri 18 Mar       | Wed 30 Mar      | Fri 1 April     | Tue 5 April     |                 |                 |                 |                 |                 |                 |
The HASSC’s functions as determined by Assembly:

- Scrutinising any matter relating to the planning, provision and operation of the health service in the borough or accessed by Barking and Dagenham residents.
- 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 (this function may be carried out by the Joint Health Overview and Scrutiny Committee in accordance with Part 2, Chapter 14, paragraph 2).
- 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 (this function may be carried out by the Joint Health Overview and Scrutiny Committee in accordance with Part 2, Chapter 14, paragraph 2).
- Acting on behalf of the Council 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 (this function may be carried out by the Joint Health Overview and Scrutiny Committee in accordance with Part 2, Chapter 14, paragraph 2).
- Exercising 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.
- Acting on behalf of the Council to make all arrangements for establishing and participating in joint health overview and scrutiny committees with local authorities that are affected by service re-configurations. Any such joint overview and scrutiny committee shall have such terms of reference, and shall exist for so long as the appointing authorities may agree.
- 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.

- 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.
- 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.
- 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.
- 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 and Wellbeing Board of any such concerns in the process.
- Monitoring of performance indicators that fall within the remit of the Select Committee.
- Addressing any Call-ins or Councillor Calls for Action as allocated by the Designated Scrutiny Officer. 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.
- Considering petitions in accordance with the Council’s Petition Scheme.

Part 2, Chapter 8, Council Constitution
### Overview

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.

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 England average for all of the indicators relating to health
Appendix C


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.

<table>
<thead>
<tr>
<th>Performance/Evidence</th>
<th>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).</th>
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Page 106
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).

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<thead>
<tr>
<th>Policy and legislation issues</th>
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<tr>
<td>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.</td>
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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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<tr>
<td>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.</td>
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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.
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<thead>
<tr>
<th>Topic</th>
<th>Does it meet the selection criteria? <em>(See paragraph 2 (ii) of report)</em></th>
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<tr>
<td></td>
<td>Public interest</td>
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<td>Ability to change</td>
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<td>Performance</td>
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<td>Extent of the issue</td>
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<td>Replication</td>
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| Policy and legislation issues | |

| Areas of potential enquiry (Terms of Reference) | |

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