Present: Cllr Eileen Keller (Chair), Cllr Peter Chand (Deputy Chair), Cllr Abdul Aziz, Cllr Edna Fergus, Cllr Adegboyega Oluwole and Cllr Hardial Singh Rai

Apologies: Cllr Sanchia Alasia

52. Declaration of Members' Interests

Councillors Keller and Chand both declared a non-pecuniary interest in item 9 of the agenda (Update on Pilot Projects to Build Resilience) as they were both members of the Citizen’s Advice Bureau Board.

53. Minutes - To confirm as correct the minutes of the meeting held on 10 February 2016

The minutes of the meeting held on 10 February 2016 were confirmed as correct.

54. Update from Children’s Services

Members noted an update report from Children’s Services outlining how the Service intended to implement a recommendation to make every contact count and introduce a scheme to encourage and possibly incentivise parents to arrange an eye test for their child prior to starting school, which arose from the Health and Adult Services Select Committee’s (HASSC) scrutiny review on local eye care services last year.

55. Update from Public Health

The HASSC noted a report setting out the Council’s plans to undertake a public health campaign to raise local residents’ awareness of the importance of having regular eye tests, whilst also delivering other important eye care messages, in response to a recommendation made by the HASSC’s scrutiny review on local eye care services.

56. Urgent and Emergency Care Services

Carla Morgan, Project Manager, and Melissa Hoskins, Communications and Engagement Manager for the Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHRCCGs), presented a report which provided the background to an initiative to transform urgent and emergency care (UEC) services across the three boroughs. This was being lead by a “BHR Systems Resilience Group”, a partnership of NHS and local authority representatives. In 2015 the NHS invited individual organisations and partnerships to apply to become ‘vanguards’ for the new care models programme, one of the first steps towards delivering the NHS Five Year Forward View and supporting improvement and integration of services. In late July 2015, the BHR Systems Resilience Group was announced as one of eight vanguards in the third wave of the funding programme.
Members noted that the way UEC services were currently delivered was complicated and the aim of this transformation work would be to fundamentally shift the way these services were provided, remove the barriers between health and social care and between organisations, and create a simplified, streamlined urgent care system, using the latest technology to personalise services.

Ms Hoskins summarised the wide ranging engagement activity undertaken by the BHRCCGs to ensure that patients and carers would be at the heart of the changes to service delivery, including an urgent care conference, research into local people’s understanding of services, a telephone survey of 3000 people across BHR, plans to collate the views of high users, input from the local Healthwatch organisations in designing and carrying out survey questionnaires, and engagement work with local GPs.

Members asked whether plans to personalise UEC services included the possibility of communicating with and providing information to people via their smart mobile phones or electronic tablets, and whether patients would be able to view their own medical records whilst having confidence that their confidentiality would be respected. The BHRCCG representatives stated that currently, research was being undertaken on what technological systems could be used to deliver better UEC services to local people; no one model had been agreed upon. They added that patient confidentiality would remain a fundamental principle in the design of new services, as required by law, and that the engagement so far with local people indicated that there was strong support for the use of new technologies to deliver future services.

In response to a question, Ms Morgan stated that the local vanguard was awarded £1.3 million in the last financial year to support the transformation work and that a business case for funding for the programme in 2016/17 was submitted to NHS England on 8 February 2016. BHRCCGs were bidding for a share of a £12 million funding allocation that all eight UEC vanguards had bid for. An announcement was expected from NHS England soon to confirm the allocation that BHR would receive, and the HASSC would be kept updated on this.

The Committee thanked Ms Morgan and Ms Hoskins for their update.

57. Barking, Havering and Redbridge University Trust's Improvement Plan Update

Barking, Havering and Redbridge University Trust’s (BHRUT) Chief Operating Officer, Sarah Tedford, delivered a presentation to the HASSC on progress against the Trust’s Improvement Plan since a re-inspection by the Care Quality Commission (CQC) in March 2015 of its services, which covered the following points:

- Delivering our potential: a quick recap
- Progress against our ‘must do’ actions
- Executive sponsors – ‘must do’ actions
- Recent key highlights
- National early warning scoring (news)
- Dementia screening
• Improvement walks
• How are we doing?
• Progress against our 24 ‘should do’ actions.

Councillor Rai asked whether the Trust had started using text messaging to remind people of their appointments. He stated that he was recently sent a text reminder for an upcoming appointment from the Royal London Hospital which included the amount it would cost the NHS if he failed to turn up and felt that this would work as an incentive to many people to ring in if they could no longer make their appointment. Ms Tedford stated that a text messaging service was not provided consistently across all BHRUT services, costs for “no show” appointments were not cited in text messages currently, and that the Trust had currently put this service out to tender so that a consistent and effective text messaging service could be provided in future.

Members asked whether the Trust had a view on whether it would be out of “special measures” by the end of its next CQC inspection. Ms Tedford stated that the Trust was continuously working to remove its special measures status and it hoped that after the next inspection, it would be out of special measures. She added that the Trust regularly met with representatives of the CQC and NHS England and sent them updates on various aspects of its progress regularly.

In response to a question Ms Tedford stated the improvement walks taking place at the Trust’s hospitals involved senior members of staff of the executive team, including herself, the Chief Nurse and the Chief Executive. She emphasised, in response to comments, that all staff were on board with the improvement plan, and played an active role in shaping the Trust’s way forward.

In response to comments, Ms Tedford stated that resolving estates and environmental issues such as dealing with clutter and general presentation was a part of the improvements being made to ensure that the Trust’s premises appeared welcoming and tidy.

Ms Modhvadia, representing Barking and Dagenham Healthwatch, asked whether an update could be provided on the investigation by NHS Improvement (previously Monitor) into the BHRCCGs’ decision to select BHRUT as the provider of elective care services at the North East London Treatment Centre. Ms Tedford stated that there was no outcome to report as of yet and provided assurance that other providers were being utilised to deliver elective care services pending the outcome of the investigation. Sharon Morrow, the Chief Operating Officer for Barking and Dagenham CCG (BDGCC), stated that the BHRCCGs had undertaken much work to assist NHS Improvement with its investigation and that she expected the findings of the investigation to be available in a few weeks’ time.

**58. Update from Barking and Dagenham Clinical Commissioning Group**

Richard Clements, Programme Lead for Service Transformation for the BDCCG, presented a report providing an update on the BDCCG’s progress in implementing three recommendations which arose from the HASSC’s scrutiny review on local eye care services.

Members noted that in response to one of the recommendations, the BDCCG had sought to offer optometrists direct referral to its community eye care service. Through the natural expiration of the current contract, the BDCCG had joined with the Redbridge CCG to re-procure community ophthalmology - direct referral was included in the service specification which stated that optometrists were to directly refer for a range of eye conditions. Members further noted that the procurement process was concluded in March 2016, but it had not resulted in the CCGs’
awarding a contract. The possible reasons would be investigated and would inform the commissioning plan for ophthalmology.

Mr Clements stated, with regards to the recommendation that the BDCCG commission an Eye Care Liaison Officer, that this service was currently provided through some secondary care providers commissioned by the BDCCG and used by Barking and Dagenham patients. The BDCCG was planning a review of major pathways using the RightCare approach (an approach to address unwarranted variation in local healthcare). The planning for pathway reviews was currently underway and it was expected that ophthalmology commissioning would be reviewed in 2016/17.

Mr Clements stated that the HASSC also recommended that the BDCCG make cost-effective improvements to local low vision services. The BDCCG currently commissioned a low vision service, which supported the delivery of low vision assessments for the borough’s residents who experienced sight problems even after having had an eye test and worn the right contact lenses or glasses. The service operated out of both King George and Queen’s hospitals. The opportunity to review and potentially extend this service could be included as part of the BDCCG’s pathway review of ophthalmology.

An update on the re-procurement of community ophthalmology and the pathway review of ophthalmology, particularly in relation to the recommendations of the Local Eye Care Services Scrutiny Review, was requested by the HASSC for a future meeting.

59. Update on Pilot Projects to Build Resilience

The Health and Social Care Integration Manager (HSCIM) presented a report which provided an update on two pilot projects which had arisen as a result of the cessation of the Local Emergency Support Service. The pilots were designed to run from November 2015 to May 2016, and were as follows:

- The Debt Counselling and Mentoring Service, which would provide 50 residents with debt management support and 25 people (who were 18 - 35 years old, non-priority homeless with additional needs) with intensive debt management support, counselling and mentoring, and,
- A Fuel Poverty Service, which would impact around 700 homes in the Ibscott Close neighbourhood, which had a high prevalence of fuel poverty.

Members noted the challenges in identifying the metrics for the cohorts for the Debt Management and Mentoring Scheme. The number of people identified for the intensive ‘18 – 35, non-priority homeless’ cohort was stated within the service specification as being 25. In the period between November 2015 and February 2016 there had been a significant amount of work to gather 25 people who fit the criteria. Initial triage work carried out had been positive but 12 of the 25 had expressed a wish to be moved to the less intensive Debt Management Service project. Early indications did not anticipate this movement across the cohorts and there was now a need to replace those who were initially identified for the 18 -35 year old intensive Mentoring Scheme. The provider was now approaching the requisite numbers to commence the programme for both cohorts within the project. 18 people had now been triaged for the intensive Mentoring Scheme and similar triaging work had been undertaken for the 50 people to take part in the Debt
Counselling part of the Scheme. The changes within the cohort had created slippage on the timeline for the project, and the pilot was now scheduled to be completed by the end of August.

In response to questions from members, the HSCIM stated that these pilot projects would not be re-commissioned after their conclusion; however, the findings from their evaluation would be incorporated into future services to help build resilience in the community.

Councillor Chand asked whether the pilots could help more people than the initially identified cohorts per project. The Project Manager stated that it was not envisaged that a person would stay on a pilot programme for its entire six month duration and therefore, as people came off the programme, more people could be taken on, although at this stage it would not possible to say exactly how many.

Members asked how the learning from the pilot projects would be incorporated into mainstream services and whether, for example, it would include staff training. The HSCIM stated that the Council had commissioned external bodies to undertake the pilots, as described in the report, and so the learning from the projects would not be relayed directly via training of Council staff. However, the pilot projects would be evaluated at the conclusion of six months and the principles around prevention and building resilience would feed into future approaches to service design, as part of the Council’s transformation programme, Ambition 2020.

The HSCIM confirmed, in response to further questions, that the pilot projects were only funded to provide services for six months, at the end of which the services offered by them would cease.

60. Proposed Relocation of Sexual Health Clinics

The Council’s Director of Public Health (DPH) and Gary Bradshaw, Service Manager, Sexual Health, BHRUT, presented a report detailing proposals to relocate two sexual health clinics to Barking Hospital in Upney Lane from 1 June 2016, as a result of considerable financial pressures presented by reductions to the Public Health Grant, which meant that the Council needed to find more efficient ways of delivering local sexual health services. The two clinics which were subject to the proposals were in Oxlow Lane in Dagenham and Vicarage Field in Barking.

Members noted that a new contract for integrated sexual health services in Barking and Dagenham was awarded to BHRUT in October 2015. Under the new agreement BHRUT was to achieve efficiencies of five per cent of the initial contract value (£79,500) in each year of the three year contract. The costs to BHRUT of maintaining services at several sites were significant. The Trust had concluded that the service was making a considerable and unsustainable loss and had itself proposed consolidating the two clinics into one site at Barking Community Hospital in order to bring its costs in line with its income.

The DPH and Mr Bradshaw explained that the consolidated service at Barking Hospital would provide access to a wider range of sexual health services under one roof. The report described what would be a ‘one stop shop’ sexual health service at Barking Hospital, with more frequent and longer opening times for appointments and walk-in sessions. Service users would also benefit from better transport links, as the Hospital was located right next to car parking facilities, and
was less than five minutes’ walk from Upney train station. Several bus routes also passed through the Hospital, enabling easier access to the services from all wards in the borough. The relocation of sexual health services to Barking Hospital would also present the opportunity to improve access to evening and weekend services not currently available at Oxtlow Lane and Vicarage Field health centres. The consolidated service would be available for a minimum of 40 hours per week, offer a dedicated young person’s clinic and have clinics on at least three evenings per week and potentially, Saturday mornings.

The DPH stated that he hoped to receive advice from the Council’s legal services shortly as to whether the proposals would amount to a “substantial reconfiguration” which would necessitate the Council carrying out a formal public consultation on the proposals before a decision was made. Mr Bradshaw stated that whatever this advice may be, it would be extremely important to inform the local community of the changes proposed and ensure that any feedback was considered seriously.

In response to questions, the DPH stated that there would a Communications Strategy that would specify how local people would be engaged in regards to the proposals and that he was happy to share it with the Committee, once it was drafted.

Members asked whether the sexual health clinics in Havering were prepared to absorb people from Dagenham, who may prefer to attend a clinic there, rather than go to Barking Hospital, if the proposals were implemented. The DPH and Mr Bradshaw stated that as these proposals had been drafted jointly between the Council and BHRUT, who provided sexual health services across both boroughs, thought had been given to the impacts of these proposals on clinics in Havering.

Members asked whether Barking and Dagenham’s teenage pregnancy rate had declined. The DPH stated that there had been the most significant fall in the borough’s teenage conception rate recently; however, it was still above the national average. He believed the reasons for the recent decrease locally was work taking place within schools and the changing attitudes of young people towards their aspirations. However, he cautioned that the rate of repeat abortions was an issue for the borough and emphasised that targeted work was yet to take place on understanding the reasons for this.

Ms Modhvadia stressed the need to engage particularly with young people around the proposals within the report and asked to see the communications strategy for the proposals, once drafted.

The HASSC indicated overall support for the proposals and noted that the Health and Wellbeing Board would be asked to make a decision on the proposals later in the year.

61. Barking and Dagenham Healthwatch’s Latest Reports

Ms Modhvadia delivered a presentation which summarised two of Healthwatch’s ‘enter and visit’ reports and two projects it had carried out between September 2015 and January 2016, as listed below:

- Enter and view visit to five Elms General Practice;
- Enter and view visit to Mental Health Assessment and Support Facility,
Morris Ward, Sunflower Court;
- Saint Francis Hospice Project; and
- Medical Dressings Project.

With regards to the ‘enter view and visit’ to Morris Ward in Sunflower Court, members noted that people from the borough were staying longer in the Ward than people from other boroughs. They noted that the service provider had stated that appropriate accommodation was readily available within the borough but that an embargo by the Council was delaying discharge for a number of patients. The Council’s Divisional Director, Adult Social Care (DDASC), clarified that the embargo was not on housing; there was a ‘3 out, 2 in’ restriction on placing people requiring a period of residential care following a stay in hospital. This ‘embargo’ was lifted on 31 March 2016 and work was underway to sequence placements appropriately. Work was also underway with Housing to identify suitable accommodation for people moving on from residential placements. This would unblock things further downstream and improve patient flow in due course.

Councillor Rai asked how Healthwatch went about deciding which services they should undertake enter and view visits upon. Ms Modhvadia stated that Healthwatch’s visits and projects were based upon evidence it received from the local community; it kept a database of feedback received on health services and once it saw trends giving rise to concern, it would investigate. Any member of the community, including professionals, councillors and members of the public, could send evidence and feedback to Healthwatch and this could be done anonymously.

Members asked how Healthwatch advertised itself locally. Ms Modhvadia stated that it put out advertisements in the local press and put up posters in public spaces, for example. She was not sure whether Healthwatch advertised itself in local GP surgeries but would look into this.

In response to questions, Ms Modhvadia stated that Healthwatch did not have powers to sanction service providers if their responses to its investigations were inadequate; however, it could escalate the matter to the CQC, raise issues with this Committee or the BDCCG, who may well intervene if they were the commissioner for the service.

She stated, with regards to Five Elms GP, that Healthwatch was not entirely satisfied with the Practice’s response to its findings and therefore, it would be carrying out another visit soon.

Ms Morrow stated that the BDCCG would be happy to discuss some of Healthwatch’s findings outside of this meeting with a view to resolving areas giving rise to concerns.

The Committee thanked Ms Modhvadia for her update.

### 62. Care Quality Commission's Inspections of Local Providers

The HSCIM presented a report providing information on the outcomes of CQC inspections of a number of adult social care providers in the borough, which were carried out in quarters two and three of 2015.

Members noted that the following providers had received a judgement of “requires
improvement” after their inspection:

- Lynwood (Dharshivi Ltd);
- Alexander Court (Orchard Care Homes);
- Harp House (Triangle Community Services); and
- Chosen Services (Chosen Services UK).

The HSCIM stated that clients of adult social care services were encouraged by the local authority to opt for providers who were on the home care provider framework’s list; however, people could choose providers who were not on the list if they wished. The provider, Chosen Services, was not on the list.

Members asked whether the CQC took into consideration, as part of its inspection of Lynwood care home, the fire (resulting from suspected arson), which took place there in late 2015, and whether, for example, the CQC had given the care home extra time to implement the recommendations for improvement. The DDASC stated that the local authority was supporting the provider, which was making very good progress, and therefore, did not necessarily need extra time.

In response to a question, the DDASC stated that the CQC would look at a wide range of evidence as part of its inspection of a provider. The Local Authority worked closely with providers in support, for example, the CQC may wish to look at the providers’ support plans for clients and the local authority would check to see whether these were personalised.