Notice of Meeting

HEALTH AND ADULT SERVICES SELECT COMMITTEE

Wednesday, 3 May 2017 - 7:00 pm
Chamber, Town Hall, Barking

Members: Cllr Peter Chand (Lead Member), Cllr Linda Zanitchkhah (Deputy Lead Member), Cllr Sanchia Alasia, Cllr Abdul Aziz, Cllr Edna Fergus, Cllr Jane Jones, Cllr Eileen Keller, Cllr Hardial Singh Rai and Cllr Faraaz Shaukat

By Invitation: Councillor Maureen Worby

Date of publication: 20 April 2017

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 1 March 2017 (Pages 3 - 9)

4. Primary Care Update (Pages 11 - 29)

5. Results of Inspections undertaken by the Care Quality Commission on Local Adult Social Care Services in Quarter 3 (Pages 31 - 39)

6. Health Checks Performance Report (Pages 41 - 55)

7. Barking and Dagenham Healthwatch Update (Pages 57 - 69)
8. Report arising from Scrutiny Review into Cancer Prevention, Awareness and Early Detection (Pages 71 - 122)


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

11. 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.**

12. 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

Our Priorities

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

Well run organisation

- A digital Council, with appropriate services delivered online
- Promote equalities in the workforce and community
- Implement a smarter working programme, making best use of accommodation and IT
- Allow Members and staff to work flexibly to support the community
- Continue to manage finances efficiently, looking for ways to make savings and generate income
- Be innovative in service delivery
MINUTES OF
HEALTH AND ADULT SERVICES SELECT COMMITTEE

Wednesday, 1 March 2017
(7:03 - 8:38 pm)

Present: Cllr Peter Chand (Chair), Cllr Abdul Aziz, Cllr Jane Jones, Cllr Eileen Keller, Cllr Hardial Singh Rai and Cllr Faraaz Shaukat

Apologies: Cllr Sanchia Alasia

33. Declaration of Members' Interests

There were no declarations of interest.

34. Minutes - To confirm as correct the minutes of the meeting held on 11 January 2017

The minutes of the meeting held on 11 January 2017 were confirmed as correct.

Members asked for information that the Select Committee had requested at the meeting on 11 January 2017 regarding the CCG’s review of continuing healthcare packages. It was confirmed that this would be sent out to them shortly.

35. Draft Report resulting from the Committee's Scrutiny Review on Cancer Prevention, Awareness and Early Detection

For 2016/17, the Select Committee had agreed that cancer would be the topic on which to undertake a scrutiny review due to the scale of the issue locally, and the serious implications on public health. It was felt that an in-depth review into this topic added value. The Select Committee had undertaken an in-depth scrutiny review of awareness and early diagnosis. The findings of the review, in line with the terms of reference and work plan, were contained in the report.

Recommendations of the Select Committee as an outcome of the scrutiny review were key to changes leading to improved cancer outcomes in Barking and Dagenham. The report focussed on recommendations that the Select Committee may wish to consider before the final report was submitted to them at the meeting on 3 May 2017.

The Director of Public Health (DPH) presented the report and added that there were lessons to be learnt from the earlier failings of Mid-Staffordshire Health Trust. He stated that HAASC held the Cabinet Member for Social Care and Health Integration to account for the services provided, and the Select Committee needed to think about what they want to see changed or recommended in respect of the Scrutiny review. The Portfolio Holder for Social Care & Health Integration would attend the next meeting of the Select Committee on 3 May 2017 and Members would be able to present these recommendations to her in the final report. It was noted that far too many borough residents went straight to A&E and had not been diagnosed with cancer via the GP. It was also noted that there were high obesity rates for children up to year six and the risk factors determining
cancer were high in the borough. Residents were also poor at spotting signs of cancer and indeed 1 in 4 bowel cancer diagnosis were spotted in A&E rather than at GP’s surgeries.

The Strategic Director, Service Delivery and Service Integration (SDSDI) suggested that the Select Committee consider three specific scenarios in terms of drafting their recommendations for the final report:

1. People who are unwell and don’t seek help
2. People who have seen a health professional but signs and symptoms have been missed
3. Doctor sends resident into a pathway

Members noted that there were a high number of incidents of lung cancer and asbestosis caused by smoking. They asked what kind of literature was available in increasing awareness and they felt that screening tests needed to be promoted. There was often no publicity in GP’s surgeries to remind patients in particular e.g. breast screening. DPH stated that asbestosis and Myeloma were not classified as lung cancer. There had been campaigning work around awareness of lung cancer and an example was the “Barking Cough Campaign” and initiatives such as these should be encouraged. He considered that the Select Committee may wish to ask what was being done to promoting awareness by GPs in relation to these cancers which could include inviting patients for a health check.

Members noted that as the borough had a very diverse community, there were some residents who could not speak English. It was important to reach out into these communities with awareness publicity. They felt that the Health and Wellbeing Board could investigate this matter and think about how to get the messages out to residents in a user-friendly way.

Members considered that visiting the borough’s places of worship for different faiths may be helpful in increasing awareness of cancers, which could include roadshows. DPH stated that the Cabinet Member for Social Care and Health Integration had challenged officers to become more involved with faiths and faith venues. It was noted that some of those attending these faith venues may not be Barking and Dagenham residents but officers can and do work collectively with neighbouring boroughs to increase awareness.

Members felt that utilising social media would be beneficial in promoting greater awareness of cancers. Younger residents could then tell others which created more awareness particularly amongst older groups in the community. DPH stated that the Council had worked with NHS campaigns, which had included posting information on Refuse Vehicles and an event had been held in Vicarage Field which publicised about awareness of bowel cancer. The Council were not at present using social media as a campaigning tool as this was the responsibility of NHS England on a one-size fits all basis. He considered that there was a need to think about targeting in promoting awareness.

Members were concerned that residents may not always recognise the symptoms of cancer. The reasons for non-awareness of signs of cancer and symptoms may include low confidence in seeking help and people may often be fatalistic and have
a low level of knowledge about cancers. In addition, public facing staff and health and social care staff need to be more professionally aware. DPH referred to familial cancer and that people can be called in for a health check and monitored. There was a ‘one size fits all’ in such matters and all boroughs had high cancer rates in North East London with Barking and Dagenham as the worst for certain cancers.

Members noted the current access arrangements for cervical smear tests, bowel and breast screening. In terms of cervical smear tests, these were usually conducted at the GP’s surgery and access was in line with national targets. In terms of bowel and breast cancer screening, these were conducted at Queens Hospital and not at the GP’s surgery. It was noted that GP’s were not paid to undertake bowel cancer screening and Members were concerned about the low take up, particularly as the test was very unpleasant and potentially off-putting. They felt that the bowel screening could be made more ‘user-friendly’ and health providers considered providing a toolkit (including gloves) to those who need it. Members asked that the CCG put pressure GP’s to promote screenings in all areas.

It was noted that performance management of GP’s had been delegated from NHS England to the CCG and GP’s needed to be more accountable at local level. The SDSDI asked the Select Committee whether it wanted to raise this concern with the CCG as to how they performance manage GP’s and in this regard a robust approach on GP services was recommended. It was felt that money could be saved if cancers were detected at an earlier stage. In particular, it was considered important that all GP’s track those patients who have had screening appointments and for those who did not attend them, although DPH stated there was information as to which GP’s kept a track and those that did not. It was felt that NHS England could be asked why they could undertake targeted campaigns to reach out to local residents.

DPH advised that in terms of borough GP’s performance, there were some very high-performing GP’s but there were approximately fifteen Practices out of forty in the borough that were under-performing and they needed to improve their performance. He gave an example of a Practice that had been in ‘special measures’ but had now improved its performance significantly. DH suggested that the Select Committee may wish to consider asking the CCG what steps they were taking to turn around failing GP practices and in general terms, to ensure that residents did not end up being diagnosed with cancer at A &E without a consultation with their own GP first. It was also noted that there were a number of women residents in the borough who did not wish to visit a male GP. He added that it was important to avoid a postcode lottery of GP practices.

Members requested that in terms of the incidence of cancers in the borough, what were actual numbers rather than percentages. DPH would send to him a breakdown of how many affected in the borough.

Members were interested to learn if there was a specific website identifying GP performance levels. DPH stated that there was a CQC website which compared GP practices although it was not very well promoted. He would share the link to the website with the Select Committee.
Members were concerned that there may be patients who do not visit their GP often and therefore may be taken off the GP’s patient list as a result. Subsequently, when they want to go and see their GP, the GP may refuse to see them.

Members wished to see how to get the message across to residents without a one-size fits all approach. They also wanted to hold NHS England and CCG to account in this matter. It was noted that black and ethnic minority women should be specifically targeted as they had a very low rate of take up for breast screening. In addition, members of Bengali community had a high rate of cancer of the mouth and could be targeted for cancer awareness promotion. Members also asked whether the East European community may need to be targeted for awareness of lung cancer owing to the high levels of smoking.

Members were concerned about the times taken to refer patients and this matter was being discussed at a future meeting of the Select Committee when Matthew Hopkins would be attending on behalf of the Trust. Members considered that early detection of cancer was very important and were concerned about those who did not attend their referral appointments. They enquired what was being done to address this rate and whether this was followed up with patients and the reasons for non-attendance. Prevention was better than cure and it may be an option to suggest increasing the referral clinics to weekends.

Recommendations

1. Why are residents of Barking and Dagenham more likely to develop cancer and less likely to survive cancer than residents in other London boroughs?

   1. One in five adult residents in the borough are likely to be smokers; more than one in two are overweight or obese. The Committee needs to know what will the Health and Wellbeing Board take to reduce the numbers of smokers, and overweight and obese individuals in the borough, to levels comparable with England.

   2. Not all residents are registered with a GP practice. The committee needs to know what actions will BHR CCG will take to ensure all residents, and particularly vulnerable residents, have a named GP within the next two years.

   3. There is significant variation between GP practices in the proportion of eligible patients that are offered and take up the Health Check. The committee need to know what actions the B&D Health and Wellbeing Board and BHR CCG will take to raise awareness of the importance of Health Check and reduce the variation in Health Check uptake between GP practices.

   4. There is significant variation between GP practices in the numbers of residents that are diagnosed at early stage and late stage in the development of their cancer. The committee needs to understand what actions are being taken by BHR CCG to ensure that GPs are auditing and acting on audit information, to ensure that patients enter
the cancer pathway appropriately, and cancer is diagnosed at as early a stage as possible.

2. What is the reason that residents are less likely to respond to requests to screen for cancer than in other London boroughs?

   a. A much lower proportion of residents, than is usual for England or London, respond to requests to act on and return bowel cancer screening kits. The committee need to understand what action the Health and Wellbeing Board, including the CCG, in partnership with MacMillan and Cancer Research UK, will take to increase the proportion of residents returning bowel cancer screening kits within the next year.

   b. There is significant variation between GP practices in the proportion of registered patients that take up the cervical cancer screening. The committee need to know what actions BHR CCG, along with MacMillan and Cancer Research UK, will take to raise awareness of the importance of screening and reduce the variation in cervical screening uptake between GP practices within the next year.

   c. There is significant variation across the borough in the numbers of residents that access breast and bowel screening. The Select Committee need to know what action the Health and Wellbeing Board, including BHRUT CCG, along with MacMillan and Cancer Research UK, will take to raise awareness of the importance of screening and to increase uptake of breast and bowel screening in the borough and to a level comparable with England within the next year.

   d. The breast screening unit has not been easily accessible to borough residents, recently a unit has been placed in the borough temporarily. The Committee need to be assured by NHS England that residents will continue to have in-borough access to breast screening.

   e. The Cancer Strategy for England recommends that NHS England work with arm's length bodies to develop a cancer dashboard of metrics at the CCG and provider level. It is proposed that this dashboard includes information on screening uptake across GP practices. The Committee need to be assured that this action is being taken by NHS England, and that the dashboard will be available within one year.

3. What is the reason that residents are not as aware of the signs and symptoms of cancer as residents in other London boroughs?

   a. Awareness of signs and symptoms of cancer by residents is low. The committee needs to know what action will be taken by the Health and Wellbeing Board to increase awareness of signs and symptoms of cancer in residents.

   b. Awareness of signs and symptoms of cancer by residents is low. The
committee needs to know what action will be taken by the North-East London Cancer Commissioning Board and the BHR Cancer Collaborative to increase awareness of signs and symptoms.

c. Awareness of signs and symptoms, and risk of developing breast or prostate cancer is high in our Black African population. The Committee need to know how the National Awareness and Early Detection Initiative (NAEDI) will target specific ‘at risk’ groups.

36. Update on the matters covered at the last Joint Health Overview & Scrutiny Committee

The report was noted.

37. Work Programme

The Work Programme was noted.

There was concern that representatives from BHRUT and CCG had not attended tonight’s meeting as the item was deferred. It was suggested by SDSDI that their attendance was required.

The Chair referred to a meeting that he had with senior officers of the Clinical Commissioning Group (CCG) on 20 February 2017, when the CCG advised him that they were having to make substantial savings across the CCG’s in 2017/18. The CCGs and Barking, Havering and Redbridge University Hospital’s NHS Trust (BHRUT) were putting together an overall savings plan for £35m (which related to activity at the Trust) and this was being discussed and agreed at the wider BHRUT partnership meeting. The CCG’s then needed to find £20m of savings from other sources. The shortfall was due to a number of factors including increasing demand and demographic pressures.

The initial savings proposals would be subject to a public engagement exercise for a number of months beginning in March 2017. Given that this affected all three boroughs in the Trust (Barking and Dagenham, Havering and Redbridge), it seemed appropriate for CCG to discuss these from a scrutiny perspective at the Joint Overview and Health Scrutiny Committee (JOSH), once the consultation was launched. There was a meeting of JOSH in April 2017 which should fall within the consultation timetable.

The SDSDI advised that Scrutiny had the right to scrutinise these proposals in detail particularly if substantial change was to occur in budgets and services and added that Cabinet members across the three boroughs were working closely together in this matter. It was noted that a list of potential savings was being drawn up by the CCG and the SDSDI agreed to share this with the Select Committee.

In discussion, Members asked for the following areas to be considered as agenda items by the Select Committee in 2017/18:

- Local vanguard
- STP/ACP
- BHRUT update

- Scrutinsing the savings programme

- Scrutiny topic for review- potentially Oral hygiene/visits to the dentist/tooth decay for children: this would be a very wide area and HAASC not considered this before. It was suggested this could be in two parts and the second one considered after the May 2018 elections. For 3 May meeting an idea of choices and vulnerable groups would be available.

- Medicines management via pharmacies

The Chair would meet with officers to discuss the work programme in detail for 2017/18 although it was noted that the municipal year would be shorter than normal owing to the forthcoming 2018 local elections.
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Personal Medical Services - GP contract review update

Report of the Director, Primary Care Transformation, Barking and Dagenham Clinical Commissioning Group

Open Report | For Information
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Report Author: Hannah Murdoch, Communications Manager, NEL Commissioning Support Unit | Contact Details: Tel: 020 3688 1338 E-mail: Hannah.murdoch1@nhs.net

Accountable Director:
Sarah See, Director, Primary Care Transformation

Summary:
The slide pack enclosed gives some basic detail of current progress on the review of Personal Medical Services (PMS) GP contracts, and is intended to be presented to members by the Director at the 3 May meeting.

The presentation will also include an update on the Care Quality Commission’s inspections of GP practices in the borough, and on new GP “localities” that are being set up to encourage sharing of good practice and increase focus on key local health challenges.

Also enclosed is a recent briefing paper issued to the Committee’s Chair, and other stakeholders, explaining more about the background to the PMS review and its current status.

Recommendation
The Committee is recommended to note the update and ask questions of the Director.

List of appendices:
Appendix 1 Presentation on PMS contracts – review update
Appendix 2 Briefing paper (previously provided to the Chair and other key stakeholders)
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Personal Medical Services - GP contract review update

Health and Adult Services Select Committee
3 May 2017

Sarah See, Director of Primary Care Transformation

Barkingdagenhamccg.nhs.uk
@BD_CCG
Background - reminder

- In February 2014 NHS England (NHSE) issued national guidance that all PMS contracts must be reviewed.

- PMS contracts allow GPs to receive extra payments for providing enhanced services to meet local needs (as opposed to General Medical Services [GMS] contracts) – BUT great variation in payments between practices and little evidence that they have improved outcomes for patients.

- The review aims to move to a consistent, equitable approach, ensuring GPs are paid equally for providing the same services, and that PMS contracts are promoting innovation and improvement as originally intended.
Background - reminder

- CCGs were asked to come up with “commissioning intentions”, to form the basis of their local PMS offer. This would be in addition to core contracts which would be consistent across the capital and were known as the “London offer”

- Contract negotiations paused in spring/summer 2016 while NHSE and Londonwide LMCs (LW-LMC) discussed the content of the London Offer in the context of the GP Forward View

- NHSE and LW-LMCs agreed a “one size fits all” approach will not work for London and wrote out to ask CCGs to progress the review at local level.
Key principles: PMS review

- This review will make the system fairer by paying every practice in a borough the same basic amount per patient.
- There will be no reduction in the level of GP funding in the CCG area: the review will give patients access to the same range of services regardless of what type of contract is held by the practice they are registered with.
- We aim to ensure no GP practice is unfairly disadvantaged by the review, and we believe most will be better off.
- We understand any practice whose basic income is seen to be reducing as a result of the review will be worried, so we are putting in place a transition plan and will work closely with them to help manage this change.
- This review is just part of a wider transformation plan, which will bring investment in new technologies and ways of working, and give GPs the opportunity to enhance their income through innovation and performance.
Key principles: local negotiations

• NHS England and LW-LMC have asked individual CCGs to determine their own core GP contracts and PMS premium, so they can recognise and address local health needs

• BHR CCGs now working to draw up new core contracts, and decide which additional services should be provided by PMS practices and how much the new premium for providing those will be

• This will of course take time, but it gives us the opportunity to design a modern local GP offer, and specify the services all residents should have access to

• At the end of this process all patients will have access to the same range of services, reflecting the unique needs and challenges of their borough, and GPs will be paid equitably for providing the same services.
Governance overview
## Local context in BHR - reminder

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<th>CCG</th>
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<th>Total premium value</th>
<th>Ranking of premium value in London</th>
<th>Min/Max premium (£pwp)</th>
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<tr>
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<td>8&lt;sup&gt;th&lt;/sup&gt; lowest premium</td>
<td>-£2.16 / £27.77</td>
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Financial affordability: reminder of principles

- Over five years GMS/PMS increase of £7.3m (from £62.9m to £70.2m) across BHR – exceeding our funding increase
- STPs required to remain overall within their control totals during timeframe of the plan
- BHR CCGs must remain within overall affordability total – individual CCG agreements must account for this
- North East London STP seeking equity for providers across the region, BHR remain more challenged in terms of funding
- Each CCG area is in a different state regarding current funding to practices. Will be necessary to reflect this in different agreements, including phasing and transition timing
- A balance in timing must be achieved for equalising PMS and GMS contracts.
Financial affordability: solutions to be explored

A number of options need to be explored to ensure contract expenditure remains within allocation.

This may include (but is not limited to) reviewing:

- current PMS offer assumptions
- premium transition costs
- Phasing of GMS alignment
- Current primary care investment funding
- GP Forward View initiatives (inc improved access)
- Economy-wide solutions.
# Draft implementation plan

## Barking and Dagenham Clinical Commissioning Group

### Transition checkpoints and governance

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<td>Finance support</td>
<td>Engage LMCs</td>
<td>Practice engagement</td>
<td>Socialise – GBs, OSC, HWBs, STP, patient forums</td>
<td>Define &amp; Agree offer</td>
<td>NI-SE due-diligence</td>
<td>Draft contracts</td>
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### Barking and Dagenham

- Draft implementation plan
- GB Meetings
- PCC Meetings
- PCC PMS Group
- PCC GB Meetings
- PCC PCC

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Milestone | Transition point

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## CQC inspections update

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<th>Number of visits taken place with published reports</th>
<th>% of visits taken place with published reports</th>
<th>No. rated 'Inadequate' (special measures)</th>
<th>% rated 'inadequate'</th>
<th>Number rated 'requires improvement'</th>
<th>% rated 'requires Improvement'</th>
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<th>% rated 'Good'</th>
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<td>7.14%</td>
<td>9</td>
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<td>6</td>
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<td>30</td>
<td>32.26%</td>
<td>57</td>
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- CQC advise all visits have been completed – but 26.77% in BHR still to be published

- Barking and Dagenham CCG (and Havering) in bottom five nationally for highest percentage of practices rated ‘inadequate’ or ‘requires improvement’
CQC: support offered to practices

- **Template policies and procedures emailed to practices** – include confidentiality, correspondence, dealing with medical device and safety alerts, repeat prescribing, recruitment, significant event review template and complaints procedure.

- Access to **online training** resource sent to practices October 2016 – includes complaints handling, equality and diversity, fire safety, health and safety, infection control and manual handling.

- **Face to face training and workshops** – include infection control (clinical and non-clinical staff), safeguarding, fire safety, health and safety, chaperone training, CPR.

- **Support programme for practices rated ‘requires improvement’** – intending to provide support programme to these practices, to help them make improvements and achieve a good rating at re-inspection.
  - All B&D practices that have been rated ‘requires improvement’ will be offered opportunity to voluntary participate in the programme.
GP networks

- Local practices have been working together to set up GP networks

- Three networks established and meeting monthly. These are:
  - North (Chadwell Heath)
  - East (Dagenham)
  - West (Barking – Thames)

- Network council being established, and network leads are to take part in leadership development programme commissioned from UCLP

- Diabetes will be a key network priority, with social prescribing also suggested as a focus.
Dear stakeholder

RE: PMS GP contract review

We wrote to you last year to tell you about the review of GP contracts that Barking and Dagenham, Havering and Redbridge CCGs (BHR CCGs) were conducting in partnership with NHS England (NHSE). The aim of this review was to reduce inequalities between practices in terms of the amount paid for providing the same services, ensuring better value for money for the NHS and fairer and more equal access to care for patients.

It was intended that the basis for all GP contracts across London would be the same, with local CCGs then being able to choose any additional services that GP practices could provide in exchange for extra payments, and which would focus on tackling specific local health needs. NHSE was leading on developing that core “London offer”, with close involvement from London wide Local Medical Committees (LW-LMCs) who represent most GP practices in the capital.

You may recall that local work on the PMS Review paused over the summer, while NHSE and LW-LMCs negotiated the London offer. It has since been determined that a ‘one size fits all’ approach is difficult to achieve for a city as diverse as London, and all parties agree that making progress on the review is the most important priority. CCGs have therefore been given responsibility for agreeing the PMS contracts as well as agreeing which ‘extra’ services practices should provide, and how much they will be paid per patient for those services.

This does mean effectively starting the review from the beginning, but it gives us an opportunity to look at our current GP service to see how we can ensure it will be resilient in the light of challenges being faced by the whole health and care economy. Through this review, we can help ensure that everyone in BHR will have equal access to the same types of service, no matter what sort of contract their GP has. We can create a service that is targeted to the unique health challenges and needs of our area – while ensuring all GPs are paid fairly and equitably for the services they provide.

We still have work to do in deciding what this service will look like and what the payments to GP practices will be. This will take time, but it is crucial that we get it right, and that we do it in a way that will not destabilise local general practice or unfairly disadvantage individual GPs. We hope that our partners will bear with us while we work out the detail, and we will of course keep you informed when we have more specific detail to share. I enclose a short briefing document which explains more about how GP contracts work, the reasons for the review, and the next steps.

If you would like to discuss any of this in more detail, please do not hesitate to contact me.

Sarah See, Director, Primary Care Transformation, BHR CCGs
Personal Medical Services (PMS) contract review

Barking and Dagenham, Havering and Redbridge (BHR) Clinical Commissioning Groups, as delegated commissioners for primary medical services alongside NHS England, have been conducting a review of all GP practices operating on a Personal Medical Services (PMS) contract.

The review is based on the principle that all GP practices should receive the same core funding for providing the core services expected of them. In order to receive additional ‘premium’ funding, practices need to be able to demonstrate that this will result in improved services, better quality, or to meet the specific needs of a particular population.

What is a PMS contract?
These are locally-agreed contracts between NHS England and an individual GP practice. PMS is an alternative to the nationally agreed General Medical Services (GMS) contract and allows for local variation in the range of services the practice provides and how it is paid for those services.

Currently, practices on a PMS contract are likely to receive more money per patient than those operating under a GMS contract. The premium is paid per patient per year, and the amount that PMS GP practices receive varies widely – both from borough to borough and within individual boroughs – and there is little evidence that the premium results in improved care or outcomes.

Forty GP practices across BHR currently operate under a PMS contract:

<table>
<thead>
<tr>
<th>CCG</th>
<th>Number of PMS contracts</th>
<th>Total number of GP contracts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking and Dagenham</td>
<td>11</td>
<td>38</td>
</tr>
<tr>
<td>Havering</td>
<td>12</td>
<td>44</td>
</tr>
<tr>
<td>Redbridge</td>
<td>13</td>
<td>45</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>36</strong></td>
<td><strong>127</strong></td>
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</table>

Why carry out the review?
The purpose of the review is to ensure that in future the NHS gets the best value for money from the ‘premium’ element of PMS funding. We need to ensure that where practices receive enhanced payments from the NHS, they are providing premium services to merit this, and that any money spent on a GP practice above the agreed contract level will:

- secure services or outcomes that go beyond what is expected of core general practice, or improve primary care premises
- help reduce health inequalities
- give equality of opportunity to all GP practices, irrespective of their contract (provided that they are able to satisfy the local-determined requirements)
- support fairer distribution of funding at locality level.

A local working group was established in October 2015 to take forward the review in BHR, and it will continue to do this under the new locally delegated arrangements for the review. It is chaired by Redbridge CCG’s lay member for patient and public engagement, Khalil Ali, and members include the primary care clinical director lead for each CCG, as well as relevant CCG finance and primary care staff. Outside the CCG, the committee includes representatives from NHS England, as well as the Local Medical Committees (LMCs) to ensure input from general practice providers.

Engagement
The CCGs have briefed all affected practices to inform them of the changes to how the review is being carried out, and we will continue to attend LMC meetings. To ensure the local authorities are kept informed, we will be attending local Health Scrutiny Committees and engaging with Health and Wellbeing Boards as soon as we have details of the proposed new contract arrangements. In terms of patient engagement, we will continue to provide updates to Healthwatch for each borough, and meet with the CCG Patient Engagement Forums when there is information to update on.

**Next steps**

Our PMS working group will continue to meet monthly. It will make recommendations to the BHR Primary Care Commissioning Committee (PCCC), which is responsible for decision-making for primary care commissioning. The PCCC will approve and sign-off the PMS contracts on behalf of the CCGs.

The indicative timeline for implementation is between 1 July and 31 October 2017, however BHR CCGs are working toward having the PMS review process completed locally by 1 July.
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**Title:** Results of inspections undertaken by the Care Quality Commission on local adult social care services in Quarter 3, 2016/17

**Report of the Commissioning Director, Adults’ Care and Support**

<table>
<thead>
<tr>
<th>Open Report</th>
<th>For Information</th>
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</thead>
<tbody>
<tr>
<td><strong>Report Author:</strong></td>
<td><strong>Contact Details:</strong></td>
</tr>
<tr>
<td>Julie Aduwa, Commissioning Manager, Quality Assurance</td>
<td>Tel: 020 8227 2965</td>
</tr>
<tr>
<td></td>
<td>E-mail: <a href="mailto:julie.aduwa@lbld.gov.uk">julie.aduwa@lbld.gov.uk</a></td>
</tr>
</tbody>
</table>

**Accountable Director:**
Mark Tyson, Commissioning Director, Adults’ Care and Support

**Accountable Strategic Director:**
Anne Bristow, Strategic Director, Service Development and Improvement

**Summary:**

This report is an overview of CQC inspection reports, published during Quarter 3 of 2016/17: (1 October – 31 December 2016). The following report provides an overview of the inspections as well as the actions that have been taken as a result of inspections where improvements are required. The report covers CQC inspection reports on providers in the Borough or those who provide services to our residents outside the Borough.

Links to the CQC inspection reports themselves and a summary of the findings can be found in Appendix 1.

**Recommendation(s)**

Members of the Select Committee are recommended to review the document and to comment on the CQC findings and the actions taken as a result.

**Reason(s)**

The Council has a responsibility for ensuring the quality and sufficiency of adult social care provision in the borough. The Care Quality Commission is the quality regulator for social care and inspects local services. It is important that local people have confidence in the social care services that are provided in the borough, and part of the approach to ensuring confidence is to provide an opportunity for Elected Members to review accounts of performance. This is one such opportunity.
1. **Introduction and Background**

1.1 The Care Quality Commission (CQC) are responsible for inspecting all health and social care providers that fall under their regulatory remit. The ratings ask five key questions of the services that CQC inspect:

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

1.2 Each question has a number of lines of enquiry to guide the inspection. The results of each category then enable an overall rating to be achieved for each provider:

- Outstanding
  *The service is performing exceptionally well.*
- Good
  *The service is performing well and meeting our expectations.*
- Requires improvement
  *The service isn't performing as well as it should and we have told the service how it must improve.*
- Inadequate
  *The service is performing badly and we've taken action against the person or organisation that runs it.*

1.3 Alternatively, a provider may be given no rating where the outcome is under appeal, their business is suspended or there was only one person using the service at the time of the inspection. There are no services locally where this has been the case.

1.4 The Council’s commissioning function uses the results of CQC inspections, together with its own intelligence about how services perform, to shape its own approach to quality assuring social care services. Similarly, we are in regular dialogue with the Care Quality Commission based on our experience of local services and they use our information to inform their approach to inspections.

2. **CQC Findings Quarter 3 2016-17**

2.1 Of the 7 providers inspected, three met the requirement for an overall rating of ‘good’, one had a rating of ‘inspected but not yet rated’ and the remaining three providers were rated as ‘requires improvement’.

2.2 The providers rated ‘good’ and the date on which they were inspected were:

- **Sincere Care.** This is a homecare provider for people with dementia, learning disabilities, physical disabilities and sensory impairments providing personal care and crisis intervention for adults over the age of 65 years. The service was inspected on 21 September 2016. Sincere Care is not on the Council’s homecare framework of providers however 21 residents have packages of care with Sincere where they have either chosen Sincere Care over other providers or because other providers on the homecare framework do not have the capacity to take on the care package.
• **Triangle Community Services Limited – Harp House.** Harp House is part of an extra care service provided by Triangle Community Services Limited. The service provides individual personal care and extra care support to older to continue to live independently as tenants at Harp House. The scheme was inspected on 20 October 2016.

• **LBBD – Kallar Lodge.** This is a residential care home run by Barking and Dagenham Council providing 24 hour care for up to 37 older people living with dementia. The home was inspected on 10 November 2016.

2.3 **Shalom Care** was inspected on 26 and 30 August 2016 but was rated as ‘inspected but not yet rated’. Shalom Care is a home care provider providing personal care to adults living in their own homes. This service was inspected on 26 and 30 August 2016. Shalom is not on the Council’s homecare framework of providers. Shalom were not given a rating by the CQC as the provider only has one service user. The CQC spoke to the service user’s family who were happy with the service and the CQC reported that care was personalised, positive relationships had been formed with the service user and the care plan was detailed. The CQC asked the provider to ensure that DBS checks were in place for all staff and to ensure that robust risk assessments were in place.

3. **Providers requiring improvement (Quarter 3)**

**Efficiency for Care Limited**
Rating – Requires Improvement

3.1 Efficiency for Care is a homecare provider, with their head office located in Barking and Dagenham. They are not on the Council’s approved homecare framework and there are currently no placements from the local authority or by self-funders who live in the Borough. However, they do provide services in other local authorities – Essex County Council, Hillingdon, Woking and they are also a registered provider of staffing for Care UK. The service offers personal care to people with dementia, learning disabilities, mental health conditions, physical disabilities, sensory impairments, and provides care to both young people and adults.

3.2 The inspection was undertaken on 6 October 2016 and the inspection report was published on 17 November 2016. The inspection found that two areas (Effective and Well-Led) required improvement and that the area of Safe was inadequate:

- Safe (inadequate) – Concerns were raised around medicine administration and prompting to show people had received their prescribed medications.
- Effective (requires improvement) – CQC required improvement around staff supervision and induction processes.
- Well-Led (requires improvement) – CQC found that effective systems were not in place to monitor quality assurance and this area was rated as requires improvement.

3.3 Quality Assurance (QA) carried out an unannounced visit and checked staff recruitment and health and safety policy and procedures and there were no concerns identified with these. QA also reviewed the CQC improvement plan and identified that Efficiency for Care have already started implementing it. With regards to medication administration, it was found that this was in relation to an incident in
Hillingdon and Efficiency for Care management advised that they no longer employ
the worker involved.

3.4 As it is their head office that is based in Barking and Dagenham, QA were advised
that Efficiency for Care did not have staff files on site (these are kept at the local
offices) so could not be reviewed. Since the visit, Efficiency for Care have provided
the local authority with training files, their statement of purpose, and other
information electronically which is currently being reviewed. A further announced
quality assurance monitoring visit will be carried out at the end of April to review
their implementation of the improvement plan.

**Abbey Care**

Rating – Requires Improvement

3.5 Abbey Care is a 20 bedded care home for older people living with dementia. Abbey
Care was inspected on 24/30/31 August and the inspection report was published on
9 November 2016. Abbey Care was rated ‘requires improvement’ in four areas:

- Safe (requires improvement) – The CQC report found that infection control
  practices were not adhered to by some of the staff, risk assessments were
  not always up to date and there were at times, inadequate staffing levels.
- Effective (requires improvement) – CQC found that the premises were in a
  poor decorative state.
- Responsive (requires improvement) - CQC found that there was lack of
  appropriate weekend activities for residents.
- Well-led (requires improvement) – CQC found that there were no effective
  systems to monitor the quality of service.

3.6 Quality Assurance carried out an unannounced QA monitoring visit on 23
November 2016. During the visit, infection control and management systems were
checked and these were found to be adequate. Service user files were also
checked and risk assessments viewed were up to date. The staffing levels at the
time of the visit appeared adequate and there appears to be a stable staff team.

3.7 At the time of QA’s follow-up visit it appeared that the premises were in the process
of being repainted and Commissioning is continuing to work closely with the
provider with regards improvements to the fabric of the care home. CQC’s
improvement plan is in place and the provider is continuing to implement the
improvement actions. Social workers and the QA team visit the care home on a
regular basis and no further concerns have been identified.

**Alexander Court**

Rating – Requires Improvement

3.8 Alexander Court Care Centre is an 82 bedded nursing home that provides 24 hour
care to older people living with dementia and young people with physical, mental
and learning disabilities. The home was inspected 10/11 March 2016 but the report
wasn’t published until 28 December 2016. This rated Alexander Court as:

- Safe: (inadequate) The CQC report found that there were inadequate
  staffing levels and medicines were not being administered safely.
• Effective: (requires improvement) People who use the service did not have access to nutritious food and drinks.
• Caring: (good)
• Responsive: (good)
• Well-led: (requires improvement) The CQC found that effective systems were not in place to monitor the quality of the service and the service did not act on the views of people who use the service.

3.9 Even though the report was not published until December 2016, following initial discussions with the CQC about their inspection and findings from the quality assurance team and the Clinical Commissioning Group, a suspension on placements to the home was put in place in June 2016 and all local authorities were informed. Following the implementation of an improvement plan the suspension was lifted in August 2016 with a limit on new placements put in place to ensure standards were maintained. Quality Assurance, social workers and the Clinical Commissioning Group have since undertaken regular monthly visits to the care home and improvements have continued to be seen.

3.10 We are aware that a further inspection was undertaken by the CQC on 28/29 November and 5 December 2016 and the report is yet to be published. However, ahead of publication of the report there have been a number of discussions with CQC about their concerns, which have resulted in enhanced monitoring by the local authority and the CCG and more regular liaison with the management of the care home about its improvement.

4. Consultation

4.1 There are no consultation requirements associated with this report, since it is presented for information and comment. In conducting their inspections, CQC consult with the Council as the host borough, and with residents and their carers.

5. Implications

Risk Management

5.1 The provision of social care services by providers who fail to meet the minimum CQC inspection rating of ‘Good’ are subject to increased monitoring both the Council’s commissioning function and CQC. This feeds into a wider approach to risk-based quality assurance which the Council uses to prioritise its work with local social care services.

5.2 Where problems are identified, quality assurance staff will work with the provider to plan and deliver improvements, including where necessary the actions contained in the CQC action plan and exchange intelligence regarding progress with CQC. The main priority is to ensure that the service is safe for service users and the quality of the delivery meets expectations.

5.3 For those providers who do not adequately comply with the action plan recommendations within the timeframe, CQC will issue a warning notice which is in the public domain and alert other authorities using that provider to use caution when commissioning services from them. There is considerable impact for the provider if this course of action is taken. Ultimately, CQC have the option available to them to suspend the provider’s registration or take legal action.
**Customer Impact**

5.4 Ensuring that services are safe and effective is a critical role for the Council in the provision of social care services and the management of the local market in social care. This ensures not only basic safety but that there remains a meaningful choice in services to meet diverse needs.

**Safeguarding Children and Vulnerable Adults**

5.5 Safeguarding vulnerable people – both children and adults – is the prime motivation for ensuring a robust system of inspection, quality assurance and regulation. This report presents one key element of that approach, led by CQC.

**Health Issues**

5.6 Effective regulation of services is important to ensure that they support people to achieve their desired outcomes, including maintaining and improving their health and wellbeing.

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

Information on the regulation approach taken by CQC, on the website at: www.cqc.org.uk

**List of appendices:**

Appendix 1: Quarter 3 2016-17 CQC Reports
<table>
<thead>
<tr>
<th>Provider name</th>
<th>Location</th>
<th>Link to report</th>
<th>Report date</th>
<th>Inspection date</th>
<th>Rating</th>
<th>Comments/Summary</th>
</tr>
</thead>
</table>
| Efficiency for Care Limited | Fortis House (Office, rather than service delivery) | [http://www.cqc.org.uk/sites/default/files/new_reports/INS2-2943093518.pdf](http://www.cqc.org.uk/sites/default/files/new_reports/INS2-2943093518.pdf) | 17 November 2016 | 6 October 2016 | Requires Improvement | CQC rated required improvement after an inspection 6 October 2016 as:  
**Safe: Inadequate**  
The administration and prompting of medicines to show people had received their prescribed medicines was not always recorded clearly. The service did not have a robust recruitment process.  
**Effective: Requires Improvement**  
The service did not have a robust induction process. Not all staff received formal supervision.  
**Caring: Good**  
**Responsive: Good**  
**Well-led: Requires Improvement**  
Various quality assurance and monitoring systems were in place but these were not always effective.  
**Action:** QA visit and no concerns raised, provider working through improvement plan. Follow-up visit planned. Services are not delivered in Barking and Dagenham. |
| Abbey Care Home Limited | Abbey Care Home | [http://www.cqc.org.uk/sites/default/files/new_reports/INS2-2370435241.pdf](http://www.cqc.org.uk/sites/default/files/new_reports/INS2-2370435241.pdf) | 9 November 2016 | 24/30/31 August 2016 | Requires Improvement | CQC rated required improvement after a three day inspection in August 2016 as:  
**Safe: Requires Improvement**  
Infection control practices were not adhered to by some staff at the service. People were at risk of harm when moving around the service. Risk assessments for |
| Lifestyle Care Management | Alexander Court Care Centre | http://www.cqc.org.uk/sites/default/files/new_reports/INS2-2458472813.pdf | 10/11 March 2016 | 28 December 2016 | Requires Improvement | CQC rated required improvement after an inspection in March 2016 as:  
Safe: Inadequate  
The CQC report found that there were inadequate staffing levels and medicines were not being administered safely.  
Effective: Requires improvement  
People who use the service did not have access to nutritious food and drinks.  
Caring: Good  
Responsive: Good  
Well-led: Requires improvement  
The CQC found that effective |
Appendix 1: Quarter 3 (2016/17) CQC Inspection Reports Summary

<table>
<thead>
<tr>
<th>Provider</th>
<th>Facility</th>
<th>Report URL</th>
<th>Inspection Date</th>
<th>Rating</th>
</tr>
</thead>
</table>

Systems were not in place to monitor the quality of the service and the service did not act on the views of people who use the service.

**Action:** Following discussions with CQC on initial findings and findings from local authority and CCG quality assurance visits, a suspension on placements was placed on provider in June 2016. Following the implementation of an improvement plan the suspension was lifted in August 2016 with a limit on new placements put in place. Regular monthly visits to the care home are undertaken by QA and the CCG and improvements have continued to be seen.
Title: Health Checks Performance

Report of the Strategic Director for Service Development and Integration

Open Report                  For Information

Report Authors:             Contact Details:
Mary Knower, Public Health Strategist and   Tel: 020 8227 2998
Susan Lloyd, Public Health Consultant      e-mail: mary.knower@lbdd.gov.uk

Accountable Director: Matthew Cole, Director of Public Health

Accountable Strategic Director: Anne Bristow, Strategic Director, Service Development and Integration.

Summary:

This report is presented to Health and Adult Services Select Committee, as a summary of the NHS Health Checks prevention programme. Health checks are done to find and treat residents with chronic diseases as early as possible. Prevention is an important part of the changes to the health service driven by the Five Year Forward View and being implemented through Sustainability and Transformation Plans.

It explains the purpose of the programme, how performance and activity in the borough is measured, and explains some important successes and challenges with the programme. Targets for achievement are behind what was expected and the report draws attention to the variability of performance within Primary Care, which is the route through which the programme is delivered.

The paper highlights the successes and issues with the programme as it runs in the borough. These issues need to be resolved if we are to address quality of life problems and health inequalities in Barking and Dagenham.

Successes are:
- As at end of March 2017 4,806 health checks had been delivered in Barking and Dagenham and in this 5 year cycle more than 17,200 health checks have been done. We are doing better than the London average and are nearer to target than Haringey, Havering and Waltham Forest.
- Given the high prevalence of long term conditions that exist in the Borough, health checks play a vital role in addressing prevention at an early stage, so the progress mentioned above is helping to address long term health problems.

The issues are:
- Large variation between practices in the number of health checks being done.
- Low rate of referrals to lifestyle services compared to the numbers of residents needing help.
- Diagnosis of chronic disease through the health check is low compared to what would be expected for Barking and Dagenham.

At March 31 2017, 13 practices had achieved their health check target and the 3 highest performers were:
- Victoria Road Surgery, IG11 8PY: Dr Chawla
- Faircross Health Centre, IG11 9LD: Dr Prasad
- Church Elm Lane Medical Practice, RM10 9RR: Dr M Goyal

In comparison, the worse performing practices who have achieved less than 20% of their yearly target were:
- Hedgeman’s Medical Centre, RM9 6HT: Dr SN Ahmad
- Valence Medical Centre, RM8 3RH: Dr MJB Finnegan
- John Smith House, IG11 7TB: Dr Chilvers
- First Avenue Surgery, RM10 9AT: Dr Fateh

The paper makes some recommendations as to how the problems of both quantity and quality might be addressed.

**Recommendation(s)**

The HASSC is recommended to note:

(i) The proposals to reduce variability in health checks delivery in both quantity and quality, and
(ii) The appendices that accompany this report:
   - Appendix 1 explains the background to the targets
   - Appendix 2 contains latest data for health check completion by practice
   - Appendix 3 shows charts of comparative between Barking and Dagenham and other areas.
   - Appendix 4 gives data on referral to lifestyle services from the health check
   - Appendix 5 has data on numbers of people admitted to disease register following a health check.

**Reason(s)**

If performance is improved and variability reduced, there will be better equity of access which means that the programme will meet the corporate objectives of living well through the life course and will help address the Council health priorities for obesity, smoking reduction, prevention, and better mental health, as well improving health inequalities. It will also contribute to better partnership working between primary care and lifestyle services.
1. Introduction and Background

1.1 Barking and Dagenham have a mandated health checks programme and contracts with Primary Care for its delivery. The quality from some Primary Care providers is good, however there are issues with large variability between the quality of service delivered through GP practices.

1.2 The aim of the health checks programme is to prevent avoidable deaths and to catch chronic illness early, for example, high blood pressure, high cholesterol or diabetes, so that the disease can be treated. This will help to prevent avoidable premature mortality, as well as reducing the health and social care costs related to long-term ill health and disability.

1.3 The purpose of the health check appointment is to assess a person’s risk of developing cardio-vascular disease, which is done by a combination of reviewing personal details and family history and by taking some key measurements, such as blood pressure, cholesterol, and waist circumference.

1.4 The programme is offered to those people between the ages of 40 and 74 who have no history of cardiovascular disease i.e. those not being treated for high blood pressure, high cholesterol, diabetes or any heart or kidney disease. The essence of the health checks therefore is to engage that section of the population who rarely attend their GP practice and haven’t had any kind of health assessment, or not for a long while.

1.5 The health check is also about important lifestyle issues like smoking, alcohol consumption, exercise and healthy eating. It provides an opportunity for the patient to discuss with the advisor what they could do to improve their health. The advisor should make use of the opportunity to refer or signpost patients to a relevant healthy lifestyle programme.
People aged 65–74 are also told about the signs and symptoms of dementia and are signposted to further support, such as memory clinics if they have concerns about possible dementia.

1.6 Where additional testing and follow up is needed, for example because of a concern about blood pressure or cholesterol results, this should be provided by the GP. If it turns out that an individual needs on-going monitoring, that person will be entered onto the practice disease register and is then cared for by the GP.

1.7 The HC programme runs on a 5-year cycle; we are in year 4 of the current 5-year cycle. Practices should invite one fifth of their eligible population to attend health checks each year (100% over a five-year cycle). PHE have advised an aspirational target that (over the long term)75% of those receiving an invite for a health check should respond and attend for a check each year. Appendix 1 gives more detailed information about health check targets.

1.8 In Barking and Dagenham, the Health Check programme is provided by GP practices, through a local enhanced contract to which all borough practices are signed up. To date for this year, 4,307 health checks have been delivered against a target of 6,003. Over this current 5-year cycle, more than 17,200 people have received a health check in Barking and Dagenham.
However, there is variability across the surgeries for completed health checks, as shown in Appendix 2. Across the borough, we are achieving a response (uptake) rate of 55-60% as most practices are not achieving the 75% response target. However, this is the same for London and nationally. Even though it’s lower than the aspiration rate the borough are delivering many more health checks than most other London boroughs and English regions.

Appendix 3 gives some comparative data for Barking and Dagenham and other areas, including London, Havering and Redbridge. The best performing borough in London at as the end of quarter 3 was Newham who were the closest to achieving target. Barking and Dagenham were in 12th place out of the 33 boroughs.

In Barking and Dagenham, at March 31st 2017, 13 practices had achieved their health check target and the 3 highest performers were:
- Victoria Road Surgery, IG11 8PY: Dr Chawla
- Faircross Health Centre, IG11 9LD: Dr Prasad
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- John Smith House, IG11 7TB: Dr Chilvers
- First Avenue Surgery, RM10 9AT: Dr Fateh

It is important that, as well as looking at the numbers around health checks, attention should be given to the issues of follow-up and outcomes of the health checks for those who have signs of cardio-vascular disease.

The health check is also a review of the individual’s health behaviour and should be helping to meet the Council health priorities – obesity and smoking reduction, prevention and to some extent, mental health, as the advisor also should discuss issues around stress management.

GPs in the borough are referring very few people to lifestyle programmes such as stop smoking services, weight management or exercise programmes, hence the opportunity for engaging individuals in health behaviour change programmes is not being fully realised. Appendix 4 gives further detail.

There is some evidence to show that diagnosis of chronic disease is being made as a result of a health check, mainly in detecting high blood pressure, but again there is disparity between practices with these diagnoses See Appendix 5.

A significant factor in this situation is that the patient journey from having a health check through to enrolling in a lifestyle programme is not working well enough to support people that need the help. It is also acknowledged that a systematic audit of the health check delivery process is required.

Public Health has started a review of the patient journey from the health check invite through to enrolment in the lifestyle programmes so that there is a clearer
process for practices and lifestyle services to follow. In time, the process will also link to Community Solutions.

1.17 An electronic referral form has recently been agreed with GP practices. It will now be re-launched and promoted to practices.

2. Proposal and Issues

2.1 Proposals to improve the Health Checks programme, with partners, are:

- To introduce a stepped audit & systematic monitoring of outcomes.
- Support sharing and implementing good practice between GP practices and localities.
- Put in place compliance monitoring that better tracks underperformance.
- Improve the patient journey from health check to lifestyle services.
- To promote healthy lifestyle services as a route to support residents to develop a healthier lifestyle.
- To link Health Checks to the healthy weight behaviour change approach.
- Potentially centralising the sending out of Health Check invitations.

Those practices performing well below the expected level are subject to performance monitoring through Public health working with the CCG. Health checks will also be included in the performance dashboard developed by Public Health that incorporates other prevention indicators like immunisation that will encourage improvement in activity around prevention work.

3. Options Appraisal

3.1 There are no other options to the health checks programme, as it is a national programme.

4. Financial Implications

Implications completed by: Katherine Heffernan, Group Manager - Finance

4.1 The Public Health Grant provides funding for the NHS Health Check Programme. The 2016-17 Public Health budget includes £350,000 for the NHS Health Check Programme. Primary care providers are paid on a performance basis, with payments based on activity levels. The proposals for the health check programme in this report aim to provide a more effective and value for money service that will improve links healthy lifestyle services and promote these services as a route to developing a healthier lifestyle. The health check budget for 2017-18 is £350,000. It is anticipated that expenditure for this service will not exceed the budget for 2017-18.

5. Legal Implications

Implications completed by: Dr. Paul Feild Senior Governance Solicitor

6.1 There are no direct legal implications arising from this report.
7. Other Implications

7.1 Contractual Issues: the current contract with Primary Care is not due to finish until March 2018, by which time a procurement process will have been undertaken to award a contract going forward.

7.2 Safeguarding Children: no direct link with safeguarding children but through practitioners using their training in safeguarding to detect an issue which needs querying or raising families.

7.3 Crime and Disorder Issues: impacted by alcohol brief interventions (as part of the Health Check)

Background Papers Used in the Preparation of the Report:


List of Appendices:

Appendix 1 Health Checks Targets
Appendix 2 Table 1 Barking and Dagenham: Variation in health check by completion
Appendix 3 Comparative data for health checks
Appendix 4 Referrals to lifestyle services from the health check
Appendix 5 Diagnosis of disease from health checks
Appendix 1

Health Check targets

There is an annual target set by Public Health England (PHE) that 20% of the total eligible population for the 5-year period should be invited for a check, so at the end of year 5, 100% of this eligible population will have been invited.

In other words, if 20 people in a 100 need to be invited, in order to achieve a 75% uptake 15 people would need to attend for a check each year. When PHE reports on achievement of completed health checks for each year, it measures how well areas are doing in getting those 15 in a 100 to have a check, therefore the yearly target it uses is 15%.

Based on practice numbers identified through system searches, each participating practice is given a yearly target for their invites which will be 20% of their total eligible population for the 5-year period. It is then the responsibility of the practice to invite their identified eligible patients for a health checks and ensure that they are set up to be able to deliver on their required number of checks.

The advantages of basing the programme within general practice is that firstly, it enables searches to be conducted so that the correctly eligible people from each practice population are identified and secondly, the coding system set up in practice systems can easily record invites and contacts, from which the data on numbers of patients invited and numbers completing a HC can easily be retrieved by health intelligence.

Public Health regularly sends out activity tables that are shared with all practices and which are welcomed by them as it shows how they are doing compared to their fellow practices. Public Health visits or makes phone calls to practices to discuss how performance. From our observation and conversations there is no doubt that some practices are better set up to deliver on the programme than others. Issues such as the loss of or inability to recruit key staff play a big part in whether the practice can deliver on its responsibility. Turnover of staff in general practice is a very influential factor and Public Heath spends a significant amount of time and budget arranging repeat training courses throughout the year in order that new practice staff can get training. It is also worth noting that as with the other public health programmes, the contract is optional, which means that if a practice opts not to do the programme, patients at that practice may be denied the opportunity to have a HC. It was partly to address the gaps in provision caused by low practice activity that the pharmacy pilot has been set up.
### Table 1 Barking and Dagenham: Variation in health check by completion.

Figures correct as at 31 March 2017

<table>
<thead>
<tr>
<th>GP Name</th>
<th>Total</th>
<th>In year Target</th>
<th>% of Target</th>
<th>Eligible</th>
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<tr>
<td>Health 1000</td>
<td>0</td>
<td>0</td>
<td>0%</td>
<td>2</td>
</tr>
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<td>Hedgemans Surgery</td>
<td>4</td>
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<td>2%</td>
<td>1136</td>
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<tr>
<td>Valence Medical Centre</td>
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<td>1149</td>
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</tr>
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<tr>
<td>First Avenue Surgery</td>
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<td>The Surgery</td>
<td>24</td>
<td>79</td>
<td>30%</td>
<td>528</td>
</tr>
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<td>29%</td>
<td>807</td>
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<tr>
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<td>965</td>
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<td>70</td>
<td>62%</td>
<td>464</td>
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<tr>
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<td>46%</td>
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<tr>
<td>Gables Surgery</td>
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<td>49%</td>
<td>732</td>
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<tr>
<td>Thames View Medical centre</td>
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<td>1184</td>
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<tr>
<td>Dr Gupta &amp; Partner</td>
<td>60</td>
<td>115</td>
<td>52%</td>
<td>769</td>
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<tr>
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<td>116</td>
<td>55%</td>
<td>772</td>
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<tr>
<td>Markyte Surgery</td>
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<td>73%</td>
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</tr>
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<td>67%</td>
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<tr>
<td>Five Elms</td>
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<td>170</td>
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<td>54%</td>
<td>1583</td>
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<td>The White House</td>
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<td>138</td>
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<td>917</td>
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<td>95</td>
<td>123</td>
<td>77%</td>
<td>820</td>
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<td>Dr Alkaisy Surgery</td>
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<td>119</td>
<td>101%</td>
<td>790</td>
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<tr>
<td>The Surgery</td>
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<td>65</td>
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<td>Venkat Health Centre **</td>
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<td>144</td>
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<td>The Surgery</td>
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<td>122</td>
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<td>811</td>
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<tr>
<td>Ripple Road Medical Centre</td>
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<td>179</td>
<td>83%</td>
<td>1192</td>
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<tr>
<td>Faircross Health Centre</td>
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<td>165%</td>
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<td>Porters Avenue Doctors Surgery</td>
<td>222</td>
<td>197</td>
<td>113%</td>
<td>1310</td>
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<tr>
<td>Highgrove Surgery</td>
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<td>120%</td>
<td>1300</td>
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<td>Halbutt Street Surgery</td>
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<td>Laburnum Health centre</td>
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<td>1984</td>
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<td>Church Elm Lane Medical Practice</td>
<td>250</td>
<td>169</td>
<td>148%</td>
<td>1129</td>
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<tr>
<td>Abbey Medical centre</td>
<td>224</td>
<td>170</td>
<td>132%</td>
<td>1133</td>
</tr>
<tr>
<td>Child &amp; Family Centre</td>
<td>257</td>
<td>185</td>
<td>139%</td>
<td>1232</td>
</tr>
<tr>
<td>Becontree Medical Centre</td>
<td>270</td>
<td>187</td>
<td>145%</td>
<td>1245</td>
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<tr>
<td>Tulasi Medical Centre**</td>
<td>350</td>
<td>250</td>
<td>140%</td>
<td>1667</td>
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<tr>
<td>Barking Medical Group Practice</td>
<td>351</td>
<td>330</td>
<td>106%</td>
<td>2199</td>
</tr>
</tbody>
</table>
This page is intentionally left blank
% of eligible population who received an NHS Health Check, BHR area, London and England, 2011/12 - 2015/16

Source: NHS Health Check programme

2.22v - Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check

<table>
<thead>
<tr>
<th>Area</th>
<th>Recent Trend</th>
<th>Count</th>
<th>Value</th>
<th>95% Lower CI</th>
<th>95% Upper CI</th>
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</thead>
<tbody>
<tr>
<td>England</td>
<td></td>
<td>4,271,889</td>
<td>27.4</td>
<td>27.4</td>
<td>27.4</td>
</tr>
<tr>
<td>Most deprived decile (HM2015)</td>
<td></td>
<td>359,215</td>
<td>32.2</td>
<td>30.1</td>
<td>30.2</td>
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<tr>
<td>Tower Hamlets</td>
<td></td>
<td>21,644</td>
<td>47.2</td>
<td>46.6</td>
<td>47.7</td>
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<tr>
<td>Rochdale</td>
<td></td>
<td>22,990</td>
<td>44.4</td>
<td>44.0</td>
<td>44.9</td>
</tr>
<tr>
<td>Blackpool</td>
<td></td>
<td>19,207</td>
<td>43.5</td>
<td>43.1</td>
<td>44.0</td>
</tr>
<tr>
<td>Birmingham</td>
<td></td>
<td>99,063</td>
<td>39.3</td>
<td>39.1</td>
<td>39.5</td>
</tr>
<tr>
<td>Hackney</td>
<td></td>
<td>21,207</td>
<td>38.3</td>
<td>37.9</td>
<td>38.7</td>
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<tr>
<td>Stoke-on-Trent</td>
<td></td>
<td>26,039</td>
<td>36.7</td>
<td>36.3</td>
<td>37.1</td>
</tr>
<tr>
<td>Barking and Dagenham</td>
<td></td>
<td>14,874</td>
<td>33.9</td>
<td>33.5</td>
<td>34.4</td>
</tr>
<tr>
<td>Middlesbrough</td>
<td></td>
<td>12,003</td>
<td>32.9</td>
<td>32.5</td>
<td>33.4</td>
</tr>
<tr>
<td>Blackburn with Darwen</td>
<td></td>
<td>10,387</td>
<td>26.1</td>
<td>25.6</td>
<td>26.5</td>
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<tr>
<td>Sandwell</td>
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<td>18,686</td>
<td>22.3</td>
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<td>22.6</td>
</tr>
<tr>
<td>Manchester</td>
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<td>22,386</td>
<td>21.1</td>
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<td>Knowsley</td>
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<td>9,195</td>
<td>21.1</td>
<td>20.7</td>
<td>21.5</td>
</tr>
<tr>
<td>Kingston upon Hull</td>
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<td>10,353</td>
<td>20.3</td>
<td>19.9</td>
<td>20.6</td>
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<tr>
<td>Liverpool</td>
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<td>24,309</td>
<td>19.6</td>
<td>19.4</td>
<td>19.8</td>
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<tr>
<td>Nottingham</td>
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<td>14,579</td>
<td>19.3</td>
<td>19.2</td>
<td>19.8</td>
</tr>
<tr>
<td>Wolverhampton</td>
<td></td>
<td>13,133</td>
<td>18.9</td>
<td>18.7</td>
<td>19.2</td>
</tr>
</tbody>
</table>

Source: Public Health England
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Table 3. Referrals to Lifestyle services from the NHS Health Check

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17 (Year to date - 22/09/16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of completed health checks</td>
<td>5,704</td>
<td>5,220</td>
<td>2,144</td>
</tr>
<tr>
<td>% given lifestyle advice</td>
<td>1.1%</td>
<td>0.9%</td>
<td>2.1%</td>
</tr>
<tr>
<td>% advised brief physical activity</td>
<td>13.4%</td>
<td>18.1%</td>
<td>19.0%</td>
</tr>
<tr>
<td>intervention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% referred to physical activity service</td>
<td>0.9%</td>
<td>0.7%</td>
<td>0.8%</td>
</tr>
<tr>
<td>% signposted to physical activity</td>
<td>5.0%</td>
<td>5.3%</td>
<td>9.7%</td>
</tr>
<tr>
<td>service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% referred to smoking cessation advisor</td>
<td>0.4%</td>
<td>0.3%</td>
<td>0.1%</td>
</tr>
<tr>
<td>% given stop smoking advice</td>
<td>22.7%</td>
<td>22.8%</td>
<td>21.3%</td>
</tr>
<tr>
<td>% referred to stop smoking clinic</td>
<td>0.4%</td>
<td>0.3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>% referred to stop smoking service</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>% signposted to smoking cessation</td>
<td>1.3%</td>
<td>1.4%</td>
<td>1.9%</td>
</tr>
<tr>
<td>service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% given weight management advice</td>
<td>16.0%</td>
<td>20.2%</td>
<td>19.6%</td>
</tr>
<tr>
<td>% referred to weight management service</td>
<td>0.5%</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>% signposted to weight management</td>
<td>4.5%</td>
<td>5.0%</td>
<td>7.4%</td>
</tr>
<tr>
<td>service</td>
<td></td>
<td></td>
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</table>
Number of diagnoses as a result of health check by condition, B&D GPs, 2015/16

Chronic Kidney Disease  Coronary Heart Disease  Diabetes
Heart Failure  Hypertension

Practice code

Number

0 10 20 30 40 50 60 70 80 90

F82060  F82012  F82650  F82679  F82678  Y02575  Y01795  F82061  F82634  F82661  F82017  F82625  F82025  F82021  F8203  F82040  Y01719  Y01280  Y04786
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HEALTH AND ADULT SERVICES SELECT COMMITTEE

3 May 2017

Barking & Dagenham Healthwatch’s Enter & View and Project Reports

Report of Barking and Dagenham Healthwatch

Open Report | For Information
---|---
**Report Author:** Manisha Modhvadia | **Contact Details:**
Tel: 020 8526 8200 | E-mail: Manisha@healthwatchbarkinganddagenham.co.uk

**Accountable Director:** Marie Kearns, Chief Executive, Harmony House

**Summary:**

The local Healthwatch, the consumer champion for both health and social care, aims to give local residents and communities a stronger voice to influence and challenge how health and social care services are provided within the borough. The role of the local Healthwatch is to undertake local research about what people who use services are looking for and identify gaps in service.

Legislation, including the Health and Social Care Act 2012, gives local Healthwatch bodies the power to carry out ‘enter and view’ of health and social care premises to see for themselves how services are provided. After conducting an ‘enter and view’, Healthwatch bodies may produce a report and recommendations for the service provider to action.

Below, this report provides the electronic internet links to reports arising from enter and view visits and projects undertaken by Healthwatch.

a) Healthwatch undertook an unannounced enter and view visit to Mandarin ‘A’ Ward at Queen’s Hospital on 16 September 2016. The report resulting from this visit and the response from the Hospital Trust can be accessed by clicking on this link: [Enter & View - Mandarin ‘A’](#)

b) On 27 September 2016 Barking and Dagenham Healthwatch carried out an announced enter and view visit to Bennetts Castle Care Centre. A copy of this report with the provider’s response can be found at the link below: [Enter & View - Bennetts Castle Care Centre](#)

A presentation summarising the findings of the visits with the providers’ responses in each case will be delivered by Healthwatch’s representatives to the Health and Adult Services Select Committee (HASSC) at the meeting.

**Recommendation(s)**

The HASSC is recommended to note the outcomes of the reports having received the presentation at the meeting, and provide any comments to the representative to support Healthwatch’s aims.
Reason(s)

It is good practice for Healthwatch to share its information about health services with the HASSC to support the Committee in its ‘critical friend’ function.

Background Papers Used in the Preparation of the Report:

None.

List of appendices:

Appendix 1 – Healthwatch Presentation Slides
Enter and View Visit to Mandarin ‘A’ Renal & General Ward
What we did...

❖ Healthwatch Representatives undertook the visit after receiving feedback from relatives of patients who were treated on Mandarin A ward. Relatives and friends told Healthwatch that the ward came across very busy and some staff were uncaring:
  • Comments included “A few staff members stand around having a chat whilst an elderly man has called them, but they continue to chat, until he has called and called” Another relative said “There is no way, there are enough nurses on that ward, people just don’t get the best care as there are too many patients and little staff”

❖ Healthwatch authorised representatives undertook a visit to Mandarin A Ward. We spoke with patients, visitors and staff about their experiences of the ward. The focus was on the three areas of nutrition, the management of personal hygiene and the interaction between staff and patients.
What we found...

- Overall patients were satisfied with the meals provided. However, the lack of hot drinks was raised as an issue. Patients told representatives that if their food arrived whilst they were sleeping nursing staff or catering staff did not wake them up.

- In general, patients were satisfied with the choice and quantity of food. Diabetic patients felt there was not enough choice and patients staying for longer than a week felt the menu got repetitive.

- Patients were happy with the way they are treated on the ward. However, it was noticed that staff during the day are more caring than those on the night shift. Most patients reported that they did not wait long when they used the call buzzer.

- The majority of patients told Healthwatch representatives that staff explained medical procedures to them, and they were able to ask questions.
What we recommended...

❖ Senior staff to examine if there is a difference in the quality of care, and the attitude of staff on the night time shifts on Mandarin ‘A’ ward

❖ The Ward Manager to explore the possibility of hot drinks being provided to patients later in the evening.

❖ The possibility of more food options for diabetic patients.

❖ Feedback to Healthwatch on the staffing issues on the ward.

❖ Ward staff to ask patients early in the day if they would like to be woken up at meal times, or if they would prefer to remain asleep.

❖ Some provision to be made for patients who have slept through a meal time so they are not hungry.
Responses from the Hospital Trust included these Outcomes...

- Discuss with Sodexo the possibility of an extra hot drinks round on the ward, supported by volunteers
- Discuss the possibility with Sodexo to include more diabetic food choices on the menu
- To aid recruitment and retention of staff to Mandarin ‘A’ Ward, the division to participate in recruitment events
- Senior leaders to provide unannounced night checks on the ward
- Monitor the ‘Friends and Family’ and ‘I want Great Care’ surveys and feedback. Act on it accordingly
- The ward team to put in place a robust process regarding whether patients wish is to be woken at meal times or not. Include on patients information board
- Work closely with volunteers service regarding meals and drink support
- Monitor patient safety thermometer data on a monthly basis
- Senior leaders to review all actions, carry out spot checks to ensure they are being implemented.
Enter and View Visit to Bennetts Castle Care Centre
What we did...

❖ Healthwatch was told by relatives who visited the care centre that the quality of care was not always as high as they would have expected and were concerned about the times when they were not there and what kind of care was being provided.

❖ We went in to engage and speak with residents; relatives and staff to find out from their feedback where the service is working well and which areas may not be. We wanted to address the concerns raised that prompted the visit.

❖ Healthwatch sought feedback and views about the following criteria: How Caring; Safe; Responsive and Effective is the Service?
What we found ...

❖ Overall, from feedback and observations made during the visit, it was evident that the needs of residents were being met.
❖ There were no recommendations made by Healthwatch for this visit.
❖ A response was required from the provider to clarify issues raised at the time.

Some findings from the visit:
❖ The people that Healthwatch spoke with had varied opinions about the food – some were satisfied, others not so satisfied.
❖ Healthwatch were informed that the care centre’s usage of agency staff is low and has been put in place for a couple of residents whose require one to one care.
❖ Representatives were satisfied that the wellbeing of the residents they met was being considered; however, from discussion with some people, at times they felt lonely; especially those who had no one to visit them.
❖ At the time of the visit, the centre was having work carried out to improve the living areas. This had been carried out on the ground floor and was due to start on the 1st floor. It was noticeable to all representatives that there was a smell of urine on the 1st floor.
❖ Staff were mainly positive about doing their job and felt supported in their role.
❖ The centre manager holds regular meetings with relatives and representatives to enable them to raise issues of concern.
The provider’s response...

❖ Overall this was a positive report.
❖ We ensure the same staff are provided on a permanent rota to ensure consistency for the resident.
❖ The centre only uses “agency” to cover sickness when all other avenues have been exhausted (such as our bank of in house staff available to cover).
❖ The centre has an exceptional team of loyal and long serving staff which provides stability and a family orientated atmosphere.
❖ The service employs a counselling psychotherapist two days a month. This service is accessible by staff and relatives of residents free of charge.
❖ With regards to the report of a residents medication being on the floor on some occasions, this was one occasion where the resident in question began to hide their medication.
❖ There was to be a total re-decoration of the Care Centre, due to be completed by February/March 2017 – this includes replacing all flooring and furniture.
❖ We take great pride in our efforts to reach out to and provide an inclusive environment in which people everyone’s opinion matters and is listened to.
Questions?
Title: The Cancer Prevention, Awareness, and Early Detection Scrutiny Review

Report of the Director of Public Health

Open Report

<table>
<thead>
<tr>
<th>Report Author: Sue Lloyd, Public Health Consultant &amp; Masuma Ahmed, Democratic Services Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Details: Tel: 020 8227 2756 E-mail: <a href="mailto:sue.lloyd@lbbd.gov.uk">sue.lloyd@lbbd.gov.uk</a></td>
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Accountable Divisional Director: Matthew Cole, Director of Public Health

Accountable Director: Anne Bristow, Strategic Director, Service Development and Integration

Summary:

At the start of the 2015/16 municipal year, the Health & Adult Services Select Committee (HASSC) agreed to undertake an in-depth scrutiny review into cancer prevention, awareness and early detection. Appended to this cover report is the proposed final report arising from this scrutiny, which makes 12 key recommendations to the Health and Wellbeing Board and partners to help improve the health and cancer awareness and early intervention and raise the profile of cancer awareness in the borough. The appended scrutiny report provides the background to why the HASSC chose to review this area, the methodology for the scrutiny, what the scrutiny found in relation to cancer prevention, awareness and early detection for Barking and Dagenham residents, and the evidence base for the recommendations made.

The HASSC was consulted on the draft report in March 2017 and Councillor Worby, the Cabinet Member for Health and Adult Social Care, and Chair of the Health and Wellbeing Board, also had an opportunity to view the recommendations.

As standard scrutiny practice, a monitoring report shall be presented to the HASSC providing an update on the progress of the 12 recommendations in approximately six months’ time to help the HASSC evaluate the effectiveness of this scrutiny review and to what extent it has helped improve services for the borough's residents.

Recommendation(s)

The HASSC is recommended to agree the appended scrutiny report on local cancer awareness and early detection services, which makes 12 recommendations.

Reason(s)

The topic of Cancer Prevention, Awareness and Early Detection relates to the Council’s priority to ‘Enable Social Responsibility’ and the objectives to ‘protect the most vulnerable, keeping adults and children healthy and safe’ and ‘ensure everyone can access good quality healthcare when they need it’.
It is best practice to ensure that reports arising from scrutiny reviews are placed in the public domain and that HASSC places on record its agreement to the report and recommendations so that officers may work to ensure that the recommendations are shared with the decision maker, in this case, the Health and Wellbeing Board, and that feedback to the Committee on which of the recommendations are accepted and the plans to ensure that they are implemented, is provided in a timely manner.

1. **Introduction and Background**

1.1 For 2016/17, the HASSC agreed that Cancer would be the topic on which to undertake a scrutiny review due to the scale of the issue locally, and the serious implications on public health. It was felt that an in-depth review into this topic would add value.

2. **Title and Terms of Reference**

2.1 Due to restrictions on time and resources, the focus of the review was on factors that help prevent cancer and increase awareness and early detection. The title of the Scrutiny Review is “Cancer Prevention, Awareness and Early Detection” and the following three key questions formed the Terms of Reference:

1. Why are residents of Barking and Dagenham more likely to develop cancer and less likely to survive cancer than residents in other London boroughs?
2. What is the reason that residents are less likely to respond to requests to screen for cancer than in other London boroughs?
3. What is the reason that residents are not as aware of the signs and symptoms of cancer as residents in other London boroughs?

3. **Why are residents of Barking and Dagenham more likely to develop cancer and less likely to survive cancer than residents in other London boroughs?**

3.2 In summary, the reasons why residents are more likely to develop cancer and less likely to survive are, that they tend to have less healthy lifestyles, and are less aware of cancer signs and symptoms. This means that cancer is more likely to develop and less likely to be identified early.

3.3 Lifestyle accounts for 4 out of 10 preventable deaths from cancer and, for many reasons, residents of Barking and Dagenham have less healthy lifestyles than in many other London boroughs (see section 4 of the Report at Appendix 1). This suggests that more action is needed to improve lifestyle in the borough.

3.4 As well as residents often having less healthy lifestyles, the evidence indicates that people in the borough are also less likely to be aware of the signs and symptoms of cancer when these do occur (see section 7). This suggests that more action is needed to raise awareness so that residents are more aware of signs and symptoms of cancer.

3.5 Rates of diagnosis of cancer through emergency routes in Barking and Dagenham are decreasing but are higher than the England average. To improve this situation, it is essential that we have improved screening rates (see section 6) and effective routes to diagnosis (see section 8).
3.6 It is recommended that:

- The Health and Wellbeing Board act to reduce the prevalence of smokers in the borough, to levels comparable with London.
- The Health and Wellbeing Board set out to the HASSC what action it is taking to meet the priorities to reduce the number of overweight and obese individuals in the borough, to levels comparable with London.
- The Health and Wellbeing Board take action to increase residents’ awareness of the how lifestyle, including exposure to sun, can affect the likelihood of developing cancer, the signs and symptoms of cancer and the importance of early diagnosis, and screening.

4. **What is the reason that residents are less likely to respond to requests to screen for cancer than in other London boroughs?**

4.2 In summary, there are many reasons why residents are less likely to present for screening, and to an extent the reason depends on the type of screening, and may be as simple as the resident not understanding the importance of being screened. In the review, we address breast and bowel screening. The reasons why residents do not always respond are presented below (also see section 7 for the report):

- Emotional – residents worry, or are scared about what the screening might find.
- Cultural – residents are not always able to understand the information that they are sent. For some residents, the process of screening can be culturally offensive, one example is bowel screening, as residents need to handle their own faeces.
- Practical – difficulty in making an appointment with the GP surgery can be a barrier as can be getting to a surgery appointment, or to a screening unit.

4.3 These findings suggest that more action is needed to be assured that the providers of screening services communicate effectively, and regularly, with residents in Barking and Dagenham, using appropriate languages and cultural approaches. The service commissioners can most effectively facilitate this approach, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Group.

4.4 Assurance can also be provided from NHS England, through the Director of Public Health’s Health Protection assurance process.

4.5 It is recommended that:

- The National Awareness and Early Detection Initiative (NAEDI) inform the commissioners on what action it is taking to target specific ‘at risk’ groups.
- The Barking and Dagenham Clinical Commissioning Group to ensure that GPs are auditing and acting on audit information to ensure that patients enter the cancer pathway appropriately and cancer is diagnosed at as early a stage as possible.
- The Health and Wellbeing Board, in partnership with MacMillan and Cancer Research UK, take action to increase the proportion of residents returning bowel cancer screening kits within the next year.
• Urges that NHS England to make the Cancer Dashboard available within one year.

• The Health and Wellbeing Board take action to raise awareness of the importance of the Health Check and reduce the variation in Health Check uptake between GP practices.

5. **What is the reason that residents are not as aware of the signs and symptoms of cancer as residents in other London Boroughs?**

5.2 In summary, Barking and Dagenham residents are not as knowledgeable about signs and symptoms of cancer as people in other London boroughs. We know that in 2009 residents in Barking and Dagenham were less aware of common signs and symptoms of cancer, such as lumps and swellings; and even less aware of less common symptoms like a long-term cough.

5.3 A small survey of residents in 2016 found that awareness of signs and symptoms amongst residents has improved slightly but the question still stands, why do residents present so often, with cancer, at the accident and emergency department?

5.4 These findings suggest that more action is needed to assure improved uptake of screening (see section 5); to support people to be aware of signs and symptoms through campaigns and face-to-face activities; to be assured that the ability of those working in primary care to recognise signs and symptoms is being maintained and enhanced; to be assured that healthcare staff facilitate timely access to the local cancer pathways; to be assured of the ability of healthcare staff, who are not routinely in touch with people who develop cancer, to recognise potential signs and symptoms and to sign post to services.

5.5 It is recommended that:

• That NHS England provides assurance that residents will continue to have in-borough access to breast screening.

• Barking and Dagenham Clinical Commissioning Group working through the North-East London Cancer Commissioning Board assure the committee of the action it is taking to increase awareness of the signs and symptoms of cancer.

6. **Cancer Survival**

6.2 Members learnt that cancer is a serious disease that can impact on life in the short term, because of treatment, and in the long term, because of disability. They were also assured that the risk of cancer can be reduced through changes in lifestyle; and the worst consequences of cancer can be reduced through early diagnosis and treatment (see Case Study on page 29).

8. **Reading List**

8.1 Officers and members drew on the following papers throughout the review to inform the report and assist with producing recommendations:

9. Financial Implications

Implications completed by: Katherine Heffernan - Group Manager, Finance

9.1 There are no financial implications arising from this report at this time.

10. Legal Implications

Implications completed by: Dr. Paul Feild Senior Governance Lawyer

10.1 There are no specific legal implications arising from this report at this time.

Background Papers Used in the Preparation of the Report:

None.

List of appendices:

Appendix 1 HASSC Cancer Scrutiny Report on Cancer Prevention, Awareness and Early Detection
Report of the Health and Adult Services Select Committee:
Cancer prevention, awareness and early detection:
Scrutiny Review 2016/17

Contact:
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Scrutiny
Democratic Services
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Lead Member’s Foreword

The Health and Adults Services Select Committee (HASSC) is a scrutiny committee made up of local councillors who want to help improve health and social care outcomes for the borough’s residents by working with the Council and its partners to improve services and hold decision makers to account.

In 2016/17, as the Chair of the Committee, I oversaw an in-depth scrutiny review into Cancer Prevention, Awareness, and Early Detection. We chose to review this area as we were concerned that there needed to be more public awareness around the importance of early intervention in tackling cancer so that residents access the right services, in a timely manner, to have the best possible outcome. We also felt that the fear of cancer was possibly stopping people discussing their symptoms with their GP, which could mean that many people were missing out on early diagnosis.

One of our residents shared her story of surviving cancer, which was uplifting; you can read it for yourself on page 29 of this report. Her journey was a mixed picture - she felt unwell for some time but didn’t immediately follow it up with her GP. Her message was loud and clear – see your GP if something doesn’t feel right, eat well, exercise, drink in moderation and if you smoke, get some help to stop!

Currently, many of our residents don’t know the signs and symptoms of cancer, which makes it more difficult for them to get help when they need it. We want all our residents to feel comfortable to talk about cancer, share positive messages and encourage early diagnosis through understanding the signs and symptoms. Early diagnosis means it will be more likely for the person to lead a full and active life after a cancer diagnosis. We also want to support residents to take up invitations to be screened and to assure them that it is the right thing to do. I will be pushing for screening letters to be sent to groups that fall into the at-risk band. It is also very important that we have an awareness road show that goes into churches, temples, mosques, and local schools.

Smoking is the leading cause of cancer in the borough, and we believe that the time has come to talk openly about how smoking is causing lung cancer in the borough. Sadly, a resident of Barking and Dagenham is more likely to develop lung cancer than people in other parts of England. All the evidence points to a ‘healthy lifestyle’ to protect against cancer, and this report encourages us all to make the healthy choice, the easy choice, by explaining how a healthy lifestyle can prevent cancer.

Barking and Dagenham must become a place where a healthy lifestyle is normal from the start, and where people who want to make healthier lifestyle choices, are supported to do so. This report sets out the local picture, recommends actions that will support residents to recognise the signs and symptoms of cancer and the importance of early diagnosis and, aims to drive the work of the borough’s health and social care partners, which we hope will help reduce the prevalence of cancer in the borough, as well as improve survival rates.

Councillor Peter Chand

Lead Member, Health & Adult Services Select Committee 2016/17 – 2017/18
Members of the HASSC 2016/17

The HASSC members who carried out this Review were:

Councillor P Chand (Lead Member)

Councillor L Zanitchkhah (Deputy Lead Member)

Councillor S Alasia

Councillor A Aziz

Councillor E Fergus

Councillor J Jones

Councillor E Keller

Councillor H S Rai

Councillor F Shaukat
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List of Recommendations arising from this Review

For ease of reference, the recommendations arising from this Review are provided below.

The Committee recommends that:

1. The Health and Wellbeing Board (HWB) takes action to reduce the prevalence of smokers in the borough, to levels comparable with London;

2. The HWB sets out to the HASSC what action it is taking to reduce the number of overweight and obese individuals in the borough, to levels comparable with London;

3. The HWB takes action to increase residents’ awareness of the how lifestyle, including exposure to the sun, can affect the likelihood of developing cancer, the signs and symptoms of cancer and the importance of early diagnosis, and screening;

4. The National Awareness and Early Detection Initiative informs the commissioners on what action it is taking to target specific ‘at risk’ groups;

5. The Barking & Dagenham Clinical Commissioning Group (BDCCG) ensures that GPs are auditing and acting on audit information to ensure that patients enter the cancer pathway appropriately, and cancer is diagnosed at as early a stage as possible;

6. The BDCCG, in partnership with Macmillan and Cancer Research UK, takes action to increase the proportion of residents returning bowel cancer screening kits, within the next year;

7. The HWB, along with MacMillan and Cancer Research UK, takes action to raise awareness of the importance of screening and to increase uptake of breast and bowel screening in the borough to a level comparable with England within the next year;

8. The HWB, along with MacMillan and Cancer Research UK, takes action to raise awareness of the importance of screening and reduce the variation in cervical screening uptake between GP practices within the next year;

9. The Committee urges NHS England to make the Cancer Dashboard available within one year;

10. The HWB takes action to raise awareness of the importance of the Health Check and reduce the variation in Health Check uptake between GP practices;

11. NHS England provides assurance to it that residents will continue to have in-borough access to breast screening; and

12. The BDCCG, working through the North-East London Cancer Commissioning Board, assures the Committee of the action it is taking to increase awareness of the signs and symptoms of cancer.
Executive Summary

In 2016/17, the Health and Adult Services Select Committee (HASSC) undertook an in-depth review into Cancer Prevention, Awareness and Early Detection.

Three questions were posed by the HASSC:

1. Why are residents of Barking and Dagenham more likely to develop cancer and less likely to survive cancer than residents in other London boroughs?
2. What is the reason that residents are less likely to respond to requests to screen for cancer than in other London boroughs?
3. What is the reason that residents are not as aware of the signs and symptoms of cancer as residents in other London boroughs?

Here we summarise the HASSC’s findings in relation to these questions.

1. Why are residents of Barking and Dagenham more likely to develop cancer and less likely to survive cancer than residents in other London boroughs?

The reason why residents are more likely to develop cancer is that they tend to have less healthy lifestyles (see Section 4). Lifestyle accounts for four out of 10 preventable deaths from cancer and there are different reasons why residents of Barking and Dagenham have less healthy lifestyles than in many other London boroughs. This suggests that more action is needed to improve lifestyle in the borough.

The evidence indicates that people in the borough are also less likely to be aware of the signs and symptoms of cancer when these do occur (see Section 7), which means that cancer is more likely to develop and less likely to be identified early. Where cancer is diagnosed late, the chances of survival are lower. This suggests that more action is needed to raise awareness so that residents are more aware of signs and symptoms of cancer.

2. What is the reason that residents are less likely to respond to requests to screen for cancer than in other London boroughs?

There are different reasons why residents are less likely to present for screening (see, Section 7), which includes the lack of awareness of the importance of early detection of cancer. In this report, we address the issue of screening for breast, bowel and cervical cancer. The reasons why residents do not always respond can be emotional (fear of what the screening might find), cultural (residents may not understand the information that they are sent), practical (travelling to the place of screening) or service related (difficulty getting an appointment with their GP).

A diagnosis of cancer after a resident has visited Accident and Emergency (A&E) usually means the cancer will be harder to treat because it has developed more. Rates of diagnosis of cancer through A&E in Barking and Dagenham are decreasing but are still higher than the England average. To improve this situation, it is essential that as well as raising awareness of the signs and symptoms of cancer, we work to improve screening rates and effective routes to diagnosis.
These findings suggest that assurance is needed that the providers of screening services communicate effectively and regularly with residents in Barking and Dagenham, using appropriate languages and cultural approaches. The service commissioners, Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHRCCGs), can most effectively facilitate this approach.

Assurance can also be provided from NHS England through the Director of Public Health’s Health Protection assurance process.

3. What is the reason that residents are not as aware of the signs and symptoms of cancer as residents in other London boroughs?

Barking and Dagenham’s residents are not as knowledgeable about the signs and symptoms of cancer as people in other London boroughs. We know that in 2009 residents in Barking and Dagenham were less aware of common signs and symptoms of cancer, such as lumps and swellings; and even less aware of less common symptoms like heavy night sweats or a persistent croaky voice.

A small survey in 2016 found that awareness of the signs and symptoms amongst residents has improved slightly but the question still stands, why do residents present so often with cancer, at the A&E department?

Cancer is a serious disease that can impact on life in the short term, because of the effects of treatment, and in the long term, because of disability. The risk of cancer can be reduced through changes in lifestyle and the worst consequences of cancer can be reduced through early diagnosis and treatment. The findings of this report suggest that more needs to be done to raise awareness amongst residents of the importance of a healthy lifestyle in reducing the risk of cancer, the signs and symptoms of cancer and the importance of screening. This can be done through campaigns and face-to-face activities. It is important to ensure that the ability of those working in primary care to recognise the signs and symptoms is being maintained and enhanced and that healthcare staff facilitate timely access to the local cancer pathways. In addition, it is important that healthcare staff, who are not routinely in touch with people who develop cancer, can recognise its potential signs and symptoms and can sign-post them to the right services.
1. **Background to the Review**

Why did the Health and Adult Services Select Committee (HASSC) choose to undertake an in-depth review on Cancer Prevention, Awareness and Early Detection?

1.1 The Council’s scrutiny committees decide what topic to undertake an in-depth review on based on the ‘PAPER’ criteria. The section below explains why according to these criteria, ‘Cancer Prevention, Awareness and Early Detection’ was a good topic to review.

| PUBLIC INTEREST | The residents of Barking and Dagenham are more likely to develop cancer and less likely to survive than residents in other London boroughs and England. Overall, the borough has the lowest net survival amongst London and West Essex Clinical Commissioning Groups (CCGs). |
| ABILITY TO CHANGE | More than 40% of all cancers are linked to behaviour and environmental exposures which could be avoided or reduced. Factors that also contribute to poor outcomes in Barking and Dagenham include poor awareness of the signs and symptoms, and late detection and diagnosis. Members considered that there was potential to improve people’s knowledge around lifestyle and risk of cancer and the signs and symptoms of cancer. |
| PERFORMANCE | As well as ranking the lowest out of 33 CCGs for net survival, one in every four cancers is diagnosed in the A&E department. This is high compared to London and England. |
| EXTENT OF THE ISSUE | As of the end of 2010, around 3,600 people in the borough were living with and beyond cancer up to 20 years after diagnosis. This could rise to an estimated 7,000 by 2030. People living with cancer can have complex and varied needs which require holistic support. |
| REPLICATION | Local partners are focusing on pathways to early cancer diagnosis via screening or primary care. This review focuses on prevention of cancer and early diagnosis through awareness in residents, local authority staff and health staff. |
2. **Scoping & Methodology**

2.1 This Section outlines the scope of the Review which includes the areas the HASSC wished to explore and the different methods the HASSC used to collate evidence for potential recommendations.

**Terms of Reference**

2.2 Having received a scoping report at its meeting on 7 September 2016, the HASSC agreed that the Terms of Reference for this Review should be:

1. Why are residents of Barking and Dagenham more likely to develop cancer and less likely to survive cancer than residents in other London boroughs?
2. What is the reason that residents are less likely to respond to requests for to screen for cancer than in other London boroughs?
3. What is the reason that residents are not as aware of the signs and symptoms of cancer as residents in other London boroughs?

As there are over 200 types of cancer, the HASSC agreed to focus on the four most prevalent cancers in the borough which are cancers of the breast, prostate, lung and bowel, which are also the most common cancers nationally. In addition, the report discusses cervical cancer as there is screening for this and it is important to review how the borough’s rates compare to others.

**Overview of Methodology**

2.3 The Review gathered evidence during the Committee’s meetings held between 7 September 2016 and 11 January 2017. Details of stakeholders and their contributions to this Review are outlined below.

**Presentation – National and Local Context on Cancer Awareness and Early Diagnosis**

2.4 On 7 September and 2 November 2016, the Council’s Public Health team delivered presentations which considered:

- The National Challenge;
- Cancer Taskforce Strategy Priorities and Ambition for 2020;
- Barking and Dagenham Cancer Numbers;
- Prevention and Early Diagnosis; and
- Barking and Dagenham – what are the problems and what is happening to overcome them.

**Talk Cancer Workshop**

2.5 Nurses from Cancer Research UK delivered an engaging workshop on 12 October 2016 to members of the HASSC as well as community health champions, which raised awareness of the risk factors for cancer and the signs and symptoms.
Report on the Pilot for Healthy Lifestyle Services

2.6 At the HASSC meeting of 11 January 2017 members considered a report on a pilot project for Healthy Lifestyle Services in the borough and how such services could help raise awareness of cancer and its prevention locally.

A Resident’s Journey

2.7 On 2 February 2017 members of the HASSC met with a resident who previously had cancer to hear about the resident’s journey and take her views into consideration as part of this Review.

Submissions

2.8 During the Review, Dr Kanika Rai (a GP in the borough), Kate Kavanagh (NHS England Commissioning Manager), and Jane Burt (Primary Care Research Facilitator, Cancer Research UK) submitted statements to the HASSC expressing views about current provision, pathways and potential areas for service improvement.

Research

2.9 During the Review, Council Officers considered the following pieces of research and evidence:

3. Introduction – Understanding Cancer

What is Cancer?

3.1 There are more than 200 different types of cancer, and each is diagnosed and treated in a particular way.

One common fact about cancers is that all cancers begin in cells. Our bodies are made up of more than a hundred million, million (100,000,000,000,000) cells. Cancer starts with uncontrolled changes in one cell or a small group of cells.

Usually, we have just the right number of each type of cell because cells produce signals to control how much and how often the cells divide. However, if any of these signals are faulty or missing, cells may start to grow and multiply too much and form a lump called a tumour. Where the cancer starts is called the primary tumour.

Some types of cancer, called leukaemia, start from blood cells. They don't form solid tumours. Instead, the cancer cells build up in the blood and sometimes, the bone marrow.

Figure 1: Cancer Cells

![Cancer Cells](image)

Source: Cancer Research UK (CRUK)

Common Signs and Symptoms of Cancer

3.2 The common signs and symptoms of cancer are:

- A lump in your breast;
- Coughing, chest pain and breathlessness;
- Changes in bowel habits;
- Bleeding;
- Moles;
- Unexplained weight loss; and
- Any changes unusual or persistent changes.

Source: NHS website and CRUK

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How is Cancer Treated?

3.3 Four common treatments for cancer include:

- Surgery;
- Radiotherapy;
- Chemotherapy; and
- Hormone therapy.

Source: CRUK

The Impact of Cancer

3.4 Cancer is a serious disease that can impact on life in the short term, because of the effects of treatment, and also in the long term, because of disability as a result of the cancer.

Cancer that is found early is more easily treated than if it is found late. We look at the importance of early detection in Section 6 of this report. The consequences of cancer and its treatment may mean that people are unable to take part in activities that had been a normal part of their life before, such as going to school or college, shopping, working, socialising, being physically active, going on holiday and enjoying sexual intimacy. This leads to a significant knock-on effect on family and friends, which in turn may cause breakdown of relationships, mental health problems and further isolation.

Source: MacMillan

Cancer Taskforce

3.5 The England Independent Cancer Taskforce established four priorities for improving cancer outcomes:

1. A radical upgrade in prevention and public health – focus on reducing smoking and obesity;
2. Achieving earlier diagnosis;
3. Patient experience on a par with clinical effectiveness and safety; and
4. Transformation in support for people living with and beyond cancer.


The HASSC decided to focus on the first two of the above priorities as part of this Review.

Based on these priorities, the Taskforce recommended six evidence-based outcomes:

1. Adult smoking rates should fall to approximately one in 10;
2. Three out of every four screening opportunities offered should be taken up;
3. Approximately six out of 10 people should be surviving 10 years or more after a cancer diagnosis;
4. More than seven out of 10 people should be surviving for one year;
5. The cancer waiting time standard of two weeks, 31 days and 62 days to be achieved; and
6. 95% of people to have a definitive cancer diagnosis within four weeks, and 50% within two weeks.

**Figure 2 - Barking and Dagenham outcomes against the Cancer Taskforce’s Targets**

Barking and Dagenham is performing less well than we could be as a borough on some of these indicators. Two in 10 people in the borough smoke and less than two of all those invited attend screening. In the next sections of the report we consider the reasons for this.
4. **Why are Residents of Barking & Dagenham more likely to Develop Cancer and less likely to Survive Cancer than Residents in other London Boroughs?**

4.1 The reasons why residents are more likely to develop cancer and less likely to survive in the borough are that they tend to have less healthy lifestyles, and are less aware of cancer signs and symptoms. Therefore, residents are more likely to present at their GP surgery at a later stage of cancer development, or even to present at the A&E department because their cancer has developed so far. This means that our residents are less likely to survive cancer. Once residents are in the healthcare system, the time that they survive (the survival rate) is the same as the survival rate across London and England.

4.2 Members of the HASSC spent the afternoon of the 12 October 2016 taking part in a ‘Talk Cancer workshop’ run by Cancer Research UK. Members felt that it was an excellent opportunity to hear experts in the field talk about some of the myths around cancer and to present the facts about incidence, diagnosis and treatment, in a very positive way. All the attendees found the session, which was presented in an enjoyable way, very helpful in increasing their knowledge and changing the way they think about cancer from a negative, to a more positive way. The words which occurred to their minds before the session were quite different to the ones which came to mind after the session, as Figure 3 below demonstrates. This gave the HASSC great confidence that it is possible to change how people think and feel about cancer, and therefore influence their behaviours and outcomes.

**Figure 3: Pre-workshop and Post-workshop Word Association**

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<thead>
<tr>
<th>Pre-workshop word association</th>
<th>Post-workshop word association</th>
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<tr>
<td>Disease</td>
<td>Early</td>
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<tr>
<td>Death</td>
<td>Treatment</td>
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<td>Help</td>
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<td>Treatment</td>
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<td>Help</td>
<td>diagnosis</td>
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<td>Educate</td>
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<tr>
<td>Treatable</td>
<td>diagnosis</td>
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The session also busted a number of common cancer myths (see Appendix 1), and gave an excellent insight into just how important a healthy lifestyle is to preventing cancer.

Cancer specialists estimate that four out of 10 cancer cases could be prevented largely through lifestyle changes. Many people believe that getting cancer is purely down to genes, fate, or bad luck. However, as members discovered at the Talk Cancer session, our risk depends on a combination of genes, age, environment, and lifestyle, the last two of which we are more able to control.
Lifestyle Influences

4.3 Members learnt that lifestyle factors that we can control such as smoking, how much alcohol we drink, what we eat, how heavy we are, how much exercise we get, and how long we expose our unprotected bodies to the sun, can affect the chances of developing cancer. A decision to smoke and continue smoking, for example, will increase a person’s risk of developing cancer. By choosing not to do anything about being overweight, a person is also increasing their risk.

Figure 4: Lifestyle Influences on Cancer Development

Lifestyle influences: In LBB

4 in 10 cancers can be avoided through lifestyle modifications

4.4 However, the ability to choose to live a healthy lifestyle is harder and more limited if you are poor than if you are more affluent. You may feel unable to afford healthy food, which is more expensive than unhealthy, more refined food and you may feel unable to afford to belong to a club that will encourage you to exercise. In fact, you may feel depressed and lacking in motivation anyway and find it hard to break a habitual cycle of unhealthy behaviours, unless there is access to the means to change, which won’t cost money. Members therefore have made recommendations in this report to support local people make these choices.
Smoking

4.5 Smoking remains the most important preventable cause of cancer Barking and Dagenham. We all know that smoking increases the risk of developing lung cancer, but it also increases the risk of developing cancer in many other areas of the body including breast, bowel, stomach, bladder, prostate and cervix. It is in fact fair to say that there isn’t a part of the body that the damaging effects of smoking do not reach.

Smoking prevalence in Barking and Dagenham is 18.4% and higher than both the London (14%) and national (16.3%) average. The numbers of smokers in Barking and Dagenham have steadily been going down, as have the national averages, particularly since the 2007 smoking ban in public places. However, we know that there are certain pockets of the population where smoking prevalence is above the averages that are cited. This is because the poorer the area, the higher the prevalence of smoking. In these communities and amongst the unskilled and manual working groups, smoking remains an acceptable, social activity. Stop smoking services have attempted through various targeting strategies, to actively engage these resistant smokers in quitting attempts with some degree of success. However, it is difficult and intensive work to break down these barriers and support the breaking of habits that are long established and often perpetuated through family and friendship networks.

Alcohol

4.6 Alcohol intake is a potential cause of some cancers in Barking and Dagenham. The level of alcohol consumption in Barking and Dagenham is difficult to measure; however, the number of deaths where alcohol is a secondary cause is comparatively high.

The majority of alcohol-related cancer deaths are expected to be from cancers of the oesophagus, bowel, mouth and throat,

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Accessed 2 Feb17
breast and liver. In Barking and Dagenham, it is estimated that 14.2% of the population binge drink at least one day a week, which is not as high as the national average of 20.1%. However, with poor rates of other healthy lifestyles and poorer outcomes on cancer compared to national and London averages, we should not be complacent and should aim to bring about a decrease in drinking levels.

**Diet**

4.7 Eating a healthy, balanced diet helps maintain a healthy body weight, which is important because obesity is the second biggest preventable cause of cancer after smoking. However, in areas of deprivation, like Barking and Dagenham, it can be harder to afford a healthy diet and some residents feel that money will go further in buying sugary, refined food than buying fruit and vegetables.

Food access, particularly to healthy food, is a problem in some areas of Barking and Dagenham. The borough also has a high number of takeaway food outlets in residential areas and intake of fruit and vegetables is low with four in 10 people eating fruit and vegetables every day, compared to 5.5 in 10 across England. It is clear that these things impact on the healthy weight of people in the borough.

**Weight**

4.8 *One in four reception children and one in three Year 6 children are overweight or obese* (2014/15 statistics). This prevalence sets Barking and Dagenham as the fifth highest prevalence of excess weight in reception (26.6%) in London, above the London and national prevalence of 23% and 22.5% respectively. Barking and Dagenham also has the third highest prevalence of excess weight in Year 6 children (42.2%) in London, above the London and national average prevalence of 37.6% and 33.5% respectively.

Nationally 64.6% of adults nationally are overweight. In Barking and Dagenham this figure is 68.4% and is the highest of all the London boroughs. Research shows that, sadly, many types of cancer are more common in people who are overweight or obese. This is essentially because fat cells affect the level of hormones and proteins in the body. These chemical messengers can then cause cells to change and divide abnormally, and so become cancerous.

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8 LBBD (2016) Joint Strategic Needs Assessment ibid

9 ibid

10 ibid
Exercise

4.9 An inactive and sedentary lifestyle can increase the risk of cancer. The risk of getting bowel and breast cancer can be reduced if people increased their physical activity. Physical activity of adults in Barking and Dagenham is low (46.4%),\textsuperscript{11} with less than one in two residents taking 150 minutes of physical activity per week. The England average is six out of 10 people doing this amount of activity. A Healthy Weight Strategy for Barking and Dagenham to address lifestyle issues in the borough, such as diet and physical activity, was approved by the Health and Wellbeing Board in September 2016.\textsuperscript{12}

Extract from Barking and Dagenham’s Healthy Weight Strategy

- Barking and Dagenham to be a place where residents can make a change to help enable them to achieve or maintain a healthy weight

- Enable families and individuals to take responsibility for achieving and maintaining a healthy weight.

- Make an active lifestyle and healthy eating the easier choice.

- Address causes that put particular groups of families and individuals at a greater risk of obesity.

- Ensure the built and natural environment support families and individuals to be more healthy and active.

RECOMMENDATION 2

The HASSC recommends that the Health and Wellbeing Board set out to the HASSC what action it is taking to reduce the number of overweight and obese individuals in the borough, to levels comparable with London.

\textsuperscript{11} ibid
Exposure to Sun

4.10 Melanoma is the most serious type of skin cancer and in the UK more than eight in 10 cases could be prevented through enjoying the sun safely and avoiding sunburn.

Residents are exposed to the sun particularly during heatwaves. The borough takes an active role in advising residents particularly those at high risk.

RECOMMENDATION 3

The HASSC recommends that the Health and Wellbeing Board takes action to increase residents’ awareness of how lifestyle, including exposure to sun, can affect the likelihood of developing cancer, the signs and symptoms of cancer and the importance of early diagnosis, and screening.

See Section 6 for more information on the importance of early diagnosis and screening.
5. The Incidence of Lung, Bowel, Breast and Prostate Cancers and Survival Rates in Barking & Dagenham

This Section compares the incidence of the four most common cancers in Barking and Dagenham against national rates.

In this report when we discuss survival periods, we talk about one and five year survival periods. These are the periods of time of survival that are measured. It is important to note that residents, happily, often survive for much longer periods than five years after diagnosis and treatment for many cancer sites.

Lung Cancer

5.1 A resident of Barking and Dagenham is one and a third times more likely to develop lung cancer than people in other parts of England.\textsuperscript{13} The incidence of lung cancer in Barking and Dagenham is higher than the national average, which is in keeping with the fact that it is the third most deprived borough in London and that smoking rates are higher than the London national average.

However, after treatment, a resident is more likely to survive up to one year. The one year survival rates at 37.6% are better than the England average (35.4%).\textsuperscript{14}

Bowel Cancer

5.2 A resident in Barking and Dagenham is slightly more likely to develop bowel cancer than a person living in the rest of England.

Once diagnosed and treated, a resident is equally likely to survive at least one year as other people living in England.

Breast Cancer

5.3 A resident in Barking and Dagenham is less likely to develop breast cancer than the England average. This is in keeping with the fact that it is less common in the most deprived areas.

Once diagnosed, a resident is likely to survive for at least one year, and this is good news. In Barking and Dagenham, nine out of 10 people survive for one year. Across England, the rate is also nine out of 10 people.

There is increasing evidence that Black African and Black Caribbean women have a higher risk of particular types of breast cancer and are more likely to get breast cancer in an aggressive form ('triple negative cancer'), and so have a much worse prognosis. The survival rate for women aged 15 - 64 years, after both one and three

\textsuperscript{13} CRUK Local stats site. The 2013 European age standardised rate for 2012-14 is 109.9 per 100,000 where the England average is 79.8.
\textsuperscript{14} LBBD (2016) JSNA
years, is significantly lower in Black African/Caribbean women than in White women.\textsuperscript{15}

**Prostate Cancer**

5.4 A resident of Barking and Dagenham has the same chance of developing prostate cancer as someone in another area of London. \textbf{However, a person who does develop prostate cancer is sadly, more likely to die when compared to the England average.}\textsuperscript{16}

Black men have a higher risk of developing prostate cancer than other ethnic groups. Prostate cancer is three times more common in Black ethnic groups.\textsuperscript{17}

Barking and Dagenham has a has larger than average young population of men of Black African and Caribbean ethnic origin and the number of cases of prostate cancer is likely to rise in the future. For this reason, it is important to raise awareness of the signs and symptoms in this group particularly.

**RECOMMENDATION 4**

The HASSC recommends that the National Awareness and Early Detection Initiative informs the commissioners on what action it is taking to target specific ‘at risk’ groups.


\textsuperscript{16} Mortality rates for prostate cancer are higher than England average – 52.4 per 100,000 as opposed to 45.9. This follows logically from the higher incidence rate.

6. The Importance of Screening and Screening Uptake Rates in Barking & Dagenham for Breast, Bowel and Cervical Cancer

Now that we have considered the prevalence of the common cancers and survival rates in the borough, in this Section, we look at the importance of screening and screening rates in the borough. In the next Section, the possible reasons why residents do not always respond to screening invites are explored.

Late Cancer Presentation

6.1 If a cancer diagnosis is made early, it is better than if it is made late. A resident who is diagnosed with Stage 1 or Stage 2 cancer is more likely to survive one or five years, than someone diagnosed at Stage 4.

The reason for this is that although early cancers that are smaller and not entangled with healthy cells are harder to find, they are easier to treat. These cancers are generally stage 1 and stage 2 cancers. Cancer grows and as it grows it gets bigger and entangled with other, healthy cells. Staging is a way of describing how big a cancer is and whether it has spread into surrounding tissues.

Figure 5: Cancer Diagnosis by Stage in LBBD in 2014\(^{18}\)

<table>
<thead>
<tr>
<th>Cancer type</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Known Stage total</th>
<th>X - Unknown stage</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>62</td>
<td>51</td>
<td>9</td>
<td>4</td>
<td>126</td>
<td>23</td>
<td>149</td>
</tr>
<tr>
<td>Proportion diagnosed by known stage</td>
<td>49%</td>
<td>40%</td>
<td>7%</td>
<td>3%</td>
<td>85%</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Colorectal</td>
<td>8</td>
<td>11</td>
<td>20</td>
<td>17</td>
<td>56</td>
<td>14</td>
<td>70</td>
</tr>
<tr>
<td>Proportion diagnosed by known stage</td>
<td>14%</td>
<td>20%</td>
<td>36%</td>
<td>30%</td>
<td>80%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Lung</td>
<td>7</td>
<td>7</td>
<td>20</td>
<td>57</td>
<td>91</td>
<td>27</td>
<td>118</td>
</tr>
<tr>
<td>Proportion diagnosed by known stage</td>
<td>8%</td>
<td>8%</td>
<td>22%</td>
<td>63%</td>
<td>77%</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>Prostate</td>
<td>27</td>
<td>12</td>
<td>12</td>
<td>6</td>
<td>57</td>
<td>24</td>
<td>81</td>
</tr>
<tr>
<td>Proportion diagnosed by known stage</td>
<td>47%</td>
<td>21%</td>
<td>21%</td>
<td>11%</td>
<td>70%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>104</td>
<td>81</td>
<td>61</td>
<td>84</td>
<td>330</td>
<td>237</td>
<td>418</td>
</tr>
<tr>
<td>Proportion diagnosed by known stage all cancer total</td>
<td>32%</td>
<td>25%</td>
<td>18%</td>
<td>25%</td>
<td>79%</td>
<td>57%</td>
<td></td>
</tr>
</tbody>
</table>

* Note - be aware of small numbers when looking at percentages

\(^{18}\) 2014 Cancer Staging Statistics by Clinical Commissioning Group
Breast cancer is the most common cancer in England, and most common in Barking and Dagenham. Most breast cancers are diagnosed at an early stage in Barking and Dagenham, with nine in every 10 known cancers diagnosed at stages 1 and 2. This rate of diagnosis is as good as the England average.

Colorectal cancer is often diagnosed at a late stage in England, and in Barking and Dagenham. We find currently that one in every three colorectal cancers is diagnosed at stage 1 or 2. Residents of Barking and Dagenham are, currently, slightly less likely than residents in other boroughs to be diagnosed at stages 1 and 2.

Lung cancer is, again, often diagnosed at a late stage in England, and in Barking and Dagenham. We find, currently, that two in 10 lung cancers are diagnosed at stages 1 and 2. Residents of Barking and Dagenham are, currently, slightly less likely than residents of other boroughs to be diagnosed at stages 1 or 2.

Prostate cancer is the most common cancer in men. It is often diagnosed at an early stage in England, and in Barking and Dagenham. We, currently, find that seven in every 10 prostate cancers are diagnosed at stages 1 and 2. This rate of diagnosis is as good as the England average.

6.2 Emergency presentation refers to residents attending Accident and Emergency (A&E) with symptoms who are then diagnosed with cancer. This is usually when the person’s cancer has developed to Stage 3 or 4.

The number of cancers diagnosed at a later stage, Stages 3 and 4, in the borough is higher than in England. Nearly one in every four (22.8%) cancer diagnosis in Barking and Dagenham are made through emergency routes, as compared to the England average, which is one in every five (20.1%) of cancer diagnoses.

Figure 5: Number of Emergency Presentations in Barking and Dagenham

<table>
<thead>
<tr>
<th>Number of Emergency Presentations per 100,000 population</th>
<th>Barking and Dagenham</th>
<th>London</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>73.68</td>
<td>64</td>
<td>2015/16</td>
<td></td>
</tr>
</tbody>
</table>

Late, emergency diagnosis results in poorer outcomes for residents because Stage 3 and 4 cancers are much harder to treat. The chances of a resident surviving for one year after a cancer is diagnosed at A&E is significantly lower than all other routes to diagnosis because this generally correlates with late stage diagnosis. The impact of this can be demonstrated by looking at the rates of survival when cancer is diagnosed at different stages. For example, in bowel cancer, an early diagnosis usually means nine out of 10 residents will survive for five years or longer, whereas a late diagnosis often results in less than one in 20 surviving five years or longer.
The Importance of Screening

6.3 Screening can help detect cancer before the person has symptoms or has become aware of any signs. It is important to note that people should still be alert to signs and changes described earlier in Section 3, as cancer can develop between screening rounds. However, attending screening is a good way to save lives, by finding cancer at an early stage. The earlier cancer is detected in a person and is treated, the longer his or her survival after diagnosis is likely to be. People need to be registered with a GP with an up-to-date address to receive screening invitations. GP practices are advised when their patients fail to attend cancer screening tests.

There are three national cancer screening programmes - bowel, breast and cervical cancer. There are no screening programmes for lung and prostate cancer. However, for prostate cancers, GPs are encouraged to review the following men who may be at higher risk:

- Black men;
- Men who have a family history; and
- Men who are overweight or obese

(See also 5.4 of this report and the recommendation at the end of that Section).

Residents of Barking and Dagenham have access to the three cancer screening programmes, breast, bowel and cervical.

The cancer screening services for the borough are commissioned by NHS England, and the services are quality assured by the Council's Director of Public Health.

Breast Cancer Screening

6.4 Breast cancer uses a test called mammography which involves taking x-rays of the breast and can help find cancers early when they are too small to see or feel. Screening is offered to women between the ages of 50 and 70, though people over the age of 70 can request a screening.

For breast cancer, early diagnosis results in nine out of 10 residents surviving five years or longer, but late diagnosis means only one in 10 surviving five years or longer. It is, however, important to note that there is a slightly lower than expected uptake of breast cancer screening in relatively high numbers of people of Black ethnic origin in the general England population, and this is likely to also be the case in LBBD. (See also 5.4 of this report and the recommendation at the end of that Section).
The uptake of breast cancer screening in the borough is decreasing. In 2012 the offer was taken up by 64% of those offered. In 2014/15 this had decreased to 60%.

There is considerable variation in uptake by patients across GP practices. Some GP practices in the borough have an uptake that is higher than 64%; others need support and have an uptake that is considerably lower than 64%.

**RECOMMENDATION 5**

The HASSC recommends that the Barking and Dagenham Clinical Commissioning Group ensures that GPs are auditing and acting on audit information to ensure that patients enter the cancer pathway appropriately and cancer is diagnosed at as early a stage as possible.
Bowel Cancer Screening

6.5 Bowel screening is offered every two years to people between the ages of 60 and 74, however; those over the age of 74 can request a screening kit. The screening can detect cancer at an early stage and also help cancer from developing in the first place. GP registered lists are used to send the bowel screening kit, shown in Figure 7, a service which is provided through NHS England.

Figure 7: Bowel Screening Kit

A much lower proportion of residents, than is usual for England, respond to requests to act on and return bowel cancer screening kits. The uptake of bowel cancer screening in the borough is low and steady.

In 2012 the offer was taken up by 43% of those offered. In 2014/15 this was still 43%, compared to the England average of 57.9%.
Barriers to taking the test include lack of awareness of the function of the test, and cultural objections to handling faeces. Barking and Dagenham is now seeing five out of 10 people sending off kits. This has happened since the start of a local scheme, developed by the Clinical Commissioning Group (CCG), to increase bowel screening uptake. There remains considerable variation in uptake by patients across GP practices with some practices achieving an uptake of 53.7% and others 31%. Once residents are referred to the diagnostic unit at the local hospital, the 'did not attend' rate is low at 0.42%.

RECOMMENDATION 6

The HASSC recommends that the Barking and Dagenham Clinical Commissioning Group, in partnership with MacMillan and Cancer Research UK, takes action to increase the proportion of residents returning bowel cancer screening kits within the next year.

Figure 9: Changes in Breast and Bowel Cancer Screening Uptake in Barking and Dagenham 2012 – 2015.

There is significant variation across the borough in the numbers of residents that access breast and bowel screening.

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19 BHRUT (2017) DNA data sigmoidoscopy unit.
The trend across the years 2012 – 2015 is for less residents to attend breast screening, and for the uptake in bowel screening to be low.

**RECOMMENDATION 7**

The HASSC recommends that the Health and Wellbeing Board, along with MacMillan and Cancer Research UK, takes action to raise awareness of the importance of screening to increase uptake of breast and bowel screening in the borough to a level comparable with England within the next year.

**Cervical Cancer Screening**

6.6 Cervical cancer screening is offered to women aged 25 – 64. Women aged 25 – 49 are invited every three years. After 50, women are invited every five years until they are 64 years old.

**Figure 10: Screening Uptake: Cervical**

**Screening Uptake: Cervical Screening**

Cervical screening coverage amongst 25-64 year old females is 70.2% in Barking and Dagenham, this is worse than the England average (73.5%).

Cervical screening coverage is the proportion of eligible people who have been screened successfully.
The uptake of cervical screening in the borough is 70.2% of all eligible women compared with 73.5% across England. Less than five cases of cervical cancer were diagnosed in Barking and Dagenham 2012-2014. There remains considerable variation in uptake of cervical screening by patients across GP practices with some practices achieving an uptake of 78% and others 55.4% of eligible population.

**RECOMMENDATION 8**

The HASSC recommends that the Health and Wellbeing Board, along with MacMillan and Cancer Research UK, takes action to raise awareness of the importance of screening and reduce the variation in cervical screening uptake between GP practices within the next year.

**Cancer Dashboard**

6.7 The Cancer Strategy for England\(^\text{20}\) recommends that NHS England work with other arm’s length bodies to develop a cancer dashboard of metrics at the CCG and provider level.

The proposed cancer dashboard will measure how well different areas of the country are performing. They will record performance in four areas - early diagnosis, one year survival, 62 day wait for treatment and overall patient experience. The dashboard will enable the comparison and improvement of cancer outcomes in Barking and Dagenham.

It is proposed that this dashboard includes information on screening uptake across GP practices.

**RECOMMENDATION 9**

The HASSC recommends that the Committee urges NHS England to make the Cancer Dashboard available within one year.

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Health Checks

6.8 The Health Check is a different type of screening that all GPs offer. It is a programme designed to screen for heart disease but it also reviews residents’ lifestyles and is an opportunity to point residents toward improved lifestyle behaviour or to pick up unintended weight loss.

All the borough’s GPs have signed up to deliver the Health Check; however, there is considerable variation on the numbers of health checks delivered by GP practices, with some practices delivering 0% and some 100% of eligible health checks. See Appendix 2.

RECOMMENDATION 10

The HASSC recommends that the Health and Wellbeing Board takes action to raise awareness of the importance of the Health Check and reduce the variation in Health Check uptake between GP practices.
7. **The Potential Reasons for Late Detection of Cancer in Barking & Dagenham, including reasons for Lower Uptake of Screening**

Barking and Dagenham residents are not as knowledgeable about signs and symptoms of cancer as people in other London boroughs. We know that in 2009 residents in Barking and Dagenham were less aware of the common signs and symptoms of cancer, such as lumps and a long-term cough.

**The Cancer Awareness Measure – Signs and Symptoms**

7.1 Members learnt that in 2009/2010 residents were asked a number of questions as part of national research to find out if people could recognise signs and symptoms of cancer. This research used the Cancer Awareness Measure (CAM). This survey found that while people are generally aware that smoking can cause cancer, only one in three residents of Barking and Dagenham were aware that a persistent cough can be a sign of cancer.

Similarly, **one in three residents could not recall any other sign or symptom of cancer** including:

- An unexplained lump or swelling;
- Persistent unexplained pain;
- Unexplained bleeding; or
- A persistent change in bowel habits.

At the same time, across England, two in three residents could recall a classic cancer symptom.

Local information\textsuperscript{21}, from a small number of residents who answered a questionnaire, suggests that in 2016, four in five residents knew that an unexplained lump or swelling could be a sign of cancer.

**Figure 11: 4 of 5 Residents Recognise a Lump as a Sign of Cancer**

In the same survey we found that three in five residents were aware that a persistent cough, persistent change in bowel habit or change in appearance of a mole is a sign or symptom of cancer.

\textsuperscript{21} LBBD (2016) Small survey of residents.
Less residents were aware of other signs and symptoms such as persistent difficulty in swallowing; a sore that does not heal; or persistent unexplained pain. Awareness of the signs of cancer is particularly low in men, teens and ethnic groups.

**Other Barriers to Getting Diagnosed**

7.2 The lack of awareness of the signs and symptoms of cancer, combined with the factors below, could mean that some residents face a number of barriers to getting diagnosed early.

**Emotional**

Cancer has many negative connotations, which can make it difficult to talk about. People may be embarrassed by a symptom they are having, feel fearful of what the doctor may suspect, or simply not quite know how to bring the topic up with the doctor.

**Cultural**

Difficulty in talking about cancer may also be a cultural issue; for example, for some residents, English is not a first language. There may also be cases where individuals are not taking tests such as bowel cancer screening because handling faeces is culturally offensive.

**Practical**

Both for screening and diagnosis, residents need to tackle practical issues such as making an appointment, and arranging or taking transport. These issues can disproportionately affect people from vulnerable groups in the community including people from minority ethnic groups, people with mental health issues, people living with learning disabilities and people living with physical disabilities.

The breast screening unit has not been easily accessible to borough residents, which may have acted as a barrier to screening for some residents. Recently, a unit has been placed in the borough temporarily. The Committee need to be assured by NHS England that residents will continue to have in-borough access to breast screening.

**RECOMMENDATION 11**

The HASSC recommends that NHS England provides assurance to it that residents will continue to have in-borough access to breast screening.
Service

Sometimes residents simply worry that they are wasting the doctor’s time with their concerns or may find it difficult to make an appointment with their GP, leading them to put off making an appointment.

7.3 However, if awareness of the signs and symptoms of cancer and the importance of early diagnosis could be raised, more people will understand the importance of overcoming the barriers and seeing their doctor, leading to a better early detection rate.

The Two Week Urgent Referral System

7.4 For those patients who do go to their GP, where the GP suspects cancer, the patient is directed to the two-week urgent referral system. The number of cases referred to the two-week wait system varies between GP practices. There is no right or wrong number of referrals, and 96% of residents have a diagnosis within 30 days.

The conversation rate gives an indication of the number of cancers diagnosed as a result of the referral to the two-week referral system. For most practices in the borough the conversation rate is 10% which means that 10% of referrals have a cancer diagnosis. This is in line with the England average. One practice falls below this rate, which indicates that some GPs in this practice would benefit from updating in primary cancer signs and symptoms.

Cast Study

7.5 Members of the HASSC met with a resident, Mary (not her real name), to talk about her cancer journey to see what they could learn from her story and how they could apply this to their Review.

Mary’s Story

Three years prior to being diagnosed, Mary had a persistent cough. She eventually visited her GP who sent her for some tests which showed a shadow on her lung. After further tests she was informed that it was not cancer which she was assured by. She was not sent for further tests to look for markers for cancer. In hindsight, she personally felt this should have been done to ensure she was in the all clear.

Soon before she was diagnosed Mary had another persistent cough and had lost weight but at the time this did not seem relevant to her. It was when she developed severe joint pains that she became concerned and went to see her GP. A test result showed a high marker for cancer in her liver and an X-ray later confirmed that there was a mass in her lung. She was an ex-smoker but at the time of her diagnosis she had not been smoking for over eight years.
Queen’s Hospital was initially not able to confirm a cancer diagnosis due the positioning of the mass in her lung and eventually, she was referred to a consultant in Bart’s for this. Three weeks later she had an operation to remove the cancer. Following her treatment for lung cancer, Mary noticed that one side of her mouth had dropped so she visited her GP again.

Her GP initially suspected Bell’s Palsy but sent her for tests to be sure, and it was after this that she found out that she had a tumour in her brain, which meant that the cancer had spread. Mary started treatment at King George’s Hospital in the chemo unit for this, which she found a comfortable environment. She felt it was very positive that there was cancer nurse who she could contact when she needed.

Mary shared that her faith played an important part in her emotional state while she had cancer. She also went to a retreat in Bristol with her sister which she found very helpful as she learnt more about cancer and the importance of diet in preventing cancer.

Mary felt her immune system was very poor prior to her developing cancer as she kept getting infections. She personally felt that this may have had part to play in her developing the tumour. Mary felt there are a lot of messages already out there in the borough about diet and other lifestyle changes; however, these are not always linked to cancer. Local services could be more explicit in their messages about the link between lifestyle and cancer but it would be important to do this in a positive way by emphasising that these measures are preventative. Mary also felt a reason people in the borough don’t always attend screening is perhaps fear, so she considered it important to explain to people what cancer is and that it can be beaten more easily if it is caught early.

HASSC took from Mary’s story:

1. Early identification and referral by a GP is key to the outcome of a cancer diagnosis;
2. It is important to raise awareness of signs and symptoms of cancer in residents;
3. It is important that residents have good access to local services for both diagnosis and treatment; and
4. It is important to raise awareness of the importance of attending screening for cancer in a positive way.
RECOMMENDATION 12

The HASSC recommends that Barking and Dagenham Clinical Commissioning Group, working through the North-East London Cancer Commissioning Board, assures the Committee of the action it is taking to increase awareness of the signs and symptoms of cancer.

(See also Section 4 and the recommendation at the end of that Section).
8. What is Working Well and What more can be Done?

What is Working Well?

8.1 The HASSC received a report on the Mayesbrook Park Pilot, an exciting piece of local work designed to increase awareness of healthy lifestyles, including signs and symptoms of cancer. This piece of work is particularly exciting because, through community engagement, many of our local residents are involved. Some are involved as community champions, and have been trained to engage with their own community, whether that be an ethnic community, a faith community of simply their neighbours. If this piece of work evaluates well, it will be rolled out across the borough.

Barking and Dagenham health partners have also been successful in introducing positive change through communities, GP practices and St George’s and Queen’s Hospital. This is detailed below.

8.2 In the Community

- Taking a local slant on NHS awareness campaigns;
- Using social media and posters such as ‘Be Clear on Cancer’;
- Some community talks to local groups; and
- Physical activity schemes for cancer patients.

8.3 In GP Practices

- A Cancer Research Facilitator is in post to support primary care to develop skills and knowledge in cancer awareness and treatment;
- Practice visits by Macmillan GPs and primary care facilitator;
- Local Enhanced Scheme from bowel cancer screening;
- GP education programme to increase awareness of common and vague signs and symptoms of cancer;
- Education programme for practice staff to support patient care locally;
- Improved patient awareness of signs and symptoms of cancer, particularly within hard to reach groups; and
- Work plan to increase the uptake of screening services.

8.4 St Georges and Queen’s Hospital

- Audit of emergency department presentations of cancer to identify potential opportunities for early diagnosis and improved patient experience. The results are not yet available but must be acted on when they are available.

8.5 Across Barking & Dagenham, Havering and Redbridge

- Collaborative working with secondary care clinicians to develop direct access to pathways for diagnosis.
What More can be Done?

8.6 Throughout this report, the HASSC has made recommendations to help improve outcomes for the borough’s residents. Below are further areas for the Health and Wellbeing Board and local health partners to consider, some which may overlap with the recommendations.

More can be done to support action to increase community awareness of importance of lifestyle. If the Mayesbrook pilot project work is deemed successful, consideration should be given to rolling this approach out across Barking and Dagenham.

8.7 The Council could introduce targeted social media campaigns linked to the national be’ Clear on Cancer’ NAEDI campaigns, with the aim of increasing uptake of screening and awareness of signs and symptoms, including:

- Encouraging attendance at the Cancer Research UK roadshow;
- A targeted approach to increase screening in vulnerable groups e.g. Increasing the uptake of bowel screening in people with learning disabilities should be put in place; and
- A targeted approach to increasing awareness and the uptake of screening in Council staff and other staff in the workplace can be encouraged through the London Work Place Health initiative.

8.8 There should be support for staff to develop skills in talking about cancer to residents, particularly community health champions, Community Solutions, social care and health staff.

One form of awareness training is making Every Contact Count (MECC). This training is designed to educate staff about early signs and symptoms of cancer, Staff who are in face-to-face contact with residents can help the residents by signposting to recognise early signs and symptoms of cancer and signpost them toward health services.

8.9 In GP Practices

- Continued and extended engagement with the Cancer Research Facilitator to support primary care to develop skills and knowledge in cancer awareness and treatment;
- Continued Practice visits by Macmillan GPs and primary care facilitator;
- Continued support for the Local Enhanced Scheme from bowel cancer screening;
- Continued and extended GP education programme to increase awareness of common and vague signs and symptoms of cancer;
- Continued and extended education programme for practice staff to support patient care locally;
- Improved patient awareness of signs and symptoms of cancer, particularly within hard to reach groups;
- Work plan to increase the uptake of screening services, particularly bowel screening;
- Support and encourage residents to register with a GP practice;
- Encourage health partners to audit and act on practice level uptake of cancer screening; and
- Encourage health partners to put in place actions that are known to improve uptake of screening:
  - Phone reminders;
  - Case note reminders; and
  - Local enhanced services agreements.

8.10 The Council should further strengthen its partnership with health providers to provide a consistent approach to awareness and early intervention. For example, it could:

- Encourage health partners to audit and act on variation in practice level early identification of cancer;
- Strengthen links through the North-East London Cancer Commissioning Board; and,
- Strengthen local CCG and public health contracts through specifications that include a requirement to increase awareness and early intervention in cancer.
10. Next steps

10.1 This report and its recommendations will be submitted to the Health and Wellbeing board and relevant health partners, who will decide whether to agree the recommendations. If the recommendations are accepted, the Health and Wellbeing Board and health partners will be asked to draw up an action plan describing how the recommendations will be implemented. In approximately six months’ time, the HASSC will request a monitoring report explaining the progress of the implementation of the recommendations and whether anything could be said of the early impact they have had.
The HASSC would like to extend its thanks to the following for contributing to this Review:

Members thank the following for their support during this Review:

- Resident who spoke to members on 2 February 2017
- Dr Kanika Rai: MacMillan GP
- Jane Burt: Primary Care Facilitator, Cancer Research UK
- Katherine Kavanagh: Cancer Commissioning Manager (BHR & West Essex)
- Sue Lloyd: Public Health Consultant
- Mary Knowler: Public Health Strategist
- Masuma Ahmed: Democratic Services Officer
Appendices
Cancer Myths

Stress causes cancer

- Some people think that stress can cause cancer but the evidence for this is poor.
- Stressful events can alter the levels of hormones in the body and affect the immune system but there is no evidence that these changes could lead to cancer.
- Stressful situations can make some people more likely to take up unhealthy behaviours such as smoking, overeating and drinking alcohol. We know these behaviours increase the risk of developing cancer.

Mobile phones cause cancer

- So far, the scientific evidence shows that it’s unlikely that mobile phones could increase the risk of cancer, but we do not know enough to completely rule out a risk.
- The use of mobile phones has skyrocketed since the 1990’s. If mobile phones increase the incidence of brain cancer, increasingly people should be developing this disease. In the UK, the incidence of brain cancer has been constant for years.
- Source: Talk Cancer, Cancer Research UK
Barking and Dagenham: Variation in health check by invitation and completion.

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*Source: NHS Health Checks, local data.*
Title: Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups’ Engagement Document

Report of the Director of Law and Governance

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<th>Open Report</th>
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**Report Author:** Masuma Ahmed, Democratic Services Officer  
**Contact Details:**  
Tel: 020 227 2756  
E-mail: Masuma.ahmed@lbdd.gov.uk  

**Accountable Director:** Fiona Taylor, Director of Law and Governance

**Accountable Strategic Director:** Chris Naylor, Chief Executive

**Summary:**

The Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups’ (BHRCCGs) have published an engagement document, provided at Appendix 1, ‘Spending NHS money wisely’ which discusses potential future savings options to achieve a saving of £55 million, in relation to the following services:

- IVF;
- Sterilisation;
- Prescribing;
- Cosmetic procedures and
- Weight loss surgery.

The BHRCCGs’ deadline to respond to the engagement document is **18 May 2017**.

**Recommendation(s)**

The Health and Adult Services Select Committee is recommended to discuss the potential savings options and provide comments to officers on the representations that should be made in the Committee’s response to the engagement document.

**Reason(s)**

This engagement document falls under the HASSC’s remit, which includes the scrutiny of any matter relating to the planning, provision and operation of the health service in the borough or accessed by Barking and Dagenham residents.

**Implications**

There are no financial or legal implications arising directly as a result of this report.

**Appendices**

Appendix 1 – Spending NHS money wisely engagement document
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Spending NHS money wisely

What do you think about our proposals for IVF, sterilisation, prescribing, cosmetic procedures and weight loss surgery?

Please tell us by 5pm on 18 May 2017
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Foreword from clinical leads

As GPs working in surgeries across Barking and Dagenham, Havering and Redbridge we know only too well the pressures that the NHS faces both here and across the country at the moment.

The care and treatment that we, along with our GP colleagues, provide every day for our patients is funded by taxpayers’ money – your money. That’s why we have a duty to spend it wisely, to make sure we get the best value we possibly can for every penny – especially when NHS funding is being severely squeezed and we are seeing more patients with more complex health issues than ever before.

That’s why we are faced with some very difficult choices if we are to protect our most essential health services – things like cancer care, emergency care, life threatening conditions and mental health services – for the coming years.

To protect those services in our area we have to make savings locally of £55 million and to do that we must look at reducing spending now. That’s why we need your help.

In this document, we talk about some of the things we think we can save money on and why. We want to know what you think. We haven’t made any decisions yet and we won’t until we have heard from you, our patients.

Unfortunately, doing nothing is not an option. We are family doctors, not politicians, but it’s up to us – with your help – to get the local NHS onto a secure and sustainable footing to ensure that we can maintain those vital local services for you and your families, both now and in the future.

We’d welcome your comments (please read our questionnaire) and any suggestions you may have about how we can save money in other areas too.

Dr Ravali Goriparthi  Dr Ashok Deshpande  Dr Anita Bhatia
Dr Anju Gupta  Dr Maurice Sanomi  Dr Sarah Heyes
Barking and Dagenham CCG  Havering CCG  Redbridge CCG
About this document

This document explains how and why we want to change some of the things that we spend NHS money on in Barking and Dagenham, Havering and Redbridge (BHR). Clinical commissioning groups (CCGs) in these three boroughs are working together to look at how we can spend the money we have wisely.

We are looking at:

- In-vitro fertilisation (IVF)
- Male and female sterilisation
- NHS prescribing – including gluten-free food prescriptions, over the counter prescribing, soya-based formula milk and travel vaccinations
- Cosmetic procedures
- Weight loss surgery.

We have set out different options and explained why we’ve identified these. We want to know what you think and if there is anything else you want us to consider.

We’d like to hear from as many local people as possible about our proposals, so please tell your friends and family about this, and encourage them to respond. Comments from health professionals and our partners in the community and voluntary sector are also welcomed.

To tell us what you think, you can fill in the online questionnaire on our websites or print off the questionnaire at the back of this document, fill it in and send it back to FREEPOST BHR CCGs, free of charge.

All responses must be received by 5pm on 18 May 2017.

This document summarises our thinking. For more information visit our websites:

- www.barkingdagenhamccg.nhs.uk/spending-wisely
- www.haveringccg.nhs.uk/spending-wisely
- www.redbridgeccg.nhs.uk/spending-wisely
About clinical commissioning groups

Clinical commissioning groups (CCGs) plan and commission (buy) health care services for the residents of their local area. They are led by local GPs.

Commissioning is about deciding what services are needed, and making sure that they are provided, and getting the best possible health outcomes for local people by assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals.

Services CCGs commission include:

- urgent and emergency care (including GP out-of-hours)
- most planned hospital care
- most community health services such as health visitors and physiotherapy
- mental health and learning disability services.

All GP practices belong to a CCG. CCGs are regulated by NHS England.

In Barking and Dagenham, Havering and Redbridge, the three CCGs work together closely under one management structure, sharing resources.
Introduction: our financial challenge

Nationally the NHS is facing a challenging time as demand for services continues to increase. A growing and ageing population and more people living with long term health conditions such as diabetes are placing further pressure on already stretched services and finances.

The population is growing

Compared to other boroughs in London, the three boroughs in BHR have population growth that is significantly higher than the London average and all three are in the top third of boroughs with the highest growth rates.

- **Redbridge**’s estimated population growth over the next five years is the highest in London
- **Barking and Dagenham** has the highest birth rate in London.

The population is aging

The greatest increases in population are expected in the 65+ age groups. Older patients generally have increased and more complex health and social care needs.

- **Havering** has the highest proportion of older people in London.

The population is changing

Some diseases are more common in specific ethnic groups, so the ethnic composition of the population influences what the population’s health needs are.

There is rising local demand for NHS services and the cost and availability of treatments continues to increase, which means it is all the more essential that we spend our limited resources in the most effective way.

In terms of funding the amount of money allocated (funding allocation) to each CCG is decided by the Department of Health, based on the size of the population and local health needs. According to the formula used by the Department of Health, the BHR area is under-funded.

### 2017/18 Total BHR budget
(all amounts in £millions)

- £394.3m
- £305.7m
- £283.3m

- Barking and Dagenham
- Havering
- Redbridge
We have reached a point where we do not have enough money to continue buying all the services in the way we do now. We are in deficit and this has been caused by a number of factors, including our funding position and pressure from the continuing population changes.

For some time local patients have been waiting too long for treatment at our main local hospitals trust, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT). We have worked closely in partnership with them and other providers to tackle these long waiting lists and ensure that patients can receive the treatment they need within a reasonable time. Together we have achieved this change, which is positive for patients, but it has been at a cost.

We have a statutory responsibility to balance our budget. To achieve financial balance, BHR would need to deliver **£55 million** savings from the budget in the 2017/18 financial year. This is just over 5% of our total annual joint budget of just over **£1 billion** for the three boroughs.

---

### 2017/18 funding allocations and the shortfall

(all amounts in £millions)

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To achieve this, we need to reduce our spending in some areas of our health budget. We have been looking closely at what we’re spending money on, to ensure we are making the most effective use of public money to commission the most appropriate healthcare services for local people. We must maintain our investment in areas such as cancer treatment, mental health services, and accident and emergency care, so this means making decisions about what services and treatments we can fund and in some cases, no longer fund.

We are not alone in doing this. CCGs all over the country are looking at how they can use limited resources responsibly to make sure the NHS is able to help those most in need. They are reducing the services and treatments they will fund. We have managed to hold off longer than some others, but we cannot carry on without making changes.
Note

We are not looking at reducing the money we spend on primary care (care provided by GPs and their practice staff).

This is protected by NHS England and cannot be reduced.

Where we can, we will continue to make the case for additional funding for the Barking and Dagenham, Havering and Redbridge area, but that is unlikely to be granted (certainly in the next few years) given the current pressure on public spending. Waiting to see if our funding will be increased is not an option – we have to act now to protect services.

**Nothing has been decided. We want to know what local people think we should do.**
What we’re already doing to save money

BHR CCGs are small organisations with a single shared management structure, which is already a cost-effective way of operating, so there are limits to what administrative savings we can make. We have already reduced our limited interim staffing and general operating costs, but are looking at other ways to make the scale of the savings required and have developed a recovery plan to identify additional savings.

To note: these figures may change as further opportunities are identified and/or plans are refined.

We have a responsibility to balance our books and make efficiencies so we are:

- working with hospital and community providers to change patient pathways (the route a patient takes from their first contact with an NHS member of staff (usually their GP), through referral, to the end of their treatment) to eliminate any unnecessary steps
- looking at contracts with providers to make sure they are cost effective and identifying where savings could be made
- making better use of technology, for example introducing web-based ‘e-clinics’ to improve management of some conditions in primary care
- reviewing continuing healthcare (the name given to a package of care that is arranged and funded solely by the NHS for people outside of hospital who have ongoing healthcare needs) to ensure the most consistent and effective commissioning of services and appropriate funding
- working with property owners to make sure we are using buildings efficiently and not paying for space we don’t need
- basing clinical practice on scientific evidence (adhering to evidence-based medicine) by making sure everyone sticks to the policy on procedures of limited clinical effectiveness (POLCE) (see box on the next page) which means that only the patients who meet the strict eligibility criteria can have the treatment.
Procedures of Limited Clinical Effectiveness (POLCE)

These are procedures that doctors have identified are usually unnecessary and don’t generally benefit someone’s health - such as taking children’s tonsils out, which used to happen a lot. As children get older they generally grow out of tonsillitis, which doctors think is better for them than operating on them (because there are always risks associated with operations).

Doctors have set criteria in the POLCE guidelines for when they think these procedures *should* be carried out. For example, a child would be eligible for a tonsillectomy if it could be shown that they had severe tonsillitis seven or more times in the past year.

Put simply, the NHS should only be funding procedures to deal with medical conditions and symptoms. The aim is to make sure that only those who will benefit clinically from the treatment receive it. This means that people won’t have unnecessary treatment and the NHS won’t waste money.

In 2016/17 we spent more than £17 million on POLCE procedures. We estimate that tightening this up will save us around £2.4 million in the next year.

Read our POLCE policy on our websites:

- www.barkingdagenhamccg.nhs.uk/spending-wisely
- www.haveringccg.nhs.uk/spending-wisely
- www.redbridgeccg.nhs.uk/spending-wisely

We need to do more

We want to make sure that local people will always be able to get treatment for conditions like cancer, heart disease, stroke and serious mental illness. To do this we have identified some other areas of NHS spending where we think could make further savings of up to about £5.21 million each year.

This involves making some difficult decisions about other things that the NHS spends money on at the moment. These are:

- In-vitro fertilisation (IVF)
- Male and female sterilisation
- NHS prescribing
- Cosmetic procedures
- Weight-loss surgery.

In the next section we explain what these are and our proposals.
**IVF**

We are considering whether the local NHS should continue to fund IVF, and, if so, how many embryo transfers we should fund.

In-vitro fertilisation (IVF) is a technique to help people with fertility problems have a baby.

During IVF, an egg is removed from the woman’s ovaries (known as ovarian stimulation) and fertilised with sperm in a laboratory culture dish. Fertilisation takes place in this dish, ‘in vitro’, which means in glass. The fertilised egg, called an embryo, is then returned to the woman’s womb to grow and develop.

Currently, we fund:

- a maximum of three embryo transfers for women aged 23-39
- one embryo transfer for women aged 40 and 41.

Women aged 42 and over are not eligible for NHS-funded IVF because it has a very low chance of success.

We are considering whether the local NHS should continue to fund IVF, and if so, how many embryo transfers we should fund. We are thinking about reducing the number of embryo transfers women have but keeping the other criteria the same.

This could mean:

<table>
<thead>
<tr>
<th>For women aged 23-39</th>
<th>For women aged 40-41</th>
<th>Estimated saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding three embryo transfers (what we do at the moment)</td>
<td>Funding one embryo transfer (what we do at the moment)</td>
<td>No saving (Doing this would cost us approximately £1.88m a year)</td>
</tr>
<tr>
<td>Funding two embryo transfers</td>
<td>Stop funding IVF</td>
<td>£298,249 a year</td>
</tr>
<tr>
<td>Funding one embryo transfer</td>
<td>Stop funding IVF</td>
<td>£1.07 million a year</td>
</tr>
<tr>
<td>Stop funding IVF</td>
<td>Stop funding IVF</td>
<td>£1.88 million a year</td>
</tr>
</tbody>
</table>

**IVF eligibility**

To be eligible for NHS-funded IVF locally:

- The woman must not be too over- or underweight (her BMI should be between 19 and 30) before treatment can begin.
- Women must be non-smokers and continue to be non-smokers throughout treatment.
- Couples cannot already have a child together
- Single applicants cannot already have a child.

Read our IVF policy:

- www.barkingdagenhamccg.nhs.uk/spending-wisely
- www.haveringccg.nhs.uk/spending-wisely
- www.redbridgeccg.nhs.uk/spending-wisely
If we did decide to stop funding IVF, aside from exceptional cases only those people already receiving IVF or who were about to have treatment would get NHS IVF treatment. Local people would need to pay for their IVF treatment privately if they wanted to and were able to afford it.

Stopping NHS funding for IVF treatment does not mean stopping all NHS fertility treatment. People experiencing fertility problems could still see their GP, who would be able to refer them for further investigation and other medical or surgical treatments, as appropriate. This would still be funded by the NHS.

We estimate that in a year around 800 women have IVF treatment paid for by the local NHS at an approximate cost of £1.88 million.

### Note

#### Exceptional cases

Whatever decision is made, we intend to continue to fund IVF for the following people:

- Patients undergoing cancer treatment or who have a disease or condition requiring medical or surgical treatment that has a significant likelihood of making them infertile.
- Couples where the male partner has a chronic viral infection such as HIV that could be transmitted to the female partner and potentially any unborn child.
Male and female sterilisation

We are considering if the local NHS should continue to fund male and female sterilisation.

Sterilisation is surgery so a person is permanently not able to have children. There are different forms of sterilisation for men and women.

For men this is a vasectomy. This works by stopping sperm from getting into a man’s semen. It means that when a man ejaculates, the semen has no sperm.

Female sterilisation is sometimes known as ‘having your tubes tied’. This is surgery to block the fallopian tubes to prevent the woman’s eggs from reaching sperm and becoming fertilised.

A sterilisation operation is difficult to reverse and so you should only be sterilised if you are certain that you do not want to have any (or any more) children.

If we made this change, we would instead encourage women to have a long-acting reversible contraceptive (LARC), such as an IUD (intrauterine device), or ‘the coil’. These work for up to ten years, so once they are in place, you don’t have to think about it. If implanted correctly in a woman, LARCs are more than 99% effective. There are no LARCs for men.

*We estimate that in a year around 70 women undergo a sterilisation procedure paid for by the local NHS at an approximate cost of £79,000.*

*We estimate that in a year around 200 men have a vasectomy paid for by the local NHS at an approximate cost of £87,000.*
NHS prescribing

We have identified a number of areas of NHS prescribing where we think we should make changes. This is because they do not have a demonstrable health benefit and/or they cost the NHS a lot to prescribe (particularly when you take into account the GP consultation time as well).

These are:

- Gluten-free food prescriptions
- Dental prescribing
- Over the counter prescribing
- Soya-based formula milk for babies and small children
- Travel vaccinations.

We have explained our thinking about these in the following pages.

Gluten-free food prescriptions

We are proposing to stop prescribing gluten-free products.

The NHS began providing gluten-free foods on prescription to patients with coeliac disease (a common autoimmune digestive condition caused by an adverse reaction to gluten, which is found in wheat, barley and rye) because gluten-free food was hard to find and was often very expensive.

Fortunately this is no longer the case and all major supermarkets and many other retailers, commonly stock gluten-free foods as well as other special diet alternatives, at a reasonable price.

People can eat a healthy, balanced, gluten-free diet without the need for any specialist dietary foods at all, because other naturally gluten-free foods such as rice and potatoes are widely and cheaply available.

Improved food labelling now means people are able to see whether ordinary food products are free from gluten and can be safely eaten.

We estimate that in a year 13,900 prescriptions are issued by local GPs for gluten-free food at an approximate cost of £210,000.
Dental prescribing

We are proposing that GPs don't prescribe medicines for dental conditions.

Prescribed medicines can be part of many dental treatment plans, for example fluoride toothpaste/mouthwashes, teething gel and treatments for dry mouth.

People can buy most dental products over the counter, without the need for a prescription.

Dentists can and should prescribe medicines for dental conditions, where appropriate. Involving GPs in prescribing medicines for dental conditions is usually unnecessary, and uses valuable appointments and GPs' time.

If this change were to go ahead, GPs would still be able to prescribe dental products where it was an important part of the care they were providing for a patient.

*We estimate that in a year over 20,000 prescriptions are issued by local GPs for dental products at an approximate cost of £96,000.*
Over the counter prescribing

At the moment many people visit their GP to get prescriptions for medication that can be cheaply and easily bought on the high street. This is often quite expensive for the NHS, especially when taking into account the cost of GP appointment times and pharmacist fees.

We are proposing that GPs should no longer issue prescriptions for the treatments listed in the table below.

<table>
<thead>
<tr>
<th>Type of medication</th>
<th>Why we want to stop funding this</th>
<th>Cost of product on the high street</th>
<th>Number of prescriptions issued last year</th>
<th>How much these prescriptions cost the local NHS last year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head lice and scabies medication</td>
<td>Treatments for head lice and scabies can be bought from a pharmacy, who can advise how to use them.</td>
<td>Tesco Head Lice Treatment, 100ml, £4.25 (Tesco online)</td>
<td>2,981 prescriptions</td>
<td>£38,500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hedrin Once Spray Gel (for head lice), 60ml, £5.99 (Boots online)</td>
<td></td>
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<tr>
<td>Rubefacient creams and gels such as ‘Deep Heat’ and ‘Tiger Balm’</td>
<td>These are used to treat minor aches and pains of the muscles but there is limited evidence about how well these creams and gels work. Evidence does not support the use of these in acute or chronic musculoskeletal pain or to treat osteoarthritis.</td>
<td>Deep Heat – Heat Rub, 42g, £2.49</td>
<td>11,463 prescriptions</td>
<td>£68,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tiger Balm Ointment, 19g, £4.39 (Boots online)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of medication</td>
<td>Why we want to stop funding this</td>
<td>Cost of product on the high street</td>
<td>Number of prescriptions issued last year</td>
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<tr>
<td>Omega-3 and other fish oil supplements</td>
<td>NICE does not recommend the routine prescribing of fish oil supplements to prevent heart disease. If people want to take these, they are widely available at reasonable cost at supermarkets, pharmacies and other retailers.</td>
<td>Boots Omega 3 Fish Oil 300mg, 30 capsules, £0.99 (Boots online) Tesco Cod Liver Oil 1000mg, 30 capsules, £1.50 (Tesco online) Seven Seas Simply Timeless Cod Liver Oil One-a-Day, 60 capsules, £5.79 (Boots online)</td>
<td>2,774 prescriptions</td>
<td>£86,000</td>
</tr>
<tr>
<td>Multivitamin supplements</td>
<td>Vitamins should be obtained through food rather than pills. If people want to take supplements to support a balanced diet, they are widely available at reasonable cost at supermarkets, pharmacies and other retailers.</td>
<td>Tesco Everyday Value Multivitamins, 30 tablets, £0.50 (Tesco online) Boots Multivitamins, 30 tablets, £0.99 (Boots online) Boots Multivitamin with Probiotics, 30 capsules, £3.49 (Boots online)</td>
<td>30,612 prescriptions</td>
<td>£168,000</td>
</tr>
<tr>
<td>Eye vitamin supplements</td>
<td>There is no evidence that eye vitamin supplements are beneficial for eye health. They are classed as food supplements and not licenced medicines. They are widely available at reasonable cost at supermarkets, pharmacies and other retailers.</td>
<td>Boots Vision Aid, 30 tablets, £7.19 (Boots online)</td>
<td>7,683 prescriptions</td>
<td>£66,000</td>
</tr>
<tr>
<td>Type of medication</td>
<td>Why we want to stop funding this</td>
<td>Cost of product on the high street</td>
<td>Number of prescriptions issued last year</td>
<td>How much these prescriptions cost the local NHS last year</td>
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</tbody>
</table>
| Colic remedies for babies | Colic eventually improves on its own, so medical treatment isn't usually recommended. There isn't much evidence that these treatments actually work, although some parents find them helpful. They are classed as food supplements and not licenced medicines. They are widely available at reasonable cost at supermarkets, pharmacies and other retailers. | Boots Gripe Water 1 month plus, 150ml, £2.49 (Boots online)  
Woodwards Gripe Water, 150ml £3.59 (Boots online)  
Dentinox Infant Colic Drops, 100ml, £2.50 (Tesco online)  
Infacol, 50ml, £3.19 (Boots online) | 1,644 prescriptions | £11,000 |
| Cough and cold remedies  | Coughs and colds usually improve on their own and have no long-term harmful effect on a person's health. They are widely available at reasonable cost at supermarkets, pharmacies and other retailers. | Tesco Mentholated Bronchial Balsam, 200ml, £1.20 (Tesco online)  
Boots pharmaceutical cough syrup 3 months plus 100ml, £2.29 (Boots online)  
ASDA cold relief capsules (16) £0.60 | 17,919 prescriptions | £28,500 |
<table>
<thead>
<tr>
<th>Type of medication</th>
<th>Why we want to stop funding this</th>
<th>Cost of product on the high street</th>
<th>Number of prescriptions issued last year</th>
<th>How much these prescriptions cost the local NHS last year</th>
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</thead>
</table>
| Painkillers such as paracetamol and ibuprofen          | Painkillers like paracetamol and ibuprofen can help treat pain and reduce a high temperature (fever). They are typically used to relieve mild or moderate pain, such as headaches, toothache or sprains, and reduce fevers caused by illnesses such as colds and flu. These symptoms usually improve on their own and have no long-term harmful effect on a person's health. They are widely available at low cost at supermarkets, pharmacies and other retailers. | Value Health Paracetamol 500mg, 16 tablets, £0.20 (Boots online)  
Value Health Ibuprofen 200mg, 16 tablets, £0.35 (Boots online) | 15,275 prescriptions                                                                                   | £19,000                                    |

We estimate that in a year around 90,000 prescriptions are issued for the medicines listed above costing the local NHS approximately £485,000.

**Note**

If you are a patient who needs these painkillers like paracetamol and ibuprofen in regular large quantities for long-term pain, don't worry – you would continue to get them on repeat prescription.

We also intend to continue to prescribe these painkillers for children when needed.
Soya-based formula milk for babies and small children

We are proposing that GPs should no longer prescribe soya-based formula milk. Where possible, we want to encourage women to breastfeed, as this is the safest, most nutritionally beneficial form of feeding for most babies.

Historically it was difficult to buy alternative formula such as soya-based formula. This is no longer the case and soya-based formula is available at most major pharmacies, supermarkets and online. The cost is similar to standard infant formula.

We estimate that in a year around 500 prescriptions for soya-based formula milk are issued costing the local NHS approximately £13,500.

Note

We think that GPs should continue to prescribe suitable specialised hypoallergenic formula milk for children with confirmed milk intolerance or conditions such as: cow's milk protein allergy (CMPA), faltering growth, premature birth, and specific medical conditions such as renal or liver disease.

Travel vaccinations

We are proposing that the NHS should no longer fund some travel vaccinations.

You don't always need vaccinations to travel abroad. If you do, the recommended vaccinations will vary, depending on a range of factors, such as:

- which country you're visiting and, in some cases, which part of the country
- the season or time of year when you'll be travelling (for example, the rainy season)
- whether you'll be staying in a rural area, or an urban or developed area
- what you'll be doing during your stay, such as working in or visiting rural areas
- how long you'll be staying
- your age and health.

Some vaccinations are currently free on the NHS because they protect against diseases which are considered to be the greatest risk to public health if they were brought into the country. We think these diseases (in the list below) should continue to be free on the NHS:

- Cholera
- Diphtheria, polio and tetanus booster
- Hepatitis A
- Typhoid.
There are a number of other travel vaccinations for the diseases listed below which we are proposing people should pay for:

- Hepatitis A and B combined
- Hepatitis B
- Meningococcal meningitis
- Japanese encephalitis
- Rabies
- Tick-borne encephalitis
- Tuberculosis
- Yellow fever.

We think travellers should include the cost of vaccines for these in their holiday budgeting, just like they have to include the cost of flights, accommodation and insurance.

*We estimate that in a year 9,054 prescriptions are issued for the travel vaccinations listed above, costing the local NHS approximately £206,000.*

### Potential savings from changes to NHS prescribing

<table>
<thead>
<tr>
<th>Prescribing area</th>
<th>Potential savings identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gluten-free food prescriptions</td>
<td>£210,000</td>
</tr>
<tr>
<td>Dental prescribing</td>
<td>£96,000</td>
</tr>
<tr>
<td>Over the counter prescribing</td>
<td>£485,000</td>
</tr>
<tr>
<td>Soya-based formula milk for babies and small children</td>
<td>£13,500</td>
</tr>
<tr>
<td>Travel vaccinations</td>
<td>£206,000</td>
</tr>
</tbody>
</table>

*If they were all implemented, these changes could save the local NHS approximately £1.01 million a year.*
Cosmetic procedures

We are proposing that the local NHS no longer funds certain cosmetic procedures.

We don’t think that the NHS should pay for surgery or treatment that is needed only for cosmetic reasons (to improve someone’s appearance). At the moment the NHS doesn’t do this very often, but it does pay for some of these kinds of procedures if the patient meets some other specific criteria.

We are now proposing that we stop funding these procedures altogether except in exceptional circumstances, like the patient has suffered from major trauma, cancer or severe burns (when an individual funding request application would have to be made).

What is an individual funding request?

An individual funding request can be made for a treatment that is not routinely offered by the NHS if the doctor believes that their patient is clearly different to other patients with the same condition or where their patient might significantly benefit from the treatment in a different way to an average patient with the same condition.

This is known as “clinical exceptionality” and evidence must be provided about why the patient should have this treatment, which is considered by a panel of clinicians who decide if funding should be granted.

We have listed the procedures we are proposing should no longer be funded by the local NHS in the table on the following pages.
## Cosmetic procedures we propose should no longer be funded by the NHS

<table>
<thead>
<tr>
<th>Name of procedure</th>
<th>What does it involve?</th>
<th>When does the NHS fund this procedure at the moment?</th>
<th>What change is being proposed?</th>
<th>Number of procedures funded by the local NHS in the last three years</th>
<th>Average cost per procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery to the outside of the ear</td>
<td>Surgery to change the size or shape of the ears, or pin them back if they stick out.</td>
<td>For children aged 5-18 with very significant ear deformity or asymmetry</td>
<td>The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved.</td>
<td>61 procedures</td>
<td>£1,433</td>
</tr>
<tr>
<td>Facelift or browlift (Rhytidectomy)</td>
<td>Surgery to lift up and pull back the skin to make the face tighter and smoother.</td>
<td>When a person's skin droops so they could have difficulty seeing</td>
<td>The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved.</td>
<td>171 procedures</td>
<td>£1,075</td>
</tr>
</tbody>
</table>
| Surgical removal of moles, scars, cysts and birthmarks (lesions on and under the skin) | Surgical removal of moles, scars, cysts, and birthmarks. | • If the lesion is regularly damaged and becomes infected, meaning two or more courses of antibiotics are needed in a year  
  • If the lesion is obstructing an orifice or making it hard for the person to see  
  • If the lesion is making it hard for the person to move their limbs more than 20 degrees | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. | Five procedures                                                             | £1,999                      |
<table>
<thead>
<tr>
<th>Name of procedure</th>
<th>What does it involve?</th>
<th>When does the NHS fund this procedure at the moment?</th>
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<th>Number of procedures funded by the local NHS in the last three years</th>
<th>Average cost per procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical removal of vascular lesions</td>
<td>Surgical removal of lesions such as spider veins, broken veins and port wine stains.</td>
<td>Only when there is evidence of significant facial disfigurement.</td>
<td>The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved.</td>
<td>3,440 procedures</td>
<td>£711</td>
</tr>
</tbody>
</table>
| Hair removal | Long term removal of excessive hair growth in certain areas of the body. | • When reconstructive surgery means that the patient has skin with hair in an area (not covered by normal clothing) that normally would not have hair.  
• When a person is having treatment for pilonidal sinuses, a small hole or 'tunnel' in the skin, usually in the cleft of the buttocks at the top of the bottom area, which is thought to be caused by loose hair piercing the skin.  
The NHS funds a maximum of six hair removal treatments. | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. | Five procedures/courses of treatment | £1,132 |
<table>
<thead>
<tr>
<th>Name of procedure</th>
<th>What does it involve?</th>
<th>When does the NHS fund this procedure at the moment?</th>
<th>What change is being proposed?</th>
<th>Number of procedures funded by the local NHS in the last three years</th>
<th>Average cost per procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast enlargement (Augmentation mammoplasty)</td>
<td>Surgery to increase the size of breasts. This usually involves breast implants.</td>
<td>When one breast is two or more cup sizes smaller than the other.</td>
<td>The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. See note 1 at the end of this table.</td>
<td>20 procedures</td>
<td>£2,455</td>
</tr>
<tr>
<td>Revising breast enlargement (Breast augmentation revision)</td>
<td>Redoing a breast enlargement</td>
<td>When:</td>
<td>The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. See note 2 at the end of this table.</td>
<td>39 procedures</td>
<td>£2,220</td>
</tr>
<tr>
<td>Name of procedure</td>
<td>What does it involve?</td>
<td>When does the NHS fund this procedure at the moment?</td>
<td>What change is being proposed?</td>
<td>Number of procedures funded by the local NHS in the last three years</td>
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</tbody>
</table>
| Breast reduction  | Reducing the size of breasts | • When a woman has cup size H breasts or larger and  
• The surgery should result in a reduction of at least three cup sizes/500 grams in each breast and  
• The patient’s BMI has been below 27kg/m2 for at least 24 months and  
• They can show that they have suffered from at least two of the following conditions for at least 12 months:  
  • Neck pain  
  • Upper back pain  
  • Shoulder pain  
  • Curvature of the spine (x-ray evidence needed)  
  • Pain or discomfort from bra straps cutting into shoulders and  
  • They can prove pain persists after a six month trial of non-surgical measures such as a properly fitted bra, painkillers and physical therapy and  
  • There is significant musculoskeletal pain or the symptoms make it hard to go about everyday life and the doctor thinks surgery will fix this. | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. | 91 procedures | £2,288 |
<table>
<thead>
<tr>
<th>Name of procedure</th>
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<th>Average cost per procedure</th>
</tr>
</thead>
</table>
| Surgery for ‘man boobs’ (Gynaecomastia) | Surgery to remove male breast tissue | • When it is clear the condition is not as a result of drug use (e.g. steroids and growth hormone)  
• the man has had the condition for at least 18 months  
• has a BMI of less than 27kg/m2  
• a surgeon has confirmed that the condition is severe (significant breast enlargement with loose, drooping skin)  
• surgery would remove more than 100 grams of tissue from each side  
• the man is aged 25 or over. | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. | 13 procedures | £2,831 |
<table>
<thead>
<tr>
<th>Name of procedure</th>
<th>What does it involve?</th>
<th>When does the NHS fund this procedure at the moment?</th>
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<th>Average cost per procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery to reduce excessive sweating</td>
<td>Surgery to cut the nerves in an attempt to reduce excessive sweating. (This surgery carries a risk of serious complications, is not always successful and can sometimes make sweating worse.)</td>
<td>When the person has significant sweating in a particular area and has undergone treatment supervised by a GP without success, and all of the following non-surgical treatments have been tried without success: • Treatment for anxiety (if a factor) • Dermatologist-prescribed skin cream • Drugs prescribed to block the effect of the nerves that stimulate the sweat glands • treating affected areas of skin with a weak electric current which is thought to help block the sweat glands • Botox injections in the armpit.</td>
<td>The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved.</td>
<td>46 procedures</td>
<td>£868</td>
</tr>
<tr>
<td>Name of procedure</td>
<td>What does it involve?</td>
<td>When does the NHS fund this procedure at the moment?</td>
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</tr>
<tr>
<td>Tummy tuck surgery</td>
<td>Surgery to make the abdomen thinner and more firm by removing excess skin and fat.</td>
<td>The person must have a stable BMI of less than 27kg/m² for at least 24 months and have had weight loss surgery at least 24 months ago (if applicable) and be suffering from associated health problems due to excess skin such as: • severe difficulties performing everyday tasks and proof that surgery will resolve this • proof that excess skin is causing infections that require four or more courses of antibiotics in 24 months of being at a stable weight • Where overhanging skin makes it impossible to care for a stoma.</td>
<td>The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved.</td>
<td>11 procedures</td>
<td>£3,006</td>
</tr>
<tr>
<td>Name of procedure</td>
<td>What does it involve?</td>
<td>When does the NHS fund this procedure at the moment?</td>
<td>What change is being proposed?</td>
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<tr>
<td>Trigger finger surgery</td>
<td>A condition that affects one or more of the hand's tendons, making it difficult to bend that finger or thumb.</td>
<td>Only if the patient doesn’t respond to non-invasive treatment and doesn’t respond to at least one corticosteroid injection or can’t fully straighten their finger or thumb or is allergic to corticosteroid injection.</td>
<td>The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved.</td>
<td>399 procedures</td>
<td>£1,041</td>
</tr>
<tr>
<td>Scrotum swellings (Varicocele)</td>
<td>Non-cancerous swellings in the scrotum caused by swollen and enlarged veins.</td>
<td>Only if a man experiences continuing discomfort despite management of the problem.</td>
<td>The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved.</td>
<td>30 procedures</td>
<td>£1,064</td>
</tr>
<tr>
<td>Name of procedure</td>
<td>What does it involve?</td>
<td>When does the NHS fund this procedure at the moment?</td>
<td>What change is being proposed?</td>
<td>Number of procedures funded by the local NHS in the last three years</td>
<td>Average cost per procedure</td>
</tr>
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</tr>
<tr>
<td>Labiaplasty</td>
<td>A procedure for altering the labia (the folds of skin that surround the vulva)</td>
<td>Only when a woman is born with malformed labia.</td>
<td>The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. See note 3 at the end of this table.</td>
<td>30 procedures</td>
<td>£1,574</td>
</tr>
</tbody>
</table>
| Surgery for varicose veins | Varicose veins are swollen and enlarged veins – usually blue or dark purple – on the legs. They may also be lumpy, bulging or twisted in appearance. | Only after:  
- discomfort continues despite six months of non-surgical management such as exercise and keeping the legs up  
- lower leg skin changes such as eczema thought to be caused by veins not working properly  
- blood clots in veins  
- a venous leg ulcer (that has healed, or has not healed within two weeks) | The NHS would no longer fund this treatment except in exceptional circumstances, when an individual funding request application should be made outlining why this is an exceptional case. This is not guaranteed to be approved. | 1,017 procedures | £1,257 |

*If all these procedures were no longer funded, this could save the local NHS up to approximately £1.93 million a year (depending on the number of cases with exceptional circumstances).*
Notes

1. Breast enlargement
We intend to continue to fund this procedure for women who have suffered from cancer.

2. Revising breast enlargement
We intend to continue to fund this procedure for women who have suffered from cancer.

3. Labiaplasty
This is not treatment for female genital mutilation (FGM). Treatment for FGM involves opening up the vagina and is known as deinfibulation. We currently fund this treatment and we intend to continue to fund it.
Weight loss surgery

We are proposing to tighten up who can have NHS-funded weight loss surgery (also called bariatric surgery).

We want to introduce new eligibility criteria, which would mean the local NHS would only fund weight loss surgery if a person:

- has a Body Mass Index (BMI) of 35 or above, which means they are defined as obese (very overweight with a lot of body fat)
  
  and

- has type 2 diabetes

The reason for this is that this group of people are more likely to develop complex health conditions if they don’t have the surgery and they are also most likely to benefit from surgery.

We estimate that in a year just over 50 people have weight loss surgery which is funded by the NHS, at a cost of approximately £370,000.

If we only funded surgery for patients who met these new eligibility criteria, around 18 people a year would have weight loss surgery funded by the local NHS, at a cost of approximately £123,000.

*Introducing new eligibility criteria for weight loss surgery could save the local NHS approximately £247,000 a year.*
How we are engaging with local people

We know that if we carry out the proposals in this document some people’s lives could be significantly affected.

We want to hear from as many people as possible so we can make the best possible decision. We are providing the opportunity for everyone to have their say.

We are also working with GPs, patient groups, local Healthwatch organisations and community and voluntary organisations to make sure we reach as many local people as possible. If you would like us to come and talk to your group about these proposals please get in touch.

No decisions have been made.

Over the next eight weeks (until 18 May 2017) we are engaging with local people in order to explain our financial position and the reasons for developing these proposals, outline how people might be affected and encourage them to respond.

All responses will form a report, which will go to our governing bodies to consider and make a decision. We will put that report and details of whatever decisions are made on our websites:

  www.barkingdagenhamccg.nhs.uk/spending-wisely
  www.haveringccg.nhs.uk/spending-wisely
  www.redbridgeccg.nhs.uk/spending-wisely

We want to know what you think.

- How might these proposals affect you or your family?
- How could we limit the effects of these proposals?
- Could we do things differently?
- Are there are any exemptions we should consider?
- Are there any circumstances where these proposed changes should not apply?

Please fill out our questionnaire by 5pm on 18 May 2017.
Impact on people’s mental health

Mental health is often a factor in patients seeking cosmetic treatment or surgery. There are no universally accepted and objective measures of psychological distress, so it is difficult to include such factors when setting clinical thresholds for agreeing when a particular treatment is effective or needed.

Couples facing infertility are also more likely to have various mental health concerns, such as increased anxiety, depression, and mood disorders. Having IVF can be extremely stressful, particularly when it is not successful.

We believe it is generally better to provide support, such as therapy, to treat the mental health need, but if a clinician thought there were exceptional mental health reasons why a patient needed treatment, they could apply through the individual funding request process explaining why this is an exceptional case. This is not guaranteed to be approved.

Mental health support: Talking Therapies

Talking Therapies is a free and confidential NHS service that provides support from an expert team who understand what people are going through, and who work with people to help them feel better. The highly professional team will introduce people to effective, practical techniques specific to their needs that are proven to work. The national programme is based on evidence and all the tools and techniques used are recommended by local GPs.

The programme has already helped thousands of local people to feel better.

To find out more: www.mytalkingtherapies.org.uk or call 0300 300 1554

Equality impact assessment

An equality impact assessment (EIA) is a process to make sure that a policy, project or proposal does not discriminate or disadvantage against the following characteristics:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

As part of this work, we will carry out an initial EIA and publish a draft on our websites. We will take into account people’s responses to our proposals and this will inform a more detailed final EIA, which will go to our governing bodies to consider before any decision is made about these proposals.
Questionnaire

Please complete this questionnaire on our website:

www.barkingdagenhamccg.nhs.uk/spending-wisely
www.haveringccg.nhs.uk/spending-wisely
www.redbridgeccg.nhs.uk/spending-wisely

Or you can fill it in and post it to FREEPOST BHR CCGs (no stamp needed). Please make sure we receive your response before 5pm on 18 May 2017.

Tell us about you

We want to see what sorts of people are responding to our proposals. This helps us to understand if our proposals might have more of an impact on some groups of people than others. These questions are optional – you don't have to answer them if you don't want to.

Please tick as appropriate

1. Are you?
   - Male
   - Female
   - Other
   - Prefer not to say

2. How old are you?
   - Under 18 years
   - 18 to 24 years
   - 25 to 34 years
   - 35 to 44 years
   - 45 to 54 years
   - 55 to 64 years
   - 65 to 74 years
   - 75 years or older
   - Prefer not to say

3. Do you consider yourself to have a disability?
   - Yes
   - No

4. Which borough do you live in?
   - Barking and Dagenham
   - Havering
   - Redbridge
   - Other (please tell us which borough)

5. What is your ethnicity?
   This is not about place of birth or citizenship. It is about the group you think you belong to in terms of culture, nationality or race.
   - Any white background
   - Any mixed ethnic background
   - Any Asian background
   - Any black background
   - Any other ethnic group (please tell us what it is)
   - Prefer not to say

6. Are you responding as:
   (choose as many as apply)
   - A local resident
   - A representative of an organisation or group (please tell us which)
   - A clinician, commissioner or other healthcare professional
   - Someone who would be personally affected by these proposals
   - Other (please tell us why)
What do you think about our proposals?

We want to understand your views on possible changes in these five different areas of healthcare:

- In-vitro fertilisation (IVF)
- Male and female sterilisation
- NHS prescribing
- Cosmetic procedures
- Weight loss surgery

We also want to know what you think about what we’re proposing to do more generally.

You don’t have to answer the whole questionnaire if you don’t want to.

---

IVF

We are proposing to reduce the number of IVF embryo transfers we fund.

1. How many IVF embryo transfers do you think we should fund for eligible women aged 23-39?
   - [ ] No change to the existing service (fund three IVF embryo transfers)
   - [ ] Fund two embryo transfers
   - [ ] Fund one embryo transfer
   - [ ] Do not fund IVF

2. How many IVF embryo transfers do you think we should fund for eligible women aged 40-41?
   - [ ] No change to the existing service (fund one embryo transfer)
   - [ ] Do not fund IVF

3. Is there anything else you want to tell us, or think we should consider, before making a decision about funding IVF?
Male and female sterilisation

We are proposing that the local NHS should stop funding male and female sterilisation.

4. Please tell us what you think by ticking the statement that best matches your views:

<table>
<thead>
<tr>
<th>Statement</th>
<th>I strongly support this proposal</th>
<th>I support this proposal</th>
<th>I am neutral about this proposal</th>
<th>I am against this proposal</th>
<th>I am strongly against this proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td>The local NHS should stop funding male sterilisation (vasectomy)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The local NHS should stop funding female sterilisation</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Is there anything else you want to tell us, or think we should consider, before making a decision about sterilisation?
NHS prescribing

There are a number of areas of local NHS prescribing where we think we should make changes. This is because these products do not have a demonstrable health benefit and are quite expensive for the NHS, when you take into account GP appointment times and pharmacist dispensing fees.

**Gluten-free prescribing**

**We are proposing to stop prescribing gluten-free products.**

The NHS began providing gluten-free foods on prescription to patients with coeliac disease because gluten-free food was hard to find and was often very expensive.

Fortunately this is no longer the case and all major supermarkets and many other retailers, commonly stock gluten-free foods as well as other special diet alternatives, at a reasonable price.

6. Please tell us what you think by ticking the statement that best matches your views:

<table>
<thead>
<tr>
<th>I strongly support this proposal</th>
<th>I support this proposal</th>
<th>I am neutral about this proposal</th>
<th>I am against this proposal</th>
<th>I am strongly against this proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td>The local NHS should stop prescribing gluten-free products.</td>
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</tbody>
</table>

7. Is there anything else you want to tell us, or think we should consider, before making a decision about gluten-free prescribing?
Dental prescribing

We are proposing that GPs don’t prescribe medicines for dental conditions.

Involving GPs in prescribing medicines for dental conditions is usually unnecessary, and uses valuable appointments and GPs’ time. Dentists can and should prescribe acute and repeat medicines for dental conditions, where appropriate. They can also suggest that a patient can buy a product without needing a prescription.

8. Please tell us what you think by ticking the statement that best matches your views:

<table>
<thead>
<tr>
<th>The local NHS should stop prescribing medicines for dental conditions</th>
<th>I strongly support this proposal</th>
<th>I support this proposal</th>
<th>I am neutral about this proposal</th>
<th>I am against this proposal</th>
<th>I am strongly against this proposal</th>
</tr>
</thead>
</table>

9. Is there anything else you want to tell us, or think we should consider, before making a decision about prescribing for dental conditions?

Over the counter prescribing

There are a number of treatments that we propose GPs should no longer issue prescriptions for.

At the moment many people visit their GP to get prescriptions for medication that can be cheaply bought over the counter from a pharmacy or supermarket. This is often expensive for the NHS, especially when GP appointment time and pharmacist dispensing fees are taken into account.
10. Please tell us what you think about our proposal to no longer prescribe certain types of medication by ticking the statement that best matches your views for each:

<table>
<thead>
<tr>
<th>Medication Type</th>
<th>I strongly support this proposal</th>
<th>I support this proposal</th>
<th>I am neutral about this proposal</th>
<th>I am against this proposal</th>
<th>I am strongly against this proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head lice medication (for nits and scabies)</td>
<td></td>
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<tr>
<td>Rubefacient creams and gels such as ‘Deep Heat’ and ‘Tiger Balm’</td>
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<td></td>
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<tr>
<td>Omega-3 and other fish oil supplements</td>
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<tr>
<td>Multivitamin supplements</td>
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<tr>
<td>Eye vitamin supplements</td>
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<tr>
<td>Colic treatments for babies</td>
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<tr>
<td>Cough and cold remedies</td>
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<tr>
<td>Painkillers such as paracetamol and ibuprofen</td>
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</tbody>
</table>

11. Is there anything else you want to tell us, or think we should consider, before making a decision about prescribing certain types of medication?
Soya-based formula milk for babies and small children

We are proposing that GPs should no longer prescribe soya-based formula milk.

Formula should only be prescribed by the NHS where there is a medical need. In the past it was difficult to buy alternative infant formula for babies. This is no longer the case and soya-based formula is available at most major pharmacies and supermarkets and online. The cost is similar to standard infant formula.

12. Please tell us what you think by ticking the statement that best matches your views:

<table>
<thead>
<tr>
<th>The local NHS should stop prescribing soya-based formula milk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I strongly support this proposal</strong></td>
</tr>
</tbody>
</table>

13. Is there anything else you want to tell us, or think we should consider, before making a decision about stopping prescribing soya-based formula milk?
Travel vaccinations

We are proposing that the NHS should no longer fund some travel vaccinations.

We think that travellers should include the cost of vaccinations in their holiday budgeting, just like they have to include the cost of flights, accommodation and insurance.

14. Please tell us what you think by ticking the box that best matches your views:

<table>
<thead>
<tr>
<th>I strongly support this proposal</th>
<th>I support this proposal</th>
<th>I am neutral about this proposal</th>
<th>I am against this proposal</th>
<th>I am strongly against this proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td>The local NHS should stop paying for some travel vaccinations</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

15. Is there anything else you want to tell us, or think we should consider, before making a decision about stopping funding some travel vaccinations?

Cosmetic procedures

We don’t think that the NHS should pay for surgery or treatment that is needed only for cosmetic reasons (this means to improve someone’s appearance). Locally the NHS does not do this very often, but it does pay for some of these kinds of procedures if the patient meets some other specific criteria. This means it doesn’t happen very often.

We are proposing that we stop funding these altogether unless there are exceptional circumstances. This might be that the patient has suffered major trauma, cancer or severe burns.
16. Please tell us what you think about our proposal to no longer fund the cosmetic procedures we’ve identified by ticking the statement that best matches your views for each:

<table>
<thead>
<tr>
<th>The local NHS should stop funding:</th>
<th>I strongly support this proposal</th>
<th>I support this proposal</th>
<th>I am neutral about this proposal</th>
<th>I am against this proposal</th>
<th>I am strongly against this proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery to the outside of the ear</td>
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<tr>
<td>Facelift/browlift</td>
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<tr>
<td>Removal of skin and under the skin lesions</td>
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<tr>
<td>Vascular lesions</td>
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<tr>
<td>Hair removal</td>
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<tr>
<td>Breast enlargement</td>
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<tr>
<td>Redoing breast enlargement</td>
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<tr>
<td>Breast reduction</td>
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<tr>
<td>Surgery for ‘man boobs’</td>
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<tr>
<td>Surgery for excessive sweating</td>
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<tr>
<td>Tummy tuck</td>
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<tr>
<td>Trigger finger</td>
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<tr>
<td>Swelling in the testicles</td>
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<tr>
<td>Surgery to alter the labia</td>
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<tr>
<td>Varicose vein surgery</td>
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</tbody>
</table>
17. Is there anything else you want to tell us, or think we should consider, before making a decision about stopping funding cosmetic procedures except in exceptional circumstances?

18. Please tell us what you think about our proposal by ticking the statement that best matches your views:

<table>
<thead>
<tr>
<th>I strongly support this proposal</th>
<th>I support this proposal</th>
<th>I am neutral about this proposal</th>
<th>I am against this proposal</th>
<th>I am strongly against this proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Weight loss surgery</strong></td>
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<tr>
<td>We are proposing to allow only people with a BMI of 35 or over and type 2 diabetes to receive NHS-funded weight loss surgery.</td>
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<tr>
<td>19. Is there anything else you want to tell us, or think we should consider, before making a decision about introducing criteria for weight loss surgery?</td>
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</tbody>
</table>
**General comments**

20. If we made these changes, would you be affected by any of them? Please tell us which.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>IVF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterilisation</td>
<td></td>
<td></td>
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<tr>
<td>Gluten-free food prescriptions</td>
<td></td>
<td></td>
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<tr>
<td>Dental prescriptions</td>
<td></td>
<td></td>
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<tr>
<td>Over the counter prescriptions</td>
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<td></td>
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<tr>
<td>Soya-based formula milk prescriptions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel vaccinations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cosmetic procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight loss surgery</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

21. Is there anything you would like to tell us about the impact it might have on you?


22. Do you have any other comments about our proposals that you’d like to make?

23. Are there any other services or treatments you think the NHS should stop funding? If so, please tell us what they are.

24. Do you have any suggestions about how the local NHS can save money?
25. If you would like us to tell you what decisions we reach regarding these proposals, please write your name and email address in the box below. We will keep your details safe and won't share them.

Thank you for taking the time to let us know what you think.

If you’re not completing this questionnaire online, please make sure you send it back to FREEPOST BHR CCGs.

All comments must be received by 5pm on 18 May 2017.
<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominoplasty</td>
<td>Tummy tuck surgery</td>
</tr>
<tr>
<td>Acute</td>
<td>In need of urgent care</td>
</tr>
<tr>
<td>Augmentation mammoplasty</td>
<td>Breast enlargement</td>
</tr>
<tr>
<td>Autoimmune disease</td>
<td>This refers to problems with the way the immune system reacts to things</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td>Weight loss surgery</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index - a measure of body fat based on height and weight that applies to adult men and women</td>
</tr>
<tr>
<td>Carbohydrate</td>
<td>Starchy foods such as potatoes, bread, rice, pasta and cereals</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical commissioning group</td>
</tr>
<tr>
<td>Chronic</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Coeliac</td>
<td>Relating to the abdomen (stomach)</td>
</tr>
<tr>
<td>Colic</td>
<td>Excessive, frequent crying in a baby who appears to be otherwise healthy</td>
</tr>
<tr>
<td>Congenital</td>
<td>A condition existing at or before birth</td>
</tr>
<tr>
<td>Continuing healthcare</td>
<td>A package of care that is arranged and funded solely by the NHS for people who are not in hospital and have been assessed as having a ‘primary health need'</td>
</tr>
<tr>
<td>Corticosteroid</td>
<td>Medicine used to reduce inflammation and suppress the immune system</td>
</tr>
<tr>
<td>Eligible</td>
<td>Whether someone qualifies. In this case, the minimum criteria to access a procedure</td>
</tr>
<tr>
<td>Exceptional circumstances</td>
<td>A patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients, with the same medical condition and at the same stage of progression as the patient.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
</tr>
<tr>
<td>Gluten</td>
<td>A protein found in wheat, rye and barley</td>
</tr>
<tr>
<td>Gynaecomastia</td>
<td>A common condition that causes boys’ and men’s breasts to swell and become larger than normal</td>
</tr>
<tr>
<td>Hyperhidrosis</td>
<td>A condition in which a person sweats excessively</td>
</tr>
<tr>
<td>Individual Funding</td>
<td>A request received from a provider or a patient with clear support from a clinician, which seeks funding for a single identified patient for a specific treatment.</td>
</tr>
<tr>
<td>IVF</td>
<td>In-vitro fertilisation</td>
</tr>
<tr>
<td>Labia</td>
<td>The folds of skin that surround the vulva</td>
</tr>
<tr>
<td>Labiaplasty</td>
<td>A procedure for altering the labia</td>
</tr>
<tr>
<td>Lesions</td>
<td>An area of abnormal tissue change</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>The nerves, tendons, muscles and supporting structures, such as the discs in your back</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
</tr>
<tr>
<td>Omega-3</td>
<td>A type of fatty acids that are good for you</td>
</tr>
<tr>
<td>Orifice</td>
<td>An opening in the body such as a nostril or the anus</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>Pharmacists receive a professional fee for every item dispensed. This fee is currently 90p per item.</td>
</tr>
<tr>
<td>dispensing fee</td>
<td></td>
</tr>
<tr>
<td>Recurrent</td>
<td>Occurring often or repeatedly</td>
</tr>
<tr>
<td>Rubefacient</td>
<td>Cream or gel used to treat minor aches and muscle pains</td>
</tr>
<tr>
<td>Rhytidectomy</td>
<td>Facelift or browlift</td>
</tr>
<tr>
<td>Scabies</td>
<td>A contagious skin condition caused by tiny mites that burrow into the skin</td>
</tr>
<tr>
<td>Stoma</td>
<td>An opening on the surface of the stomach surgically created to divert the flow of faeces or urine</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Subcutaneous</td>
<td>Under the skin</td>
</tr>
<tr>
<td>Varicocoele</td>
<td>Non-harmful swellings within the scrotum caused by swollen and enlarged veins</td>
</tr>
<tr>
<td>Vascular</td>
<td>Relating to blood vessels</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>Procedure to sterilise a man, where the tubes that carry sperm from a man's testicles to the penis are cut, blocked or sealed.</td>
</tr>
<tr>
<td>Venous</td>
<td>Relating to the veins</td>
</tr>
</tbody>
</table>
This document is about changes we want to make to some health services in Barking and Dagenham, Havering and Redbridge. We want to know what you think about this.

If you would like to know more, please email haveyoursay.bhr@nhs.net or call 020 3688 1615 and tell us what help you need. Let us know if you need this in large print, easy read or a different format or language.