Notice of Meeting

HEALTH AND ADULT SERVICES SELECT COMMITTEE

Tuesday, 19 July 2016 - 7:00 pm
Committee Room 2, 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

Date of publication: 11 July 2016

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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 9 June 2016 (Pages 3 - 8)

4. Update on the Recommendations of the Eye Care Scrutiny Review (Pages 9 - 12)

5. Report on the Brookside Young People’s Mental Health Unit (Pages 13 - 16)

6. Update Report on the Sustainability and Transformation Plan and the Accountable Care Organisation Devolution Pilot (Pages 17 - 26)

7. Work Programme 2016-17 Report (Pages 27 - 44)

8. Any other public items which the Chair decides are urgent
9. 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.

10. Any other confidential or exempt items which the Chair decides are urgent
Our Vision for Barking and Dagenham

One borough; one community; London’s growth opportunity

Encouraging civic pride

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

Enabling social responsibility

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

Growing the borough

- Build high quality homes and a sustainable community
- Develop a local, skilled workforce and improve employment opportunities
- Support investment in housing, leisure, the creative industries and public spaces to enhance our environment
- Work with London partners to deliver homes and jobs across our growth hubs
- Enhance the borough’s image to attract investment and business growth
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1. Declaration of Members' Interests

There were no declarations of interest.

2. Minutes - To confirm as correct the minutes of the meeting held on 13 April 2016

The minutes of the meeting held on 13 April 2016 were confirmed as correct.

3. Referral to treatment issues in Barking, Havering And Redbridge University Hospitals NHS trust

The Health and Adult Services Select Committee (HASSC) noted that on 26 April 2016 the Health and Wellbeing Board (HWB) received a report on concerns regarding Barking, Havering and Redbridge University Hospitals Trust's (BHRUT) waiting times for planned surgery and outpatient treatment (referral to treatment times) for patients across the three boroughs. At the meeting the HWB expressed grave concerns at the scale of the issue, having noted that BHRUT revealed in its March 2016 Board papers that it had a large number of patients waiting more than 52 weeks on the elective referral to treatment pathway. The Chair of the HWB, Councillor Maureen Worby, suggested that the HASSC consider the issue of the referral to treatment times (RTT) for further investigation as a matter of priority, which is why this HASSC meeting had been arranged.

Matthew Hopkins, the Trust's Chief Executive, delivered a presentation on the Trust's RTT performance which covered:

- The Trust's approach
- Frame – strategic context
- Diagnosis – key issues
- Options review – review of actions
- Summary of the additional activity required
- Prioritisation – chosen approach
- Demand management measures
- Delivery – leadership and resource
- Delivery – risk management
- Governance – management and assurance
- RTT Update.
Councillor Chand expressed disappointment that the borough's residents were suffering again as a result of the Trust's poor performance and asked who within the Trust was responsible for the lack of oversight of RTT performance. Mr Hopkins stated that he started in his position of Chief Executive of the Trust in April 2014 when the Trust was about to stop reporting its RTT data due to a lack of confidence in it. Some members of staff felt that the problems in the robustness of the data were down to the Trust starting to operate a new computer system in December 2013 but others were saying that there were problems even before this. An investigation was launched which found that the cause of the problems with the data was a lack of proper oversight from Board to ward level which meant that his predecessor did not receive the correct RTT data. Patients and GPs were complaining about RTT but as an organisation, the Trust had lost its grip on RTT and did not act fast enough which lead to a substantial number of people waiting longer than 18 weeks to start treatment, the standard set by the NHS Constitution.

Councillor Chand referred to Mr Hopkins' presentation which cited 'demand management' measures to reduce RTT by putting in place pathways to refer certain patients to physiotherapy, for example, rather than more intensive treatment. He stated that he had had a knee operation a few months ago which he felt had been very successful in alleviating his symptoms. He asked whether, if he was to see his GP about the same problem now, he would simply be referred to physiotherapy, rather than surgery. Mr Hopkins stated demand management meant that each case would be looked at individually and it would be down to the clinical judgement of professionals whether someone was referred to physiotherapy or surgery. Cases would be triaged and furthermore, physiotherapists would know relatively quickly if someone would not benefit from it.

Councillor Worby referred to Mr Hopkins’ statement during his presentation that one of the ways referrals could be dealt with more quickly in future, was that, where appropriate, referrals could be made to GPs with special interests, avoiding the need for the patient to come into hospital. Councillor Worby asked how this would be achievable given that currently there was a significant shortage of GPs in the borough and therefore GPs did not have the time to develop special interests. Sharon Morrow, Chief Operating Officer for the Barking and Dagenham Clinical Commissioning Group (BDCCG) stated that the BDCCG was looking to bring GPs with a special interest into the borough to offer consultation in community clinics; for example, dermatology clinics in Barking Hospital. Mr Hopkins agreed that work could not be pushed out to other services that were facing capacity issues themselves. The Trust was aware of this which is why it was working extremely hard to clear backlogs.

Councillor Zanitchkhah asked how the Trust's RTT performance would affect its next Care Quality Commission (CQC) inspection outcome and, why the CQC had not picked up that there were problems with the Trust's RTT performance when it last inspected the Trust. Mr Hopkins stated that as mentioned, due to a lack of oversight, the data being compiled was inaccurate which meant that the CQC would not have been given the correct data at the time and therefore, would not have picked up that there was a RTT issue. The Trust was now providing the CQC with regular updates on waiting times. The CQC would not, at its next inspection of the Trust, expect it to start meeting the 18 week standard straight away but it would be looking to see that the Trust was being open and transparent and had a thorough plan in place to make the required improvements as fast as possible.
Councillor Zanitchkhah asked whether the Trust had deliberately provided inaccurate data to the CQC. Mr Hopkins stated that this had been investigated and whilst there was no evidence to suggest that any member of staff had intentionally fabricated data, the data was full of errors because of the way the numbers were recorded and added up.

Councillor Zanitchkhah asked what assurances Mr Hopkins could give that the Trust would not have RTT problems in future, after the current crisis was resolved. Mr Hopkins stated that the Trust was working with a company with expertise in managing these types of problems, which had identified that the Trust should improve in four specific areas, and the Trust was currently implementing these which would lead to a strong foundation for ensuring good RTT oversight in future. The company would retest the Trust’s data after these areas were fully implemented and once it was verified, only then would the Trust start reporting its data again. He would expect this Committee to hold the Trust accountable for the robustness of its RTT data going forward.

Councillor Jones asked how the public could have confidence in the data the Trust held for other performance areas. Mr Hopkins stated that the Trust had sought independent assurance on many of its performance measures, such as the four hour A&E waiting data, infection control data and cancer waiting times. The Trust’s commissioner, Barking and Dagenham, Havering and Redbridge (BHR) CCGs would also keep oversight of the Trust’s data across a range of performance areas.

Councillor Jones stated that Mr Hopkins had stated during his presentation that many patients were reluctant to take up the option of having their treatment carried out by another provider. She asked whether the Trust was being absolutely clear with patients about their options, and whether the Trust had a conflict of interest when it came to informing patients that they could go elsewhere. Mr Hopkins stated that some patients had taken the offer up and some had not. The organisations that were supporting the Trust had helped it script the conversation that the Trust was having with patients. However, he felt he needed to re-emphasise with staff the need to be absolutely clear. Some patients who were referred to alternative providers were ‘returned’ without treatment because of other illnesses they had. He did not feel that there was a conflict of interest as alternative providers would be paid at the same rate as the Trust and the Trust was not able to provide treatment to people immediately.

Councillor Jones referred to an issue brief the Trust had published in March 2016 provided at Appendix 1 of the report and highlighted that it made no mention of the options available to patients in terms of treatment by alternative providers. Mr Hopkins stated that he acknowledged this and would ask for this to be rectified.

Councillor Chand stated that he worked with people with learning disabilities, a vulnerable group, who often did not present themselves to health services until it was too late. He asked how the Trust was targeting people with learning disabilities who were on the waiting list. Mr Hopkins stated that clinical assessment and priority of treatment processes would help to ensure people with highest need took priority. The Trust employed learning disability nurses which would assist this process. He added that he would be taking this point away to ensure that the Trust was doing all it could for vulnerable groups like this as well as those with mental health problems.
In response to a question, Mr Hopkins stated that one of the causes of RTT problems was the lack of staff. The Trust was addressing this at the moment and was investing considerably in recruiting extra staff, including 19 consultant posts. Last year the vacancy rate had been reduced from 13 percent to 10 percent, which suggested that the tide was turning, although the Trust could do more to recruit more local people, as opposed to people from overseas.

Councillor Zanitchkhah asked, given that the population of the borough was set to increase, what would the Trust do around its estates to ensure it would have the right capacity moving forward. Mr Hopkins stated that the statement during the presentation that the Trust would need to undertake approximately 5000 operations and 90000 Outpatient appointments over the next 18 months, took into account the expected population growth rate. The Trust had plans to build theatres at King George Hospital. Furthermore, as well as having the right estates, as the Trust worked through its RTT issues, it would embed a system that would encourage consultants and other staff to take ownership of their waiting lists so that early warnings and steps could be put in place to ensure RTT were manageable.

Councillor Shaukat asked how long it would take for the Trust to resolve its RTT issues. Mr Hopkins stated that the Trust had already seen a massive reduction in number of patients waiting for a year and was set to achieve the standard for 90 percent of those waiting by April 2017. The Trust aimed to start reporting RTT data in autumn 2016.

Councillor Worby asked currently, how many people in total were waiting more than 18 weeks, to which Mr Hopkins replied 12 000, and stated that he would ensure the Committee was provided the specific figure for Barking and Dagenham.

Councillor Shaukat asked how the Trust had come to the view that no one waiting had been harmed. Mr Hopkins stated that a harm review had been done and a small number of people were identified to have suffered serious harm and cataract implications. The Trust did not have an accurate way to determine what level of psychological harm, or harm from taking painkillers for a long time, may have occurred. Patients attending appointments now would be reviewed by their Consultant who would assess the level of harm.

Councillor Zanitchkhah stated that whilst Mr Hopkins had discussed the recruitment of more consultants, no mention had been made of recruiting nurses and she felt that they would be crucial to ensuring the right level of care was being provided. Mr Hopkins stated that the greatest recruitment need was for doctors in Outpatients; however, the Trust would be spending £32 million in investing staff and a significant proportion of this would be spent on recruiting more nurses. Furthermore, these members of staff would be in post permanently as opposed to just until the RTT issues were resolved.

Councillor Jones asked what proportion of those waiting had life threatening conditions. Mr Hopkins stated that patients would have been triaged and urgent or A&E referrals would have been made for those with life threatening conditions. For example, people with suspected cancer were not included in RTT. If whilst waiting for their appointment, a person’s condition becomes life threatening, their GP would need to make an urgent referral.
In response to a question, Mr Hopkins stated that the number of people coming in via the two week cancer referral pathway had increased substantially recently. GPs were referring more patients, and the Trust was seeing most of these within two weeks. The Trust had to do more to achieve the target for the percentage of cancer patients waiting a maximum of two months from urgent GP referral to treatment.

Cllr Jones referred to one of her constituents who had been waiting for weeks for a CT scan report and Mr Hopkins asked that he send her the details of the case so that he could raise queries internally.

In response to comments, Mr Hopkins agreed that staff attitude and culture within the Trust would also have a part to play in ensuring waiting times were reasonable in future. The group of staff who scheduled Outpatient appointments, now had the voice to notify seniors when appointments could not be booked quick enough.

Councillor Worby asked why it took the intervention of NHS Improvement for the Trust to tackle its RTT issues in a transparent way. Ms Morrow stated that last summer the BHR and Waltham Forest CCGs decided to award a contract to run the North East London Treatment Centre to BHRUT. However, the current provider put in a complaint about the tender process which led to a lengthy investigation process by NHS Improvement. The CCGs had recently given undertakings to NHS Improvement as part of the conclusion of the investigation to abandon the procurement and extend the contract to operate the Centre with the current provider, Care UK. Members noted that a key question in the investigation was whether selecting the Trust to operate the treatment centre was consistent with the local CCGs’ obligations to act in the interests of patients in line with regulations and, that the CCGs rescinded their decision because they arrived at a better understanding of the challenges that BHRUT faced as part of the investigation.

Returning back to the issue of the Trust’s RTT performance, Councillor Worby stated that she found it shocking that NHS England simply accepted in 2014 that the Trust would stop reporting its RTT data. She stated that she felt the Trust ‘got away’ with this scandal because the local population did not complain. She believed that the Trust only took real action after a number of private providers had raised questions around their ability to provide treatment to people who were on BHRUT’s waiting list with the Prime Minister. Mr Hopkins stated that the Trust did act as soon as it became aware of the actual number of people waiting for treatment; last year it offered 30 000 more outpatient appointments than the previous year to help reduce the number of people waiting. He acknowledged that the Trust had not done enough to share its action plan with all key local partners but emphasised that this was not because it wished to hide its problems.

Councillor Shaukat asked for more detail as to why the Trust stopped reporting the Trust RTT data in the first place. Mr Hopkins stated that the Trust was meant to measure RTT from the point of GP referral to the point of the start of the treatment, but what the Trust was measuring in reality was, for example, the time from referral to diagnostic appointments, with months passing before treatment was started, and several entries being made for one person, which lead to inaccuracy in the data and ultimately, a lack of confidence in the data held by the Trust. The Trust had now reviewed each referral and knew what its actual RTT performance
Councillor Chand thanked Mr Hopkins for attending and stated that members would consider the information received today and Mr Hopkins would be notified of the recommendations the HASSC wished to make to the Trust in relation to RTT.

4. Joint Health Overview & Scrutiny Committee

The HASSC noted a report providing information on the arrangements for joint health scrutiny across Barking and Dagenham, Havering, Redbridge and Waltham Forest and agreed to appoint Councillors Chand, Zanitchkhah and Jones to the Joint Overview and Health Scrutiny Committee for 2016/17.
In 2014/15 the Health and Adult Services Select Committee (HASSC) conducted an in-depth review of local eye care services and the final report was presented to the Health and Wellbeing Board in October 2015. The reason for commissioning the review was a concern that the people may be experiencing difficulties in obtaining care and therefore missing treatment that could otherwise prevent serious sight loss.

The key findings of the review was that:

- The current arrangements [for eye care] seemed complex and difficult for patients to understand;
- It was not clear that everyone who should have a sight test was getting one; and
- It was not clear to that the pathway fully promoted choice and control by service users.

The Health and Wellbeing Board agreed to oversee a review of the eye care pathway and this paper provides on how the recommendations have been taken forward and what changes have been put in place or are planned.

Recommendation(s)

The Committee is asked to note this update report.

1.0 Purpose of the Report

1.1 The purpose of the report is to provide an update to the Committee on the actions taken in response to the recommendations of the HASSC’s review of local eye care services.

2.0 Background/Introduction

2.1 Eye care services are commissioned by the CCG (secondary and tertiary care ophthalmology services), NHS England (community optometry and diabetes retinopathy services) and Public Health (school nursing services). The CCG’s commissioning action has focused on introducing service change and innovation through its current main contracts. This approach has potential to identify resource that can be redeployed for additional pathway improvements.
2.2 The Health and Adult Services Select Committee undertook an in-depth scrutiny review into local eye care services in 2014/15. The final report was presented to the Health and Wellbeing Board on 20 October 2015.

2.3 The findings of the review led to a number of recommendations being made to the Health and Wellbeing Board. Having considered the review and its recommendations, the Board agreed to:

(i) Oversee a review by the Barking and Dagenham Clinical Commissioning Group (CCG) of the local eye care pathway, given that:

- The current arrangements seemed complex and difficult for patients to understand;
- It was not clear that everyone who should have a sight test was getting one; and
- It was not clear to the HASSC that the pathway currently fully promoted choice and control by service users;

(ii) Oversee a review by the CCG, which would consider the clinical benefits of community optometrists (high street opticians) being able to refer patients directly to hospital eye clinics and other services, rather than having to do this via GPs;

(iii) Ask the CCG to consider the benefits of commissioning an ‘Eye Care Liaison Officer’ for local residents, to ensure that people with newly acquired sight loss were provided with support at the point of diagnosis and were signposted to appropriate services;

(iv) Ask the CCG to consider whether cost-effective improvements could be made to local low vision services;

(v) Oversee a local communication campaign, to be undertaken by the Council’s Public Health Team, which would emphasise the importance of having regular eye tests, whilst also delivering other important eye care messages as part of the future programme of public health campaigns;

(vi) Consider what options could be used to ‘make every contact’ count and introduced a scheme or schemes to encourage and possibly incentivise parents to arrange an eye test for their child prior to starting school;

3.0 Update on CCG actions

3.1 The CCG was asked to review the eye care pathway and consider the clinical benefits of community optometrists (high street opticians) being able to refer patients directly to hospital eye clinics.

3.2 The CCG initiated a joint procurement for a community eye service in September 2015 with Redbridge CCG. The procurement sought to commission a community-based service for the management of minor eye conditions (such as blepharitis, dry or watering eyes and eyelash problems) as well as suspected cataracts and the treatment and/or management of glaucoma.
3.3 Direct referral by optometrists to the community-hospital eye clinics was included in
the service specification, which was designed to streamline the referral process.
The potential opportunity for this change was confirmed at a pre-procurement
meeting attended by the Local Optical Committee and other providers.

3.4 The procurement process was concluded in March 2016 and did not result in the
CCG awarding a contract.

3.5 The ophthalmology pathway review is now being taken forward in the context of the
referral to treatment time (RTT) programme across the BHR CCGs and BHRUT.
This programme has been established to ensure delivery of the NHS constitutional
target for waiting time performance in response to long waiting times for some
specialities provided by Barking Havering and Redbridge University Hospitals NHS
Trust (BHRUT). Ophthalmology has been identified as one of the top ten specialities
where further work around RTT and sustainability is required.

3.6 Each CCG is leading on three pathway reviews. Havering is leading on the
ophthalmology review on behalf of the Barking & Dagenham and Redbridge CCG’s.
Havering CCG and BHRUT Clinical Leads have started to work jointly on the
glaucoma pathway redesign, with the support of designated clinical directors and
clinical leads. Glaucoma has been agreed as the priority area as this provides a
substantial amount of ophthalmology activity at BHRUT, and delays in treatment
could have an impact on patient outcomes.

3.7 A clinical review of the review of the current glaucoma pathway has identified
improvements to the glaucoma pathway, this includes provision of glaucoma referral
refinement, and monitoring of stable glaucoma patients with community services.
This will be implemented by December 2016, to increases the capacity of
secondary care for patients with complex glaucoma.

A project group has been established to oversee the delivery of the new pathway.
The Ophthalmology Glaucoma pathway has been based on the following evidence

- Report of the Health & Adult Services Select Committee – Local Eye care
  services In depth Scrutiny Review 2014/15
- UK Vision Strategy case for change
- Commissioning Guide: Glaucoma (recommendation (June 2016), The royal
  College of Ophthalmologists

The pathway will also allow for direct referrals from optometrists, as is the case in
other areas, and discussions have begun with the Local Optical Committee agree
how to take this forward.

3.8 The CCG was asked to consider the benefits of commissioning an ‘Eye Care
Liaison Officer’ for local residents. This service is provided through some secondary
care providers (e.g. Barts Health) commissioned by the CCG and used by Barking
and Dagenham patients. Further consideration is required to determine whether this
is a service that BHRUT could provide within existing financial resources. It is
expected that this will be taken forward in wider discussions regarding the redesign and sustainability of local ophthalmology services.

3.9 The CCG was asked to consider whether cost-effective improvements could be made to local low vision service which operates out of both King George’s and Queen’s hospitals. This service supports the delivery of low vision assessments for residents of Barking and Dagenham who still experience sight problems after having an eye test and wearing the right contact lenses or glasses.

The service offers a two-stage assessment of visual need where the service user will see both a low vision therapist and an optometrist. At the end of the assessment they may be issued with a low vision aid that best meets their need and provided with the support/training on how to use the aid. The service user may also be offered advice about using magnification, task lighting, contrast and managing glare.

The opportunity to review and potentially extend this service can be included as part of the CCGs pathway review of ophthalmology.

4.0 Update on LBBD actions

4.1 A local communication campaign has been designed and developed in partnership between the Vision Strategy Group, LBBD communications team and public health. A campaign is due to be run in conjunction with eye health week – 19 -15 September 2016. The campaign will emphasise the importance of having regular eye tests, whilst also delivering other important eye care messages.

4.2 Eye tests for pupils are a requirement as part of the school nursing contract.

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<tr>
<th>Activity Indicators</th>
<th>Threshold</th>
<th>Method of measurement</th>
<th>Reporting frequency</th>
<th>Consequence of breach</th>
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<tbody>
<tr>
<td>Routine health reviews: Year 1 vision test</td>
<td>95%</td>
<td>% children at Year 1 Health Review with Vision Test completed</td>
<td>Per term end</td>
<td>Improvement plan to be agreed with Commissioners</td>
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Author: Sab Jenner, Strategic Delivery Project Manager, BHR CCG’s
Date: July 2016
HEALTH AND ADULT SERVICES SELECT COMMITTEE
19 July 2016

Title: Update regarding Brookside Young People’s Mental Health Unit

Report of the North East London Foundation Trust (NELFT)

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<th>Open Report</th>
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<tr>
<td>Report Author: Melody Williams, Integrated Care Director NELFT</td>
<td>Contact Details: Tel: 0300 555 1201 65067 E-mail: <a href="mailto:melody.williams@nelft.nhs.uk">melody.williams@nelft.nhs.uk</a></td>
</tr>
<tr>
<td>Accountable Divisional Director: Melody Williams</td>
<td></td>
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<tr>
<td>Accountable Director: Jacqui Van Rossum</td>
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Summary:
The NELFT Brookside Inpatient Unit for the north east London area is commissioned by NHS England. Located in Redbridge (Barley Lane) it provides mental health inpatient care (commonly referred to as Tier 4 services) for 13 -17 year olds. The vast majority of patients are from the surrounding London Boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest; however beds are also available through a national allocation system to support a nationwide access to inpatient beds for this age group. This can result in many patients being from areas far beyond those of the neighbouring boroughs. A Trust decision to temporarily close the Unit was taken on the 25 April 2016.

This report is to provide the Health and Adult Services Select Committee (HASSC) with an update on progress since the closure and an outline of plans for re-opening and transformation of care for children and young people with the most severe mental health needs.

Recommendation(s)
The Committee is recommended to note the progress made to date and the actions for commissioners.

1. Introduction and Background

1.1 Staffing and environmental concerns were identified by the clinical team, these have been risk assessed and a Trust decision was taken to temporarily close the Unit to support remedial actions to be undertaken in a swift manner that would not be possible should the Unit remain open. The decision to temporarily close the Unit was supported by the CQC and was communicated to the commissioners; NHS England and key partner agencies as soon as the decision was taken. This included the Local Authority, the CCG, Healthwatch, LSCB chairs and surrounding acute NHS Trusts and specialist CAMHS providers.
1.2 All current patients were either moved to other inpatient units within the London/Essex areas, or where possible have been supported at home through a revised model of care in their home environment. For Barking and Dagenham this has meant that one young person in the high dependency Unit was transferred to another London based inpatient unit and two day attendance patients are now accessing support, care and education services at home. Each child has an individual care plan and the parents/carers have been fully involved in this process. The young people have also had a definitive say in the best place for their care and for many the option to be supported at home as opposed moving to a new unit has been positively received. All community CAMHS services, who share the care of these children and young people, have also been involved in developing care plans and discharge plans where appropriate.

2. **Action taken to date**

2.1 The Trust has been working with NHS England and the CCG on a recovery action plan and urgent estates modifications have been accelerated. This has included further enhanced modifications to the Unit to enable it to be a safe and welcoming environment. The unit management team have actively recruited a number of staff who are now in the process of appointment which will bring the total substantive establishment to an appropriate operational level.

In addition funding to support the development the extension of the Interact service (available beyond the current operating times of Monday – Friday, 9 - 5pm) has ensured that urgent and crisis response has been achieved through the Vanguard Urgent and Emergency Care work stream.

NELFT have supported the CCG commissioner for CAMHS Transformation for a further funding opportunity to establish a self-harm crisis support function as part of the overall high intensity service offer as these are often the most risky young people who are considered for admission. Further formal notification on the outcome of the bid is awaited.

Those young people who are being treated in the community under a home based, high intensity support programme has been particularly successful with a reduced number of incidents and risk reduction seen in all cases.

3. **Options for future provision**

3.1 Further discussion over future models of care and support has taken place with the commissioners with a view to reopening the Brookside Unit for admissions. This is anticipated to be in Early August dependent on agreement from NHSE Specialist Commissioning. This will also include the repatriation of any young people in other units in conjunction with where they are in their care pathway – this is to ensure that progress in recovery is not interrupted by change in supporting clinicians.

3.2 Clinical evidence supports a different model of care for those young people with emerging personality disorders that often manifest as admissions to CAMHS inpatient units through serious self-harm and risk. This model of care would be an extension of the home treatment team model that has been put in place following the closure of the unit at the end of April 2016.
4. Consultation

4.1 Public consultation will not be required for the enhanced model if commissioned as the original service offer – inpatient unit will still exist. The Commissioners as part of the CAMHS transformation plans are reviewing the total system for CAMHS services so as to provide an offer that is accessible and responsive to needs as opposed based on a historical Tiered model of provision. This was publicised in the ‘Futures in Mind’ document (DH 2015).

5. Financial Implications

None to LBBD, current funding decisions sit with the Local CCG and NHS England.

6. Legal Implications

None identified.

7. Other Implications

7.1 Customer Impact

To date NELFT have received positive feedback from the patients using the young people’s home treatment team which has been in operation since the temporary closure.

- 60% of those asked said they would recommend the service to friends and family.
- 100% found it easy to get care, treatment and support.
- 80% agreed that they had been fully involved in their own care.

The incidents of self-harm have reduced dramatically for this client group. Further analysis on what works and how this service can be further improved will be ongoing, as a new a rapidly developed service in response to the closure of the unit we feel this level of satisfaction is a clear indication of a positive change and there is opportunity to build on this current position.

7.5 Safeguarding Children

Children mental health issues have been at the forefront of service review for some time following a number of reports that have highlighted the poor offer of care, lengthy waiting times, frustration at a lack of local service offer and at the highest end of need many high profile cases of children being placed hundreds of miles away from home due to a lack of appropriate provision. There is clear evidence that the vast majority of mental health problems for adults actually occurred during childhood so the review and transformation of services to provide the most appropriate and timely care is in the interests of safeguarding children and ensuring that they achieve the greatest possible health outcomes as they progress to adulthood.

The dramatic reduction in the number of incidents, including self-harm incidents has demonstrated that the new service model has had a positive impact on safeguarding children at a time of crisis and greatest vulnerability. The future, depending on commissioning decisions will build on this positive change.
7.6 **Health Issues**

It is anticipated the new service model will reduce young people’s length of stay in an acute inpatient unit supporting them through the young people’s home treatment team to reintegrate into their family, education and social setting sooner than would have taken place in the previous model.

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

Futures in Mind (Department of Health 2015)

**List of appendices:**

None.
Title: Update on North East London Sustainability and Transformation Plan and the Accountable Care Organisation Devolution Pilot

Report of the Strategic Director, Service Development and Integration and Deputy Chief Executive

Open Report | For Information
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Report Author: Andrew Hagger
Health and Social Care Integration Manager

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E-mail: andrew.hagger@lbbd.gov.uk

Accountable Divisional Director: Mark Tyson, Commissioning Director, Adults’ Care & Support

Accountable Director: Anne Bristow, Strategic Director, Service Development and Integration and Deputy Chief Executive

Summary:

This report provides an update to the Committee on the development of the north east London Sustainability and Transformation Plan (known as the NEL STP) and the development of the business case for the Barking and Dagenham, Havering and Redbridge (BHR) Accountable Care Organisation (ACO) devolution pilot.

A draft ‘checkpoint’ STP was submitted to NHS England on 30 June 2016, setting out the high level priorities for the STP, with further work to develop the plan before final submission in the winter. Appendix A provides an update on the plan’s development including the draft vision, priorities and enablers which have been identified to support the work of the STP. (This information has been circulated to the eight local authority areas in NEL.)

For Barking & Dagenham, Havering and Redbridge, the detail of the local contribution to the Sustainability & Transformation Plan for north east London will be the propositions developed through the programme to develop a business case for an Accountable Care Organisation.

The Accountable Care Organisation Business Case is part of the local health devolution pilot to tackle the significant health and wellbeing, care and quality and finance challenges that exist across the health and social care system in our area. A strategic outline case is currently being developed which will set out the way forward for the development of an ACO.

A presentation will be made at the meeting providing an update on progress made between the date of the publication of the agenda and the meeting itself.
**Recommendation(s)**

The Health and Adult Services Select Committee (HASSC) is recommended to:

(i) Note and discuss the content of the report, and

(ii) Agree to consider the Accountable Care Organisation business case at its September meeting

**Reason(s)**

The NEL STP Board is developing a plan as stipulated by the NHS England guidance. The plan will reflect the work that has been initiated as part of the local devolution bid approved in December 2015, and which is being taken forward through the local programme to develop a business case for an Accountable Care Organisation.

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### 1 Introduction and Background

1.1 In December 2015 NHS England planning guidance required health and care systems across the country to work together to develop sustainability and transformation plans (STPs) for accelerating the implementation of the NHS Five Year Forward View (5YFV). England has been divided into 44 areas (known as footprints); Barking and Dagenham is part of the north east London footprint. STPs are place-based, five year plans built around the needs of local populations.

1.2 A draft STP was submitted on 30 June to NHS England. Guidance issued on 19 May set out that the draft STP is a ‘checkpoint’ that will form the basis of a local conversation with NHS England in July. Further work will continue beyond this to develop the plan in more detail.

1.3 For Barking & Dagenham, the work to develop the detail underpinning the STP is being taken forward jointly with Havering and Redbridge through the work to develop the business case for an Accountable Care Organisation.

1.4 The issues that any ACO would need to address in order to achieve improved outcomes from health and social care, in the context of a financially sustainable health economy, are reflected in the contributions from Barking & Dagenham, Havering and Redbridge to the NEL STP.

### 2 NEL Sustainability and Transformation Plan

2.1 Appendix A provides an update on the progress towards developing the NEL STP, covering the draft vision, priorities and enablers which have been identified to support the work. This update went to the Health and Wellbeing Board on 14 June 2016.

### 3 BHR Accountable Care Organisation

3.1 On 15 December 2015, the London Health and Care Collaboration Agreement was published by the London Partners (London’s 32 Clinical Commissioning Groups, all 33 LA members of London Councils, the Greater London Authority, NHS England London Region and Public Health England London Region). It set out the overall
commitment of the Partners to the transformation of health and social care through integration and devolution. Alongside it, five pilot projects were announced, one of which was for “Barking & Dagenham, Havering and Redbridge [to] run a pilot to develop an Accountable Care Organisation, where primary and secondary care are more closely integrated and patient pathways are redesigned with a focus on intervening early and managing the chronically ill.”

3.2 The announcement followed the submission of a bid to NHS England London Region for the support to develop a business case, focused on whether the model of an Accountable Care Organisation could deliver the next stage of integrated service delivery across the three boroughs, with the aim of delivering the improvements that are needed in the health of the population, the quality of care they receive, and the efficiency with which it is delivered.

3.3 Accountable Care Organisations are forms of joint health and social care delivery that emerged in the United States in response to the need to improve preventive care, and reduce the costs associated with poorly planned care. They were referenced in the NHS 5-Year Forward View as one of the possible mechanisms for improving joint working across health and social care. In essence, they involve groups of providers taking responsibility for all healthcare for a defined population, under agreements with a commissioner about the sharing of financial risk. It is intended that the health of population, as well as the services that are provided for it, are improved through fully integrated service delivery and an ability to ensure that greater levels of preventive activity are better targeted, both of which should release savings and efficiencies.

3.4 Over the past six months, nine organisations across Barking & Dagenham, Havering and Redbridge (BHR) have worked together to develop a strategic outline case for the development of an Accountable Care Organisation (ACO). Each organisation faces common challenges including a growing population, a rapid increase in demand for services and scarce resources. With this in mind, our system leaders have joined forces to create a single integrated response.

3.5 In BHR, there are significant health and wellbeing, care and quality and finance challenges need to be tackled; we have a diverse, highly mobile and in some cases very deprived population – all with unique health and wellbeing needs. Healthy life expectancy in Redbridge (63.0 years for women, 62.7 years for men) and Barking & Dagenham (55.5 years for women, 61.1 years for men) is far below comparable figures in London (63.8 years for women, 63.4 years for men) and nationally. Patients have often found it challenging to navigate the system and all too often access services in the wrong setting. Our acute trust (BHRUT) is in special measures and has struggled with the rising number of A&E attendances, admissions and referral to treatment time (RTT) pressures – but has demonstrated a real to commitment to working with the system to implement an achievable turnaround plan. All of this together has created a significant financial challenge - in order to continue providing services consistently, if it were to deliver care in the same way that it does today, without achieving any efficiencies, expenditure in 2020/21 is forecast to exceed income by £623 million.

3.6 The first priority is to develop a new integrated health and wellbeing service model for the BHR population; based on the principles of place based care, we are proposing to implement a locality delivery model, complimented by a range of targeted best practice interventions (for example changes to the diabetes and
gastro pathways). Collectively these changes will strengthen the primary, secondary and social care offer in BHR while simultaneously focusing on the importance of prevention and self-care. Multidisciplinary teams involving clinicians and professionals from every part of the system will deliver treatment in homes, care homes, GP surgeries and elsewhere. Carers and patients will find this model easier to navigate, accessible and responsive to their needs. Above all this model will promote personal autonomy, helping the population to access high quality services in the right setting every time.

3.7 The service model is designed to promote wellbeing services which will tackle the root causes of poor physical and mental health, recognising that prevention is critical to helping manage forecast demand over the next five years and beyond. As part of the locality delivery model, community hubs will be set up to support people and families with their employment, education, housing and health needs. These hubs will make the best use of existing community assets across BHR.

3.8 As well as changing the service model there will be to the business model including collaborative productivity, transactional commissioning and rationalisation of the estate footprint with further integration to achieve efficiencies in these areas beyond what is possible on an individual organisational basis. Workforce, technology and estates have been identified as the key enablers which will require investment and development.

4 Governance and timelines

4.1 In governance terms, the development of the business case and the content to contribute to the NEL STP is overseen by the Democratic and Clinical Oversight Group, which has been meeting with a fortnightly frequency to take regular update reports and to shape the emerging propositions. Democratic leadership sitting alongside NHS leaders and clinicians is a key to the partnership. The transformation journey ahead is very challenging and can only be delivered through democratic leadership working to support and champion what needs to be done.

4.2 The Democratic and Clinical Oversight Group is chaired by the Leader of Barking & Dagenham Council, Cllr Darren Rodwell, with the Health & Wellbeing Board Chair, Cllr Maureen Worby as a member, together with non-executives, medical directors and CCG clinical directors. The practical work is overseen on their behalf by the Accountable Care Organisation Executive Group and a Steering Group.

4.3 In mid-June, the product of the various workstreams were brought together into an overall account of how the system will function and a strategic outline case has now been drafted which is due to be considered shortly by the steering group. A joint Democratic and Clinical Oversight Group and ACO Executive meeting on 21 July, will consider the strategic outline case for a formal ratification and a Memorandum of Understanding to set out the governance of the transformation plan for the future. Following this the strategic outline case will be taken through the appropriate statutory governance mechanisms in place for all constituent organisations. In Barking and Dagenham this will involve the paper coming to the HASSC and HWBB in September.
5 Consultation

5.1 The involvement of patients, staff and communities is crucial to the development of the STP as it should be based on the needs of local patients and communities and command the support of clinicians, staff and wider partners. Where possible, the STP will build on existing relationships, particularly through health and wellbeing boards and patient panels and forums.

5.2 In terms of shaping local work, and informing the development both of the NEL STP and the ACO business case, there has been significant activity to bring a range of perspectives and priorities into an emerging overall strategy. These have included:

- Workshops for clinicians to develop the priorities for clinical improvement;
- Local authority workshops that have sought to expand a wider vision for population health improvement and links between health impact, worklessness, welfare and housing;
- Substantial work to ensure a developed locality model that can form the basis for the future operating model for accountable care across Barking & Dagenham, Havering and Redbridge;
- Two voluntary sector workshops to expand the range of voices informing the development of the potential ACO proposition;
- Regular meetings of senior finance representatives of the constituent organisations, facilitated by PwC, in order to ensure that the emerging financial model is robust, both in terms of the challenge and the activities that can close the gap.

5.3 A telephone survey of 1,000 people from each of the three boroughs has been completed and the first cut of the results are being reviewed to see how they shape and refine the vision for local health and social care services. Additionally, a staff survey received 746 responses, by far the highest number of respondents (around a third of the total) being from Barking & Dagenham Council. Again, this is providing useful information to guide thinking about the future model of services.

6 Implications

Joint Strategic Needs Assessment

6.1 A recent public health profile of north east London (March 2016) is being used to help us understand the health and wellbeing, care and quality and the financial challenges locally.

Health and Wellbeing Strategy

6.2 The NEL STP links well with the Barking and Dagenham Health and Wellbeing Strategy 2015-18 which identifies three important stages of life: starting well, living well and aging well. These are included in the draft one page summary at the back of Appendix A. Many of the emerging themes of the STP are covered in B&D HWBB strategy including prevention; care and support; and improvement and integration.
Integration

6.3 The STP will act as an ‘umbrella’ plan for change: holding underneath it a number of different specific local plans to address certain challenges. It will build on existing local transformation programmes and support their implementation. These include the Barking and Dagenham, Havering and Redbridge: devolution pilot (ACO).

List of Appendices:

Appendix A: Delivering the NHS five year forward view: development of the north east London Sustainability and Transformation Plan (briefing note provided by NEL STP Programme Office)
Appendix A

Delivering the NHS five year forward view: development of the north east London Sustainability and Transformation Plan

Closing the gaps: working together to deliver improved health and care for the people of north east London

Update for Health and Wellbeing Boards
2 June 2016

Background

Across north east London, the health and care system - clinical commissioning groups (CCGs), providers and local authorities are working together to produce a Sustainability and Transformation Plan (STP). This will set out how the NHS Five Year Forward View will be delivered: how local health and care services will transform and become sustainable, built around the needs of local people. The plan will describe how north east London (NEL) will:

- meet the health and wellbeing needs of its population
- improve and maintain the consistency and quality of care for our population
- close the financial gap.

The STP will act as an ‘umbrella’ plan for change: holding underneath it a number of different specific local plans, to address certain challenges. Crucially, the NEL STP will be the single application and approval process for transformation funding for 2017/18 onwards. It will build on existing local transformation programmes and support their implementation.

These are:

- Barking and Dagenham, Havering and Redbridge: devolution pilot (accountable care organisation)
- City and Hackney: Hackney devolution in part
- Newham, Tower Hamlets and Waltham Forest: Transforming Services Together programme
- The STP is also supporting the improvement programmes of our local hospitals, which aim to supports Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust out of special measures

Additional guidance was issued on 19 May which sets out further details of the requirements for 30 June. The guidance states that the draft STP will be seen as a ‘checkpoint’ and does not have to be formally signed off prior to submission; it will form the basis of a local conversation with NHS England in July.

Developing the submission

A NEL STP Board and Partnership Steering Group meet regularly and are attended by both health and local authority colleagues. A meeting is scheduled for local authority chief executives and updates are being shared at each health and wellbeing board.

The involvement of patients, staff and communities is crucial to the development of the STP. We want it to be based on the needs of local patients and communities and command the support of clinicians, staff and wider partners. Where possible, we will build on existing relationships, particularly through health and wellbeing boards and patient panels and forums.

In addition, we are taking account of recent public engagement on the transformation programmes outlined above and where relevant the outputs are being fed into the STP process; this will ensure that the views of residents from each local authority area are
incorporated into the draft submission. In addition, a specific session was held for Healthwatch and patient engagement forum chairs to discuss the STP and how they would like to be engaged.

**Barking and Dagenham involvement in the development of the STP**

Barking and Dagenham health and social care colleagues are actively engaged in the development of the STP including Conor Burke (Accountable Officer for Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups) and Mathew Hopkins (Chief Executive, BHRUT), and John Brouder (Chief Executive, NELFT) who are core members of the STP leadership team and members of the STP Board.

- Conor Burke is the senior responsible officer overseeing the development of the urgent care and transformation workstreams
- There is Barking and Dagenham LA, CCG and provider representation in portfolio workshops, system leadership events (held and planned)
- A session was held with Healthwatch and Patient Engagement Forum Chairs
- Face to face meetings have been held with the Mark Tyson, Commissioning Director, Adults’ Care & Support and Andrew Haggar, Health & Social Care Integration Manager

Following Cheryl Coppell’s retirement, Martin Esom (Chief Executive, LB Waltham Forest) is now the Local Authority executive lead supporting the development of the NEL STP.

**Our draft vision and draft priorities**

Throughout May the STP team has been holding a series of meetings and workshops with key stakeholders including providers, on a variety of topics including prevention, workforce, estates, technology and specialised commissioning. Key priorities raised will be included in the June submission.

**Our draft vision**

- To measurably improve health and wellbeing outcomes for the people of north east London and ensure sustainable health and social care services, built around the needs of local people.
- To develop new models of care to achieve better outcomes for all; focussed on prevention and out of hospital care.
- To work in partnership to commission, contract and deliver services efficiently and safely.

**Emerging priorities**

Based on the recent assessment of our health and wellbeing (Public Health Profile of NEL, March 2016), care and quality and the financial challenges we know that in order to create a better future for the NHS, and for local people to live long and healthy lives, we must make significant changes to how local people live, access care, and how care is delivered. Some of our initiatives will be delivered at local level, some at borough level, some across boroughs and others at NEL level.

For NEL the key emerging areas of focus which we think will be key to addressing our health and wellbeing, care and quality and financial challenges are:
Transformation: focussing on prevention and better care to ensure local people can start well, live well and age well. This will include: whole system prevention and early help; urgent care and mental health. We also see community resilience as having an essential part to play: looking at wider determinants of health (e.g. work, housing, education), to make sure residents have an improved quality of life and confidence to embrace a model of self-care in managing their health and care needs.

Productivity: ensuring our providers and local authorities operate in the most effective efficient way possible to deliver value, considering shared opportunities for development.

Infrastructure: considering the best use of our estates across the system.

Specialised services: establishing sustainable specialised services for NEL, both for residents and those accessing services in NEL.

We have identified the following enablers to support our work:

- **Workforce**: recruitment and retention of a high calibre workforce, including making NEL a destination where people want to live and work, ensuring our workforce is effectively equipped to support delivery of new care models, caring for the workforce and reduction in use of bank/agency staff.

- **Communications and engagement**: ensuring stakeholders, including local people, understand and support the need to deliver the Five Year Forward View.

- **Technology**: considering the best use of technology to support and enable people to most effectively manage their own health, care and support, and to ensure a technology infrastructure which supports delivery of new care models.

- **Finance**: access and use of non-recurrent fund to support delivery of the plan, delivering financial sustainability across NEL.

These initial discussions have led us to produce a draft summary of what will be included in the submission (see attached). We welcome the HWBB’s views on the following questions:

- Does the vision capture what we need to achieve?
- Have we identified the right priorities?
- How can we continue to work with you as we develop the STP?

Next steps
A meeting for local authority chief executives will take place in June.

The draft of the submission will be shared with NEL STP Board members for review and comment in the second week of June and the draft ‘checkpoint’ STP will be submitted to NHS England on 30 June. Further work will continue beyond this to develop the plan in more detail and engage with partners on it.

For more information: [www.towerhamletsccg.nhs.uk/nelstp](http://www.towerhamletsccg.nhs.uk/nelstp) or [nel.stp@towerhamletsccg.nhs.uk](mailto:nel.stp@towerhamletsccg.nhs.uk)
## DRAFT One Page Summary

### Vision:
- To measurably improve health and wellbeing outcomes for the people of north east London and ensure sustainable health and social care services, built around the needs of local people.
- To develop new models of care to achieve better outcomes for all, focused on prevention and out of hospital care.
- To work in partnership to commission, contract and deliver services efficiently and safely.

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<tr>
<th>Prevent ill health and improve wellbeing</th>
<th>Better Care</th>
<th>Productivity</th>
<th>Specialised Services</th>
<th>Enablers for change</th>
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<td>High level priorities</td>
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<td>• Reduce prevalence</td>
<td>• Increase independence and deliver better outcomes</td>
<td>• Reduce unit cost</td>
<td>• Optimise specialised services</td>
<td>• Enable transformation and change</td>
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<td>• Deliver wider health benefits</td>
<td>• Reduce bed-base activity to enable growing population</td>
<td>• Implement new ways of delivery within and between providers</td>
<td>• Ensure effective and efficient use for every pound of health &amp; social care</td>
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<td>• Support health &amp; well being strategies of our boroughs</td>
<td>• Transform care pathways to reduce acute demand</td>
<td>• Ensure effective whole pathway with patient at centre</td>
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<td>Core summary</td>
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<td>A. <strong>Starting well</strong> to embed healthy lifestyles from birth onwards</td>
<td>A. <strong>Self-Care</strong> to better manage health conditions and minor ailments</td>
<td>A. <strong>Standardise and consolidate business support services</strong></td>
<td>A. <strong>Realise benefits</strong> of world class cancer and cardiac provision</td>
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<td>B. <strong>Living well</strong> to support prevention – obesity, alcohol, smoking, exercise, mental health</td>
<td>B. <strong>Transform primary care</strong> – coordinated, proactive and accessible</td>
<td>B. <strong>Consolidate clinical support services</strong></td>
<td>B. <strong>Work collaboratively</strong> to manage, commission and deliver specialised services</td>
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<td>C. <strong>Ageing well</strong> to keep older people healthier and independent for longer</td>
<td>C. <strong>Supporting children &amp; young people to live healthy lives</strong></td>
<td>C. <strong>Hospital productivity</strong></td>
<td>C. <strong>Transformati</strong> on programme for specialised services in North East London</td>
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<td>D. <strong>Identify ill health &amp; take early action</strong> e.g. screening programmes, health checks, diabetes prevention</td>
<td>D. <strong>Coordinated and consistent urgent and emergency care</strong></td>
<td>D. <strong>Theatre utilisation</strong></td>
<td>D. <strong>Financ</strong> e including payment methods <strong>to support delivery of system outcomes</strong></td>
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<td>E. <strong>Nurturing a social movement for change</strong> to encourage people to support each other</td>
<td>E. <strong>Reduce admissions</strong> to hospitals and care homes, and improve discharge, re-enablement and supporting independence to keep people at home</td>
<td>E. <strong>Pharmacy &amp; medicines optimisation</strong></td>
<td>E. <strong>New models of care delivery / provider reform</strong></td>
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<td>F. <strong>Wider changes</strong> to improve the lives and prospects of the population – housing, employment</td>
<td>F. <strong>Strong sustainable hospitals</strong></td>
<td>F. <strong>Workforce, tackling bank and agency challenge</strong></td>
<td>F. <strong>Organisational development</strong> to support new delivery models</td>
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<td>G. <strong>Personal responsibility</strong>, all engaged and empowered to take control of their health</td>
<td>G. <strong>Transform patient pathway and outpatients, incl cancer</strong></td>
<td>G. <strong>Capitalise on estates utilisation</strong></td>
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<td>H. <strong>Mental health</strong> strategy for NEL</td>
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<td>H. <strong>Capitalise on our collective buying power</strong></td>
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<td>I. <strong>Learning disability care</strong></td>
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<td>J. <strong>End of life care</strong> to support people to die in the way they wish</td>
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Health and Adult Services Select Committee’s Work Programme 2016/17

Report of Law & Governance

Open report

For decision

Report Author: Masuma Ahmed, Democratic Services Officer, Scrutiny, Law & Governance

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Accountable Divisional Director: Operational Director, Adults’ Care and Support

Accountable Director: Anne Bristow, Service Improvement and Development

Summary:

Each of the Council's scrutiny select committees has a work programme which is a timetable of the matters the Health and Adult Services Select Committee (HASSC) wishes to consider in the current municipal year. A part of the Committee’s work programme usually involves undertaking a Scrutiny Review into an area of interest for members where the select committee may add value and help the Council achieve its vision and priorities. This report explains what a Scrutiny Review entails and provides three options prepared by officers to the HASSC for undertaking an in-depth Scrutiny Review. The report also suggests other areas which may need to be scrutinised at HASSC meetings in 2016/17. The option that is chosen for a Scrutiny Review, together with the other areas for potential scrutiny, constitute the HASSC’s proposed work programme for 2016/17.

The following are appended to this report:
- The Committee’s remit as described in the Council's Constitution
- A chart explaining the Scrutiny Review process
- Three options for undertaking an in-depth scrutiny review for members to choose from.
- A draft Work Programme for the HASSC for 2016/17.

Recommendations

Members are recommended to:

(i) Indicate one which of the three options they would prefer to under-take a Scrutiny Review on and
(ii) Agree the Committee’s Work Programme for 2016/17.
1. Scrutiny Work Programmes

Scrutiny Work Programmes generally consist of two types of scrutiny:

(i) Scrutiny Reviews

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

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

The chart at Appendix B describes the Scrutiny Review process in detail and the role of officers and members throughout.

Appendix C provides overviews to provide an idea of the kinds of issues a scrutiny review would entail for the following topic options:

- Option 1: Cancer survival rates in Barking & Dagenham
- Option 2: Oral Health in People with Learning Difficulties in Barking & Dagenham
- Option 3: Teenage conception rates in Barking & Dagenham

At the meeting, members will be asked to agree one of the topics for an in-depth Scrutiny Review.

(ii) 'One-off' Items

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

As well as evidence sessions to progress the Scrutiny Review, the draft Work Programme at Appendix D lists other areas for one-off scrutiny at HASSC meetings in 2016/17.

Members may also wish to undertake pre-decision scrutiny of issues being determined by the Health and Wellbeing Board or Cabinet, which are listed on their Forward Plans, which can be found on the following link:

Members are asked to state at the meeting if they feel an item on the Forward Plans need pre-decision scrutiny. The Committee as whole will need to discuss whether the item is a priority for HASSC, in light of a busy proposed work programme.

2. **Matters to Consider before deciding items to scrutinise**

When deciding what matters should be scrutinised, it is good practice to reflect upon the following matters:

(i) **The Committee's Remit**

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

(ii) **The 'PAPER' Criteria**

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

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

3. **Next Steps – Scoping the Scrutiny Review**

Scoping is also known as methodology. It refers to the different methods that may be used to gather evidence for a Scrutiny Review and achieve what is set out in its terms of reference, including:

- Desktop-based analysis and research
- Commissioning reports or presentations from council departments, partner organisations, or external bodies to be considered at formal meetings or informal meetings
- Organising themed workshops with stakeholders
- Surveys, site visits, walkabouts, or ‘mystery shopping’ exercises
- Inviting experts, officers, partners, those who are affected by the issue or other relevant persons or organisations to give oral or written evidence to a Select Committee meeting.

Once members have selected a topic, officers will aim to produce a full scoping report that will outline to members the suggested terms of reference, methodology for evidence gathering, and the time-table for producing the Scrutiny Review report with recommendations. This will list which experts the Committee will talk to and what site visits will be undertaken, for example.
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HEALTH AND ADULT SERVICES SELECT COMMITTEE (HASSC)

Scope
The scrutiny of the work of the NHS bodies serving Barking and Dagenham in accordance with the Health and Social Care Act 2001 and associated Regulations and Guidance and the provision, planning, management and performance of services relating to adult social care.

The HASSC’s functions as determined by Assembly:

- Scrutinising any matter relating to the planning, provision and operation of the health service in the borough or accessed by Barking and Dagenham residents.
- Requesting information from NHS bodies and any health service provider. Exempt from this power are requests for information that are confidential (i.e. information that identifies a living person or is prohibited under any enactment) or relate to NHS Trusts in special administration (this function may be carried out by the Joint Health Overview and Scrutiny Committee in accordance with Part 2, Chapter 14, paragraph 2).
- Requesting attendance from any member or employee of a relevant NHS body or health service provider to attend before it to answer any questions; provided those questions do not relate to confidential information or information that they would be entitled to refuse to provide in a court of law. The request for attendance may also be refused if reasonable notice has not been given (this function may be carried out by the Joint Health Overview and Scrutiny Committee in accordance with Part 2, Chapter 14, paragraph 2).
- Acting on behalf of the Council as the statutory consultee where NHS bodies propose substantial developments or variations in the provision of services and thus have a duty to consult with the local authority before taking a decision. When being consulted with, the HASSC must notify the relevant NHS body of its response to the consultation and any intention to refer the matter to the Secretary of State within the timescales agreed by both parties (this function may be carried out by the Joint Health Overview and Scrutiny Committee in accordance with Part 2, Chapter 14, paragraph 2).
- Exercising the Council’s right of referral to the Secretary of State on substantial variations to local health services. The HASSC will have regard to the criteria and process for making a referral to the Secretary of State which are prescribed in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.
- Acting on behalf of the Council to make all arrangements for establishing and participating in joint health overview and scrutiny committees with local authorities that are affected by service re-configurations. Any such joint overview and scrutiny committee shall have such terms of reference, and shall exist for so long as the appointing authorities may agree.
- Receiving referrals from the local Healthwatch on matters relating to the planning, provision, and operation of health services in the borough, acknowledging receipt within five working days. Further to the regulations, Healthwatch can expect a referral to be discussed at the next formal meeting of HASSC, or at a formal meeting within three months (whichever is most timely). In accordance with the regulations the HASSC is obligated to keep the referrer informed of any action taken in relation to the matter.
- Holding to account the Health and Wellbeing Board for the delivery of its functions, and in doing so, having particular regard to the robustness of the Joint Strategic
Appendix A

Needs Assessment and Health and Wellbeing Strategy as effective documents to ensure commissioning of health and social care services is reflective of local need.

- Presenting recommendations arising from scrutiny investigations in accordance with the Council's agreed processes, submitting recommendations to the relevant decision-maker as determined by Council's Scheme of Delegation. Where recommendations or reports are issued to NHS bodies/health service providers, that body or provider must, if requested to do so, respond to the HASSC within 28 days.
- Monitoring progress of implementation of recommendations in accordance with the Council's agreed processes, ensuring that decision-makers have due regard to findings and recommendations arising from scrutiny investigations.
- Representing local people and bringing local concerns and feedback about health and social care services to the attention of leaders within the local health and social care economy, formally advising the Health and Wellbeing Board of any such concerns in the process.
- Monitoring of performance indicators that fall within the remit of the Select Committee.
- Addressing any Call-ins or Councillor Calls for Action as allocated by the Designated Scrutiny Officer. Where the decision called-in is owned by the Health and Wellbeing Board the HASSC will, by default, be the receiving Select Committee of that Call-in regardless of the subject of the decision.
- Considering petitions in accordance with the Council's Petition Scheme

The HASSC's functions as determined by Statute
All the powers of an Overview and Scrutiny Committee as set out in section 9F of the Local Government Act 2000, Local Government and Public Involvement in Health Act 2007 and Social Care Act 2001 (including associated Regulations and Guidance).
# Scrutiny Review Process

## Members’ Roles

- Members prioritise topics according to a number of factors such as issues of local concern, Council priorities and performance.
- Select Committees prioritise reviews to be undertaken.
- Members decide on objectives, outcomes, evidence/witnesses, methodology, visits, consultation, etc, taking account of officer advice.
- Members identify and call for evidence as appropriate.
- Members compile questions for witnesses with officer support if required.
- Members undertake visits.
- Members meet with witnesses and engage users/community groups.
- Members evaluate the evidence received and collated by Officers.
- Members formulate findings and recommendations.
- Members consider the draft report, make amendments as appropriate and approve for referral to the relevant Service and, if necessary, the Cabinet.
- Members decide basis of feedback on review outcomes to stakeholders.
- Implementation of agreed actions arising from the report is the responsibility of the Service Officer.
- Service Officer reports progress on the implementation of the adopted recommendations to the Select Committee.
- Members may choose to undertake further scrutiny if required.

## Officer Roles

- Officers present to members information and evidence performance reports or statistics to inform the process of selection.
- Officers advise members on topic selection having regard to agreed criteria.
- Scrutiny Officer and Service Officer provide advice on how best the topic can be tackled.
- Officers make arrangements for the gathering of evidence, including research, focus groups, liaising with witnesses, etc.
- Officers support Members in compiling questions if required.
- Officers collate the evidence received and support members in formulating their findings and recommendations.
- Based on members’ findings and recommendations, Officers drafts a report for approval by the relevant Select Committee and, where necessary, the Cabinet/ Health & Wellbeing Board.
- Officers support members in considering how to feedback the review outcomes to stakeholders.
- Service Officer ensures that adopted recommendations are actioned.
- Service Officer reports progress to the Select Committee at the appropriate time.

## Stage 1 – Topic Selection

**Criteria for selection:**
- Potential impact for significant section(s) of the population
- Matter of general public concern
- Key deliverable of a strategic and/or partnership plan
- Key performance area where the Council needs to improve
- Legislative requirement
- Corporate priority

## Stage 2 – Scoping the Review

- Rationale and key issues
- Objectives/Terms of Reference
- Relevant corporate priorities
- Indicators of success/outcomes
- Evidence required and methodology
- Key officers involved
- Key stakeholders/expert witnesses
- Consultation
- Publicity
- Risks
- Timescales

## Stage 3 – Gathering Evidence

- Site visits
- Written submissions
- Research
- Experts/witnesses
- Focus groups/workshops
- Consultation

## Stage 4 – Considering Evidence

- Look at the evidence obtained from the different methods used- what are the areas for improvement based on this?

## Stage 5 – Report

- Report to Select Committee for approval
- Recommendations and template implementation plan to the relevant service and, if necessary, the Cabinet/ Health Wellbeing Board for consideration.

## Stage 6 – Implementation & Feedback

- Implementation plan developed by relevant Service Officer
- Recommendations actioned by relevant Officers
- Feedback outcomes to stakeholders/community

## Stage 7 – Monitoring

- Implementation monitored by the Select Committee
- Further investigation/recommendations if dissatisfied
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## Option 1: Cancer Survival Rates in Barking and Dagenham

### Overview

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, Barking and Dagenham has the lowest net survival amongst London and West Essex CCGs, ranking lowest out of 33 CCGs.

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.

1 in every 4 cancers is diagnosed in the Accident and Emergency department. This is a high compared to London and England. Two of the reasons for this are that the population has a poor awareness of cancer symptoms and low attendance for screening:

- Low percentage of B&D residents able to recall a symptom of cancer
- Breast cancer screening coverage and uptake is consistently lower than the England average
- Low bowel screening uptake compared to London boroughs
- There are 352 cancer deaths per 100,000 people each year. This is higher than the England average
- Significantly lower healthy life expectancy

An option for Scrutiny Review is cancer prevention, awareness and early diagnosis in the borough building locally on the work of the Barking, Havering and Redbridge (BHR) Cancer Collaborative Commissioning Group.

### Performance/Evidence

Survival from cancer in B&D compare poorly with the England average. Overall, B&D has the lowest net survival amongst London and West Essex CCGs, ranking lowest out of 33 CCGs.

More than 40% of all cancers are linked to behaviour and environmental exposures which could be avoided or reduced. Factors that contribute to poor outcomes in B&D include poor awareness of the signs and symptoms, and late detection and diagnosis.

“Achieving world-class cancer outcomes: A strategy for England 2015-2020” was published by the Independent Cancer Taskforce in 2015. This identifies six strategic priorities for cancer to be delivered over the next 5 years. The goal nationally is to significantly improve one-year survival to achieve 75% by 2020 for all cancers combined.

As of the end of 2010, around 3,600 people in B&D 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.
B&D has a one year survival rate of 62%, which is below the England average of 68%. Overall, it has the lowest net survival amongst London and West Essex CCGs, ranking 33 (1 highest, 33 lowest).

Latest cancer survival rates for B&D show:-

<table>
<thead>
<tr>
<th></th>
<th>Barking &amp; Dagenham</th>
<th>England</th>
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</thead>
<tbody>
<tr>
<td>All cancers</td>
<td>64.9%</td>
<td>70.2%</td>
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<tr>
<td>Breast</td>
<td>94.1%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Bowel</td>
<td>75.8%</td>
<td>77.7%</td>
</tr>
<tr>
<td>Lung</td>
<td>37.5%</td>
<td>35.4%</td>
</tr>
</tbody>
</table>

(Cancer Research UK, 2013/2014)

This data represents the percentage of patients diagnosed in 2013 who survive their disease by at least one year following diagnosis (followed up in 2014).

The ‘all cancers’ data is for all cancers, except non-melanoma skin cancer and prostate cancer.

1 in every 4 cancers is diagnosed in the Accident and Emergency department. This is a high compared to London and England. Two of the reasons for this are that the population has a poor awareness of cancer symptoms and low attendance for screening:

- Low percentage of B&D residents able to recall a symptom of cancer
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- Significantly lower healthy life expectancy

Cancers diagnosed via A&E generally present at a later stage of the disease which significantly affects one-year survival rates. B&D has a higher rate of cancers diagnosed in A&E than the England average (B&D – 29.2%; England – 20.6%)

Policy and legislation issues


A new approach to delivering transformational change in cancer outcomes will be required to deliver the 2020 ambition of the national cancer strategy. The Health and Adult Services Select Committee has a key role to play in developing a shared vision for transformation and in
engaging with the local population on the prevention and early detection of cancer.

<table>
<thead>
<tr>
<th>Areas of potential enquiry</th>
<th>The Committee is asked to consider a number of areas of activity that contribute to preventing, increasing awareness and improving survival from cancers in Barking and Dagenham.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>It is suggested the Committee begin with an overview of the impact of cancers and an estimate of the costs to both the NHS and adult social care, and the evidence for the effectiveness of cancer prevention, awareness and early diagnosis measures.</td>
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<td></td>
<td>Following from the above, it is suggest that there is an examination of the approach the Council and partners take to improve survival through the following areas:</td>
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<tr>
<td></td>
<td>• The need to improve people’s knowledge around signs and symptoms of cancer</td>
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<td>• The significant negative effect that smoking was having on cancer rates locally and action that might be taken to reduce smoking, including:</td>
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<td>- Partners using their own building / organisations estates and practices to make smoking less acceptable.</td>
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<td></td>
<td>- Looking at providing smoking cessation services in a radical new way.</td>
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<td></td>
<td>- Targeting young smokers in a different way and by empowering them to make healthy lifestyle choices.</td>
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<td></td>
<td>• The potential to coordinate health messages /campaigns, which issues should be targeted jointly and if there needed to be prioritisation to stop information overload.</td>
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<td></td>
<td>• Partners might want to jointly consider community needs and look at the potential to operate direct outreach services to difficult to target groups.</td>
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<tr>
<td></td>
<td>• The impact of improved survival rates on health and social care.</td>
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<td></td>
<td>• How this could be undertaken by supporting radical change through funding and commissioning initiatives.</td>
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</tbody>
</table>
## Overview

Everyone in the UK has a right to access dental care and we all have a part to play in looking after our own teeth. Poor oral health can reduce a person’s ability to consume nutritious food, impact on communication, affect self-confidence and cause significant pain.

Good oral health can, however, be particularly challenging for people with learning disabilities (LD). These challenges include a lower understanding about the importance of good oral hygiene and regular dental checks; diets that are low in nutrition and high in sugar content; the side effects for certain medications; reliance upon carers for support with teeth cleaning; a heightened sense of anxiety about visiting the dentist; issues of competence to make decisions; the lack of awareness on the part of service providers and behaviours that challenge services.

The 2015 JSNS contains a considerable amount of data about what we know about the general health of local people who have a learning disability.

- One person in three people with LD is classed as obese, compared with one in five of the general population.
- The incidence of respiratory disease is three times higher and the leading cause of death for people with LD
- People with LD are 10 times more likely to have a sight or hearing impairment
- People with LD tend to have lower bone density and are more likely to get osteoporosis.
- Epilepsy is 20 times more common
- 26% of people with LD are admitted to hospital each year, compared with 14% of the general population.

We, however, currently have little publically available data about dental problems amongst local residents with LD and the quality of local dental services available to them.

In the Borough we have learned from feedback from family carers about their difficulties in finding local Opticians with the skills and confidence to provide sight tests for people with LD. This learning led to the development of the Bridge to Vision Project and the Enhanced Optometry services for people with LD.

Although we are aware that similar barriers exist when it comes to dental care we do not yet fully understand the details and the magnitude of the problem.

## Performance/Evidence

One in three adults with learning disabilities and four out of five adults with Down’s syndrome has unhealthy teeth and gums (Emerson et al 2011).

There are an estimated 3571 people over the age of 18 in the borough who LD (DoH). This figure is projected to rise to 3804 by 2020. It is projected that the number of borough residents with moderate and severe LD, who are the group most likely to face barriers to good dental health, will rise to 830 by
2020, which is a 19% higher than in 2012.

There is a community dental service in the borough catering for children and adults with learning disabilities, in addition to children and people with complex dental problems.

The service runs from:

- **Vicarage Fields Health Centre**, Vicarage Drive, Barking IG11 7NR
- **Child and Family Centre**, Axe Street, Barking IG11 7LZ
- **Five Elms Health Centre**, Five Elms Road, Dagenham RM9 5TT

All clinics are open from 8:45am to 12.30pm and 1.30pm to 4.45pm.

<table>
<thead>
<tr>
<th>Policy and legislation issues</th>
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<tr>
<td>The Equalities Act 2010 protects disabled people from discrimination and indirect discrimination and places a special duty on the public sector to be proactive in eliminating discrimination. This is relevant because if barriers exist, however, subtle these may be, to people with LD access the dental services that they need, this may constitute unlawful discrimination.</td>
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<tr>
<td>Under the Care Act 2014 the Council is under a duty to promote the wellbeing of disabled people, this includes promoting their physical and mental health. The Council’s social care responsibilities therefore include the provision of support to help disabled people with assessed needs to maintain oral hygiene and access dental care.</td>
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<table>
<thead>
<tr>
<th>Areas of potential enquiry</th>
</tr>
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<tbody>
<tr>
<td>Areas for potential enquiry could include:</td>
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<tr>
<td>- A briefing by Public Health setting out what is known nationally about the dental health of people with LD</td>
</tr>
<tr>
<td>- Expert briefings from Public Health and local dental practitioners about the state of dental health of local people, including those with LD, and take-up of dental services</td>
</tr>
</tbody>
</table>
| - A survey with people with LD and their carers to gauge:  
  - attitudes and understanding in relation to oral hygiene  
  - taking up dental care  
  - experiences when attempting to access services |
Option 3: Teenage Conception Rate in Barking and Dagenham

| Overview | Teenage pregnancy is an important public health issue within Barking and Dagenham. It is a priority within the Health and Wellbeing Strategy and within the Children and Young Peoples Plan.

Whilst becoming a teenage parent may be a positive turning point for teenagers we know that for many teenage parents, raising a child can be difficult and is widely associated with poor health outcomes and social exclusion for the child and parents. Examples include increased risk of infant mortality, low birth weight and child poverty for the child. For the adult there is a higher risk of postnatal depression, low educational attainment and unemployment and poverty.

The rates of teenage pregnancies (under 18s) and younger teenage pregnancies (under 16) have been high in Barking and Dagenham in comparison with London and UK. Recently we have seen an encouraging decrease in rates in under 18 conception rates. However these rates are still high. In addition conception rates in the under 16s, the proportion of teenage pregnancies that end in legal abortions, and the number of repeat abortions is of concern.

The reduced rates in under 18s follows from a number of interventions and concerted efforts to reduce teenage pregnancy locally. Examples include an expanded condom distribution scheme (C card) and developing Sex and Relationship Education (SRE) in schools.

The current context provides challenges and opportunities to build on the progress made in reducing teenage pregnancy rates to ensure that it is sustained and that other related outcomes are improved. |

<table>
<thead>
<tr>
<th>Performance/Evidence</th>
<th>Rates of teenage pregnancy and abortions</th>
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<tbody>
<tr>
<td></td>
<td>At the time of reporting (2014/15 quarter 4 (Q4) to January to March 2015), Barking and Dagenham had the <strong>third highest teenage conception</strong> rate in London for the last 12 months (29.3 per 1,000 women aged 15-17 years compared to the regional rate of 20.6). This was also statistically significantly higher than the national rate (22.4 per 1,000 women aged 15-17 years). The highest quarterly rate in the last four years was 48 conceptions per 1000 women aged 15-17 years in 2011/12 Q1 and the lowest rate was 20 in 2014/15 Q2.</td>
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<td></td>
<td>Rates of under age conceptions by ward varies. For example in 2010-2012 this varied from 18.4 in Whalebone to 70.9 per 1000 young women aged 15-17 in Albion. However both quarterly rates and ward level data should be treated with caution due to small numbers.</td>
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<td></td>
<td>As stated, however there have been improvements in under age conception rates in recent times. Both the 12 month average and the three year rolling averages for under 18 conceptions show a narrowing of the gap between Barking and Dagenham and London and England from 2011/12 to 2014/15</td>
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Q4.

For teenage conceptions in the younger group – under 16s – the rate is higher in Barking and Dagenham than in any other London borough. There were 6.9 conceptions per 1,000 women in the age group in 2012-2014 in Barking and Dagenham, compared to 4.2 in London and 4.9 in England.

The legal abortion rate in under 18s is also high in Barking and Dagenham compared to London and England. Again, though, we have also seen a fall off of 26.5% in the rate of legal abortions for under-18s in Barking and Dagenham over the last four years, from 26.3 per 1,000 women aged 15-17 years in 2011, to 19.3 in 2014. The rate in Barking and Dagenham has been decreasing more quickly than both London (reduction of 21.1%) and England (reduction of 22.5%) over this time period. The number of repeat abortions for women aged under 19 years in 2015 was 18. This made up 14.4% of all abortions in under 19 year olds in Barking and Dagenham. This compares with 13.6% in London and 10.0% in England.

Best practice interventions

The National Teenage Pregnancy Strategy and recent NICE guidance gives examples of key interventions. In addition, a review of strategies and interventions from boroughs which have seen a major reduction in teenage conceptions has been used to identify common approaches, evidence based practice and essential elements that contribute to the effectiveness of local interventions.

Examples of recent work in Barking and Dagenham

Significant work has been undertaken in Barking and Dagenham to reduce the trend in teenage pregnancies. This includes the expansion of the C Card condom distribution programme coordinated by the Integrated Youth Service and including outreach. This has led to an increase in distribution of condoms, increased involvement of pharmacy and general practice for example, alongside education from the providers of the service.

Sexual Relationship Education (SRE) has been developed in primary and secondary schools. This has been supported by coaching and developing staff within the schools.

An Integrated Sexual Health Board is established as a collaborative approach to address sexual health priorities identified by the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy, including teenage pregnancies.

Engagement with young people: For example insights work has been undertaken by Activ Mob and a Young Inspectors Parliament has been set up.

| Policy and legislation issues | Local Health and Wellbeing Board and Children’s Plan places teenage pregnancy as a priority. The Office of National Statistics (ONS) conception |
statistics were established in 1998, with an aim to halve England’s under 18 conception rate from the 1998 baseline by 2010.

Teenage pregnancy is also a key indicator in the Public Health Outcomes Framework.

Aspects of sexual health commissioning are a legally mandated service following the Health and Social Care Act, 2012.

The council is undergoing an important transition programme – Ambition 2020 - and major financial challenges. The public health grant, that supports some key services in relation to teenage pregnancy and public health is ring fenced until March 2018. In this context, priorities for the public health grant are also being reviewed.

### Areas of potential enquiry

This paper outlines the high teenage conception rates in Barking and Dagenham. Currently these rates are reducing and, at a faster rate, than in London and England. Yet local rates in under 18s are still high, we have the highest teenage pregnancy rates in the under 16s in London. The local rates of abortion and repeat abortions in young women in Barking and Dagenham are also high. The current financial context of the local authority and partners and the major change agendas provide a challenge and an opportunity to build on and sustain the improvement seen in local teenage pregnancy rates in Barking and Dagenham.

In this context the following areas of potential enquiry are proposed:

- What are the interventions and approaches that have contributed to the reduction in teenage pregnancy rates and narrowing of the gap in those rates between Barking and Dagenham and London and England?
- What other interventions should be put in place to sustain and/or further reduce the reduction in teenage pregnancy in Barking and Dagenham?
- Have we got in place appropriate and effective services to support those young people who become pregnant and their children?
- How do we ensure that current or future approaches to preventing teenage pregnancy, giving young people informed choices or supporting teenage parents are equally accessible to those who need them?
- Given the challenging financial and organizational context and how can we ensure services and programmes that give teenagers the opportunity to make informed choices and support teenage parents and their offspring are supported into the future?

These lines of enquiry can build on the work already undertaken to understand best practice and engage with young people and partners.
<table>
<thead>
<tr>
<th>Meeting date</th>
<th>Agenda item</th>
<th>Presenter</th>
<th>Drafts deadline for Chair's pre-meeting</th>
<th>Chair's pre-meeting date</th>
<th>Final versions deadline</th>
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<tbody>
<tr>
<td>Weds 7 Sept</td>
<td>Scrutiny Review – evidence session (to be confirmed)</td>
<td>Chair</td>
<td>Mon 8 Aug</td>
<td>Mon 15 Aug</td>
<td>Weds 19 Oct</td>
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<td></td>
<td>Accountable Care Organisation – Business case</td>
<td>Commissioning Director, Adults' Care &amp; Support</td>
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<td></td>
<td>Primary Care Transformation Strategy update (and PMS contracts review outcomes)</td>
<td>Sarah See, CCG</td>
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<td></td>
<td>JHOSC update</td>
<td>Democratic Services Officer</td>
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<td>CQC inspections</td>
<td>Health &amp; Social Care Integration Manager</td>
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<td>Weds 12 October</td>
<td>Scrutiny Review – evidence session</td>
<td>TBC</td>
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<td></td>
<td>Healthwatch reports</td>
<td>Manisha Modhvadia, Healthwatch</td>
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<tr>
<td>Weds 2 Nov</td>
<td>Service change proposals (to be confirmed)</td>
<td>Cabinet Member for Social Care &amp; Health Integration and Strategic Director for Service Improvement and Development</td>
<td>Mon 3 Oct</td>
<td>Mon 10 Oct</td>
<td>Fri 21 Oct</td>
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<tr>
<td>Date</td>
<td>Agenda Item</td>
<td>Chair and Officers</td>
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<td>Weds 11 Jan</td>
<td>Accountable Care Organisation update</td>
<td>Commissioning</td>
<td>Mon 5 Dec</td>
<td>Mon 12 Dec</td>
<td>Tue 20 Dec</td>
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<td></td>
<td>Scrutiny Review- evidence session</td>
<td>Director, Adults'</td>
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<td></td>
<td>JHOSC update</td>
<td>Care &amp; Support</td>
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<tr>
<td>Weds 1 March</td>
<td>To be confirmed - London Assembly reports relating to health</td>
<td>Democratic Services Officer</td>
<td>Mon 30 Jan</td>
<td>Mon 6 Feb</td>
<td>Weds 15 Feb</td>
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<td></td>
<td>Discharge from Hospital - Recent Health and Local Government Ombudsman report on failures in discharge from hospital. Look at impact of failure in discharge (sparking safeguarding concerns)</td>
<td>Operational Director, Adults’ Care and Support</td>
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<td></td>
<td>Scrutiny Review – draft report and recommendations</td>
<td>Chair and Officers</td>
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<tr>
<td>Weds 3 May</td>
<td>Scrutiny Review - final report</td>
<td>Chair</td>
<td>Mon 3 April</td>
<td>Mon 10 April</td>
<td>Fri 28 April</td>
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<td>Public Health - Health checks performance</td>
<td>Director of Public Health</td>
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<td>Mental health</td>
<td>Public Health Consultant</td>
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<td>Healthwatch reports</td>
<td>Manisha Modhvadia, Healthwatch</td>
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