Notice of Meeting

HEALTH AND ADULT SERVICES SELECT COMMITTEE

Wednesday, 21 June 2017 - 7:00 pm
Chamber, Town Hall, Barking

Members: Cllr Peter Chand (Lead Member), Cllr Adegboyega Oluwole (Deputy Lead Member), Cllr Sanchia Alasia, Cllr Jane Jones, Cllr Eileen Keller, Cllr Hardial Singh Rai, Cllr Linda Reason, Cllr Chris Rice and Cllr John White

Date of publication: 7 June 2017

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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 3 May (Pages 3 - 9)

   The Chief Operating Officer for the Trust will deliver a presentation.

4. Barking, Havering and Redbridge University Hospitals Trust - Improvement Plan Update (Pages 11 - 15)

   The Chief Operating Officer for the Trust will deliver a presentation.

5. Barking, Havering and Redbridge University Hospitals Trust - Response to the Parliamentary and Health Service Ombudsman Report on Failures in Discharge from Hospital (Pages 17 - 25)

   The Chief Operating Officer will deliver a presentation.
6. **Barking, Havering and Redbridge University Hospitals Trust's Response to the Cyber Attack on the NHS**

   The Chief Operating Officer will provide a verbal update.

7. **Results of Inspections undertaken by the Care Quality Commission on Local Adult Social Care Services in Quarter 4 (Pages 27 - 39)**

8. **Joint Health Overview & Scrutiny Committee (Pages 41 - 52)**


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

11. **To consider whether it would be appropriate to pass a resolution to exclude the public and press from the remainder of the meeting due to the nature of the business to be transacted.**

    **Private Business**

    The public and press have a legal right to attend Council meetings such as the Health and Adult Services Select Committee, except where business is confidential or certain other sensitive information is to be discussed. The list below shows why items are in the private part of the agenda, with reference to the relevant legislation (the relevant paragraph of Part 1 of Schedule 12A of the Local Government Act 1972 as amended). **There are no such items at the time of preparing this agenda.**

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

One borough; one community; London’s growth opportunity

Our Priorities

Encouraging civic pride

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

Enabling social responsibility

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

Growing the borough

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

Well run organisation

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

Wednesday, 3 May 2017
(7:00 - 8:50 pm)

Present: Cllr Peter Chand (Chair), Cllr Sanchia Alasia, Cllr Edna Fergus, Cllr Jane Jones, Cllr Hardial Singh Rai and Cllr Faraaz Shaukat

Also Present: Cllr Maureen Worby and Cllr Adegboyega Oluwole

Apologies: Cllr Eileen Keller

38. Declaration of Members' Interests

There were no declarations of interest.

39. Minutes - To confirm as correct the minutes of the meeting held on 1 March 2017

The minutes of the meeting held on 1 March 2017 were confirmed as correct, with one amendment

Minute 35- to remove the line “caused by smoking”

40. Primary Care Update

The report was introduced by the Director, Primary Care Transformation (DPCT). She confirmed that the CCG were looking at modelling and locally commissioned contracts that are nationally negotiated. There should be equity for providers and patients. The CCG were also looking at affordability and have overall funding issues with a growth in delegated budgets. The presentation as part of the report provided some basic detail of current progress on the review of Personal Medical Services (PMS) GP contracts and also included an update on the Care Quality Commission’s inspections of GP practices in the borough, and on new GP “localities” that were being set up to encourage sharing of good practice and increase the focus on key local health challenges.

Members were concerned as to what sanctions could be imposed if GP practices were inadequate and/or needing improvement. It was noted that there were three GP practices in the borough that were rated as ‘inadequate’ and under “special measures, seven ‘required improvement ‘and the others were “good.” Those deemed as inadequate were requested to attend a voluntary improvement programme. The DPCT provided an example of the Abbey GP practice which had moved from “inadequate” to “good” in a four-month period. There was also a range of training programmes available. She stated that two practices were participating in the voluntary scheme and had a willingness to engage and improve and would be subject to action plans for improvement. They wanted to address issues with the practices, get them working together and improve learning, prior to future CCG visits. Members were concerned that the courses were not compulsory. If GP practices did not improve in the long run, the CCG could ultimately close down the practice and special measures were implemented too. The DPCT added that GP
practice performance was taken very seriously.

Members were concerned that in visits to 30 practices, a number needed improvement particularly as the borough was short of 50 GP’s. The DPCT stated that £2.1m was the previous PMS budget and all GP practices were paid approximately £80 per patient. B&D practices had an average of 2,600 patients on their records, which was one of the worst ratios in the country. The CCG were working with NHS England to try and recruit more GP’s into the borough and want to attract them into London.

Members were concerned that many residents had difficulties in obtaining GP appointments and some were waiting several weeks and asked if there was anything that could be done to ensure that patients could be seen quicker. The DPCT stated that as part of the PMS review, the CCG were seeking to secure more appointments at “hub” practices. A number of these appointments would be “out of hours”. She added that work was being undertaken to ensure that patients see the right clinician. There was a need to improve access for patients and this included booking appointments online and work with pharmacists. Members noted the new the ‘hub model’ but were concerned that there were some patients with complex needs to which this may not be suitable. The hub appointments would run into existing GP practice normal hours in order to provide greater access to patients and ease demand on other GP practices.

In answer to a question, it was noted that there was low morale amongst GP’s and some younger GP’s were leaving the profession earlier but all were very committed to the profession. There was an emphasis on training for health education and improving morale and GP skills.

Members were concerned about the high level of GP appointments where patients were not attending or providing any explanation for their non-attendance (known as ‘do not attend’ or DNA). They asked what actions were being taken to address this. The DPCT stated that there were a number of practical steps that were being taken by some GP practices, including follow-up letters and conversations with patients. It was hoped that with booking appointments on-line with text reminders would assist in reducing the number of DNA’s.

The DPCT advised that GP appointments were generally ten minutes in duration although the contract did not detail a specific time and had stated a “reasonable” time. This could be reviewed at a future stage and monitored.

The Select Committee noted the update.

41. Results of Inspections undertaken by the Care Quality Commission on Local Adult Social Care Services in Quarter 3

This report was an overview of CQC inspection reports, published during Quarter 3 of 2016/17 (1 October – 31 December 2016). The report provided an overview of the inspections as well as the actions that have been taken as a result of inspections where improvements were required. The report covered CQC inspection reports on providers in the Borough or those who provide services to our residents outside the Borough. A summary of the findings was shown at appendix 1 of the report.
It was noted that three adult social care providers inspected required improvement: Efficiency for Care Limited, Abbey Care and Alexander Court. There were programmes in place for improvement and in the case of Alexander Court, it had been taken over by a new social care provider. An update report would be provided at the next meeting of the Select Committee in June 2017.

Members sought clarification about the term “safe” as referred to in the report and it was clarified that this did not mean safe in terms of the building but a safe environment for residents.

The Select Committee noted the report.

42. Health Checks Performance Report

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

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

The report was introduced by the Director of Public Health (DPT). It was noted that the checks were well resourced and GP’s were paid to undertake screenings. The programme offered checks for patients aged 40-74 who were not already identified with chronic heart disease. In a five-year cycle, patients would be invited for a check and there was a recall system. He also advised that the health checks had been extended to Council staff via occupational health.

Members noted that the health check take up was about 50-60% but the target take up is 75% and 17,000 have been screened so far. The 75% target needed to be reached as there is poor health in the borough. It was noted that there was quite a wide variation in GP practices in the borough and there was even over-performance in some cases. The Cabinet Member for Health and Social Care Integration stated that she met Conor Burke and Dr Mohi in this regard and considered that take up on health checks needed to be improved. She provided an example of a free programme to stop smoking but this was only for a period of twelve weeks, which was not anywhere not long enough.

Members also expressed concern about the low take up and requested the DPH to do a report on progress to both Health and Wellbeing Board (HWBB) and the Select Committee including the risk factors for cardiovascular disease e.g. smoking. This should also address the variations in take up at GP practices in the borough.

The Select Committee noted:
(i) The proposals to reduce variability in health checks delivery in both quantity and quality, and

(ii) The appendices that accompanied this report:

- Appendix 1 explains the background to the targets
- Appendix 2 contains latest data for health check completion by practice
- Appendix 3 shows charts of comparative between Barking and Dagenham and other areas.
- Appendix 4 gives data on referral to lifestyle services from the health check
- Appendix 5 has data on numbers of people admitted to disease register following a health check.

43. Barking and Dagenham Healthwatch Update

The report was introduced by Manisha Modhvadia at Healthwatch and referred to two visits undertaken by them with reports of their findings and recommendations.

a) An unannounced enter and view visit to Mandarin ‘A’ Ward at Queen’s Hospital on 16 September 2016. This would be followed up at some stage in the future.

b) On 27 September 2016 Barking and Dagenham Healthwatch carried out an announced enter and view visit to Bennetts Castle Care Centre. It was noted that the agency staff at this inspection was very low. In answer to a question about agency staff, it was the responsibility of managers to ensure that staff at care homes required sufficient training and DBS checks.

The Select Committee noted the report.

44. Report arising from Scrutiny Review into Cancer Prevention, Awareness and Early Detection

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

The Select Committee was consulted on the draft report at its meeting on 1 March 2017 and Councillor Worby, the Cabinet Member for Health and Adult Social Care,
and Chair of the Health and Wellbeing Board, also had an opportunity to view the recommendations.

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

Members welcomed and agreed the report and extended thanks to officers for their hard work in this matter, especially Sue Lloyd and Masuma Ahmed.

The Cabinet Member for Health and Adult Social Care welcomed the report and extended her thanks to the Select Committee. In particular, she asked them to let her know any ideas and suggestions how these recommendations could be implemented and for views on what worked for residents. She referred to the “prevalence of smoking” and announced that there would be an important event in this regard be held in summer 2017. All of the current programmes were held in term times and they would be targeted in the school holidays. She was working with DPH on programmes for hard to reach groups. She felt that there needed to be greater cultural sensitivity and awareness and there were a number of national initiatives being carried out and promoted but they were not necessarily pertinent to the local community.

The Select Committee agree the appended scrutiny report on local cancer awareness and early detection services, which makes twelve recommendations as follows:

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

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

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

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

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

6. The BDCCG, in partnership with Macmillan and Cancer Research UK, takes action to increase the proportion of residents returning bowel cancer screening kits, within the next year;
7. The HWB, along with MacMillan and Cancer Research UK, takes action to raise awareness of the importance of screening and to increase uptake of breast and bowel screening in the borough to a level comparable with England within the next year;

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

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

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

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

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

45. Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups' 'Spending NHS Money Wisely' Engagement Document

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

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

The Chief Operating Officer, CCG stated that the CCG needed to identify financial savings and spend money wisely and this largely reflected policy elsewhere. She clarified that consultations were on-going and the deadline for responses was 18 May, which had commenced on 23 March. The CCG Governing Body would make decisions in this matter in summer 2017. There had been 90 responses from Barking and Dagenham residents and they were seeking as much feedback on their proposals as possible.

Members provided their views on a number of areas and requested details of the Equality Impact Assessment as shown in the report in order to demonstrate it was reaching all members of the community. They were particularly concerned about the following areas:

- IVF: they considered that IVF treatment should not cease.
Sterilisation: this should continue to be funded. If this ceased, other forms of contraception would need to be considered. It was also noted that some women may need this option owing to cases of domestic violence.

Soya milk prescribing: this should remain as the borough was a deprived area. If someone receives currently whilst receiving benefits, it could be considered that this could be accessed via tokens to be redeemed at supermarkets.

Cosmetic procedures: this should be considered on an individual basis.

Breast reduction surgery: this should remain as an option.

Bariatric/weight loss surgery: this should remain as it could cost more in the long run if surgery is not provided.

Dental prescribing: this should continue as some residents may have difficulty swallowing and it could lead to other issues and problems.

The Select Committee would provide a response to the CCG by the deadline of 18 May.
QUALITY IMPROVEMENT PLAN UPDATE

Health & Adult Services Select Committee Update

Sarah Tedford
Chief Operating Officer
WHERE WE ARE …

• The Care Quality Commission has recognised the significant improvements and changes that we have made in the March 2017 report

• We have established an Improvement Portfolio Board with clear lines of reporting and accountability

• The Quality Improvement Plan has been developed and is in place. It is monitored through the Improvement Portfolio Board

• Joint working with our partners is essential to continue to deliver sustainable change across North East London and Essex

• We undertake continual external and internal assurance
<table>
<thead>
<tr>
<th>Improvement Plan Must Do Action</th>
<th>Must Do BRAG (To End of May 2017)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Must Do 1</strong> - Ensure there is oversight of all training done by locums particularly around advanced life support (ED)</td>
<td>Completed</td>
<td>Completed and process in place</td>
</tr>
<tr>
<td><strong>Must Do 2</strong> - Take action to address the poor levels of hand hygiene compliance</td>
<td>Completed</td>
<td>Completed with an improvement in compliance that meets Trust target. A further detailed plan is in place to continue to improve.</td>
</tr>
<tr>
<td><strong>Must Do 3</strong> - Ensure fire safety is maintained by ensuring fire doors are not forced to remain open (PAEDS)</td>
<td>Completed</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>Must Do 4</strong> - Ensure staff have a full understanding of local fire safety procedures, including the use of fire doors and location of emergency services (PAEDS)</td>
<td>Completed</td>
<td>Completed – A further plan is in place to train ward staff to be fire safety marshals within working area</td>
</tr>
<tr>
<td><strong>Must Do 5</strong> - Ensure hazardous waste including sharps bins is stored according to related guidance and EU directives. This includes the consistent use of locked storage facilities. (PAEDS)</td>
<td>Completed</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>Must Do 6</strong> - Take action to improve the response to patients with suspected sepsis</td>
<td>Completed</td>
<td>Completed – The response time has improved and further work is being done in line with a national CQUIN to further develop and improve</td>
</tr>
<tr>
<td><strong>Must Do 7</strong> - Take action to improve the levels of resuscitation training</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td><strong>Must Do 8</strong> - Ensure all patients attending the ED are seen by a clinician in a timely manner</td>
<td>On track</td>
<td>Plan in place with in ED. Continues to improve since inspection but with on-going work and monitoring.</td>
</tr>
</tbody>
</table>
TRUST BOARD
Chair: Dr Maureen Dalziel (Chair)
Monthly

Quality Assurance Committee
Chair: Dusty Amroliwala
(NED) Monthly

Finance and Investment Committee
Chair: Eric Sorensen
(NED) Monthly

People and Culture Committee
Chair: Mark Lamb
(NED) Monthly

Audit Committee
Chair: Tom Phillips
(NED) Monthly

Trust Executive Committee
Chair: Matthew Hopkins
(Chief Executive)
Monthly

Improvement Portfolio Board
Chair: Mathew Hopkins
(Chief Executive)
Monthly

Programme Meetings
(Chair SROs)
Fortnightly

Projects
Weekly

Clinical Quality Review Meeting
Chair: CCG
Monthly

Oversight Assurance Committee
Chair: TBC
Bi-monthly

All CQC Must Do and Should Do Actions
ENSURING DISCHARGES ARE SAFE

Health & Adult Services Select Committee Update
Sarah Tedford
Chief Operating Officer
HOW OLDER PEOPLE CAN DEFINE ‘WELLBEING’

Not just medical model of “absence of disease”

- Control over daily life
- Personal care and appearance
- Food and drink
- Accommodation (cleanliness and comfort)
- Personal safety
- Social participation
- Occupation/activity
- Dignity (in care) once you are acutely ill or dependent on care

Wider Determinants: Potential for multiple disadvantages. Role of local government, benefits, housing etc?
AREAS TO COVER

• What is a safe discharge?
• Why is it important?
• How we are working to make our discharges safe
• How we will know that we have improved
• Whether all discharges can be ‘safe’
WHAT IS A SAFE DISCHARGE?

• One that delivers the outcome that the person, and where appropriate, their family/carers want

• Where everyone knows what is happening every day from the point of admission or before if a person admitted for elective surgery. Every day each person should be able to answer these questions.
  – What is wrong with me?
  – What is being done to fix it?
  – What do I need to be able to do or have achieved before I can go home?
  – When am I going home?
  – What support will I receive when I get home and what do I do if I am worried?
WHY IS SAFE DISCHARGE IMPORTANT?

• A fundamental part of good person-centred patient care
• 10 days in hospital (acute or community) leads to the equivalent of 10 years aging in the muscles of people aged 80+
• Over 85% of discharges are simple (primarily advice/follow up instructions without additional care)
• Everyone needs the right information about what has happened in hospital, and what will happen next (e.g. changes to treatment/medication)
• Every person needs to feel safe and supported especially at points of transition
• What ‘safe’ means to every person is different
• Relatives and carers should be involved but their wishes cannot dominate
WHAT WE ARE DOING TO IMPROVE – FLOW PROGRAMME

- Communicating better with patients and their family and carers
- Setting clear clinical plans from admissions with expected dates of discharge (see attached Rapid Improvement Guide RIG)
- SAFER patient flow bundle being implemented on all wards linked to a red to green day approach (see RIG)
- Reducing the amount of time people waste in hospital which leads to deconditioning, reduced independence and premature admission to long term care at home or in a residential/nursing home (see RIG)
- Home First for the 15% complex patients – assessment for long term care back at home or in the community with additional support in the short term if required
HOW WE WILL KNOW WE HAVE IMPROVED

• Patients’ feedback
• More people will return home and remain independent
• Placements into long term care will reduce
• Readmissions due to poor discharge will reduce
• Size of care packages required after re-ablement and rehabilitation will reduce
• Numbers of patients in the hospital for over six days will reduce
• Numbers of Delayed Transfers of Care will reduce
• Numbers of occupied beds will reduce and performance against constitutional standards will improve
CAN ALL DISCHARGES BE SAFE?

• We have to make changes in the light of what people want.
• Putting the person in control gives them better outcomes
• We are committed to change, but we need support from the entire system of care and support in terms of:
  – Attitudes
  – Behaviours
  – Culture
Title: Results of inspections undertaken by the Care Quality Commission on local adult social care services in Quarter 4, 2016/2017

Report of the Commissioning Director, Adults' Care and Support

Open Report

Report Author: Julie Aduwa, Commissioning Manager, Quality Assurance

For Information

Contact Details: Tel: 020 8227 2965 E-mail: julie.aduwa@lbbd.gov.uk

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

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

Summary:

This report is an overview of CQC inspection reports, published during Quarter 4 of 2017: (1 January – 31 March 2017). The following report provides an overview of the inspections as well as the actions that have been taken as a result of inspections where improvements are required. The report covers CQC inspection reports on providers in the Borough or those who provide services to our residents outside the Borough.

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

Recommendation(s)

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

Reason(s)

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

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

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

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

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

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

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

2. CQC Findings Quarter 4 2016/2017

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

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

- **Disablement Association of Barking and Dagenham (DABD)** – DABD provides a number of services to support adults and children in the community which include transport services, support with independent living and personal care (homecare). The service was inspected on 18, 25 and 29 January 2017. DABD is not on the Council’s homecare framework of providers however 6 residents have packages of care with DABD where they have either chosen DABD over other providers or because other providers on the homecare framework do not have the capacity to take on the care package.
• **Siloam Lodge – Siloam Care** – Siloam Lodge is a care home that provides accommodation and personal care to a maximum of two people with mental health needs. The service was inspected on 8 December 2016. Although CQC gave the provider, Siloam Care, a 'good' rating, the local authority have concerns about this provider and have placed the provider on our highest risk rating (BLACK) and suspended all placements to the provider. The local authority have no placements at Siloam Lodge, although Thurrock Council have one individual placed at the property. Our own quality assurance processes, as well as safeguarding enquiries, have found concerns regarding recording, administration of medication and staffing levels. The Clinical Commissioning Group’s pharmacy team are currently trying to arrange a review of medication management at the premises and the Quality Assurance team are in communication with Thurrock Council.

2.3 **Evita Care Limited – Homecare UK (Dagenham)** had their first CQC inspection since the service was registered on 22 December 2016. The service is registered to provide support with personal care to people living in their own homes. The provider is not working with any Barking and Dagenham service users and is not on the local authority’s approved homecare list. CQC was unable to provide an overall rating for this service due to the lack of evidence available because of the limited size of the service at the time of the inspection. The service was therefore given an ‘inspected but not yet rated’ rating.

3. **Providers requiring improvement (Quarter 4)**

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

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

3.2 The inspection was undertaken on 28 September and 6 October 2016 and the inspection report was published on 14 January 2017. The inspection found that two areas (Effective and Well-Led) required improvement and that the area of Safe was inadequate:

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

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

3.4 As it is their head office that is based in Barking and Dagenham, QA were advised that Efficiency for Care did not have staff files on site (these are kept at the local offices) so could not be reviewed. Since the visit, Efficiency for Care have provided the local authority with training files, their statement of purpose, and other information electronically.

3.5 A further announced quality assurance monitoring visit was attempted at the beginning of May 2017, however there was nobody in the office. The QA team have since found out that the provider has moved offices and is now located in Ilford. The provider did not let the CQC or the local authority know and the QA team have since informed the CQC, as well as London Borough of Redbridge in order that they can complete their checks on the service.

Triangle Community Services – Darcy House
Rating – Requires Improvement

3.6 Darcy House is part of an extra care service provided by Triangle Community Services Limited. The service provides individual personal care and extra care support to older adults to continue to live independently as tenants at Darcy House. The service is contracted by the local authority as part of four extra care schemes. The other three schemes have been rated as ‘good’ with the same provider. The scheme was inspected on 8 December 2016 and the report was published on 28 January 2017. The scheme was rated as ‘good’ in the categories of Caring and Responsive, but ‘requires improvement’ in three areas:

- Effective (requires improvement) – CQC found that staff did not always receive regular one to one supervision in line with the provider’s procedure.
- Safe (requires improvement) – The CQC report found that there were at times not enough staff working at the service and staff were often late in providing care to people. Although medicines were administered correctly there was poor practice with medicines record keeping.
- Well-led (requires improvement) – CQC found that Quality Assurance and monitoring systems in place were not always effective.

3.7 Triangle completed an improvement plan following the publication of the CQC report which was monitored through contract monitoring and quality assurance checks and was fully implemented over a period of 4 weeks. Unannounced and announced visits were carried out by the Quality Assurance team on 14 and 15 March respectively to check the implementation of the improvement plan. The Commissioning team also had regular meetings with the management team to provide support and follow up on the improvements on 15 March and 3 April. During the visits, it was found that files were updated and medication records were now well maintained. The service has changed their internal structure and appointed two lead carers as well as having a more defined management presence over the weekend. Following the implementation of the action plan, service users who have previously provided feedback on the service have stated that they have seen a marked improvement in the service.
3.8 In April, the Commissioning team completed consultation exercises for the upcoming re-tender of the service at Darcy House and the other extra care schemes. The visible presence of Council staff at the service has given residents and their family members an additional point of contact and we have subsequently seen one family make a complaint to the local authority about the service at Darcy House. Commissioners and Quality Assurance are working with the provider and the service user and their family to resolve the complaints that have been raised and will continue to monitor the improvements that the provider has made in response to the CQC report.

Br3akfree Ltd
Rating – Requires Improvement

3.9 Br3akfree Ltd service provides support with personal care and outreach services to adults living in their own homes. The provider is not on the LBBD provider framework and the Council do not have anyone placed with them. Two people were using the service at the time of the inspection both funded by other local authorities. The service was inspected on 6 February and the report was published on 30 March 2017. The service was found to be good in three areas (safe, responsive and caring) but requires improvement in two areas:

- Effective: Requires Improvement - CQC found that the service had sought consent from relatives without checking they had the legal authority to consent on people’s behalf.
- Well-led: Requires Improvement - CQC found that the service auditing system was not robust and had not identified the gaps in obtaining consent.

3.10 The Quality Assurance team visited Br3akfree Ltd on 30 May 2017 and discussed the CQC Service Improvement Plan with them, which was progressing. After discussions with the provider about the service provided to the two service users, it was not clear if the service should be registered with CQC. The Quality Assurance team has written to the CQC for clarification and will work with the provider accordingly following the advice from CQC.

4. Providers rated as inadequate (Quarter 4)

Reline Care Limited – Reline Care
Rating: Inadequate

4.1 Reline Care is located at the Barking Enterprise Centre in Barking. Reline Care is a large domiciliary care service providing personal care to people in their own homes. This provider is not on the LBBD providers’ framework and LBBD do not have anyone placed with them, although services are provided to service users in the London Boroughs of Newham, Waltham Forest and Redbridge. CQC inspected the service on 1, 2 and 5 December 2016 and published their report on 20 January. The service was rated as the following:

- Safe: Inadequate - CQC found that instances of neglect and abuse were not raised as safeguarding issues and staff did not identify neglect as a type of abuse. Risk assessments were not robust and did not contain sufficient measures to mitigate risks faced by people receiving a service.
- Effective: Inadequate - CQC found that staff training was not effective at ensuring staff had the knowledge required to perform their roles.
• Caring: Requires Improvement - CQC found that care plans were not robust and did not contain enough information about the service user’s personal histories.
• Responsive: Inadequate - CQC found that care plans were task focussed and did not contain information about people’s preferences.
• Well-led: Inadequate - CQC found that Reline was not submitting notifications to CQC.

4.2 Barking and Dagenham undertook a joint unannounced visit with Newham Council in December 2016 and contacted the other Boroughs for their concerns regarding the provider. Waltham Forest and Redbridge had few concerns, although Newham had concerns and were working closely with the provider to monitor improvements against the improvement plan. Newham formally reviewed the progress made against the improvement plan in January and February 2017 with the provider and a joint meeting between Barking and Dagenham, Newham, Redbridge and Waltham Forest was held in February 2017 where it was confirmed that the provider was improving. Improvements were further confirmed by the Barking and Dagenham Quality Assurance team via a joint visit with Newham in April 2017. The provider will continue to work through the service improvement plan with Newham Council and the Barking and Dagenham QA team is in regular communication with the provider and the other local authorities to ensure that improvements are sustained.

5. Consultation

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

6. Implications

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

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

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

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

Safeguarding Children and Vulnerable Adults

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

Health Issues

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

Background Papers Used in the Preparation of the Report:

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

List of appendices:

Appendix 1  Quarter 4 2016/2017 CQC Report
<table>
<thead>
<tr>
<th>Provider name</th>
<th>Location</th>
<th>Link to report</th>
<th>Report date</th>
<th>Inspection date</th>
<th>Rating</th>
<th>Comments/Summary</th>
</tr>
</thead>
</table>
| Br3akfree Ltd | Br3afree ltd   | [http://www.cqc.org.uk/sites/defaul\t/files/new_reports/INS2-2513200629.pdf](http://www.cqc.org.uk/sites/default/files/new_reports/INS2-2513200629.pdf) | 30 March 2017    | 6 March 2017      | Requires Improvement    | CQC rated required improvement after an inspection on 6 March 2017 as:  
**Safe:** Good  
**Effective:** Requires Improvement  
The service had sought consent from relatives without checking they had the legal authority to consent on people’s behalf.  
**Caring:** Good  
**Responsive:** Good  
**Well-led:** Requires Improvement  
The service auditing system had not identified the gaps in obtaining consent.  
**Action:** QA team visited the provider on 30 May and they are working through the improvement plan. Clarification being sought with CQC regarding whether provider should be registered with CQC. Awaiting feedback. |
| Triangle Community Services Ltd | Darcy House | [http://www.cqc.org.uk/sites/defaul\t/files/new_reports/INS2-2647724076.pdf](http://www.cqc.org.uk/sites/default/files/new_reports/INS2-2647724076.pdf) | 30 January 2017  | 8 December 2016   | Requires Improvement    | CQC rated required improvement after the inspection on 8 December 2016 as:  
**Safe:** Requires Improvement  
There were not enough staff working at the service and staff were often late in providing care to people. Although medicines were administered correctly there was poor practice with medicines.                                                                                     |
Effective: Requires Improvement
Staff did not always receive regular one to one supervision in line with the provider's procedure.

Caring: Good

Responsive: Good

Well-led: Requires Improvement
Quality assurance and monitoring systems in place were not always effective.

Action: Quality Assurance and Commissioning have worked with the provider through a number of monitoring visits and meetings. Improvements have been seen in all areas and feedback from service users has confirmed improvement.

Reline Care Ltd

20 January 2017

Inadequate

CQC rated required Inadequate after a 3 day inspections in December 2016 as:

Safe: Inadequate
Instances of neglect and abuse were not raised as safeguarding issues and staff did not identify neglect as a type of abuse. Risk assessments were not robust and did not contain sufficient measures to mitigate risks faced by people receiving a service. Recruitment was not completed in line with the provider's policy and discrepancies in staff applications were not explored. Medicines were not managed or recorded in a safe way.

Effective: Inadequate
Staff training was not effective at ensuring staff had the knowledge
required to perform their roles. The service was not working in line with legislation and guidance regarding consent and care for people who lacked capacity. Care plans did not contain information about people's dietary needs and preferences. People were not consistently supported to eat and drink or to maintain a balanced diet. People's healthcare diagnoses were included in their care plans. However, there was limited information about the impact people's health had on their care.

Caring: Requires Improvement
Care plans contained brief personal histories with information about people's pasts and significant relationships.

Responsive: Inadequate
Care plans were task focussed and did not contain information about people's preferences. Records did not show that people's care plans were followed.

Well-led: Inadequate
Audits were completed, but they were not effective as they had not identified issues with the quality of records and plans found during the inspection. Quality complaints were dealt with on an individual basis and lessons learned were not applied to the overall quality of the service. The service was not submitting notifications to CQC as required.

Action:
No LBBD service users with the
<table>
<thead>
<tr>
<th>Provider</th>
<th>Efficiency – For Care Ltd</th>
<th><a href="http://www.cqc.org.uk/sites/default/files/new_reports/INS2-2943093518.pdf">http://www.cqc.org.uk/sites/default/files/new_reports/INS2-2943093518.pdf</a></th>
<th>13 January 2017</th>
<th>28 September, 6 October 2018</th>
<th>Requires Improvement</th>
</tr>
</thead>
</table>

CQC rated required Requires Improvement after a 2 day inspections in September and October 2016 as:

**Safe: Inadequate**
The administration and prompting of medicines to show people had received their prescribed medicines was not always recorded clearly. The service did not have a robust recruitment process.

**Effective: Requires Improvement**
The service did not have a robust induction process. Not all staff received formal supervision.

**Caring: Good**

**Responsive: Good**

**Well-led: Requires Improvement**

Various quality assurance and monitoring systems were in place but these were not always effective.

<table>
<thead>
<tr>
<th></th>
<th>Provider</th>
<th>Inspected but not rated</th>
<th>Date Inspection</th>
<th>Date Follow-up</th>
</tr>
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<tbody>
<tr>
<td>Evita Care Ltd</td>
<td>Homecare UK (Dagenham)</td>
<td>7 February 2017</td>
<td>22 December 2016</td>
<td>Inspected but not rated</td>
</tr>
<tr>
<td>DABD</td>
<td>DABD</td>
<td>8 March 2017</td>
<td>18, 29, 25 January 2017</td>
<td>Good</td>
</tr>
<tr>
<td>Siloam Carehomes Ltd</td>
<td>Siloamlodge Dagenham</td>
<td>24 January 2017</td>
<td>8 December 2016</td>
<td>Good</td>
</tr>
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</table>
HEALTH AND ADULT SERVICES SELECT COMMITTEE

21 June 2017

Title: Joint Health Overview and Scrutiny Committee

Report of the Director of Law & Governance

<table>
<thead>
<tr>
<th>Open Report</th>
<th>For Decision</th>
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<tbody>
<tr>
<td><strong>Report Author:</strong> Masuma Ahmed, Democratic Services Officer</td>
<td><strong>Contact Details:</strong> Tel: 020 8227 2756 E-mail: <a href="mailto:masuma.ahmed@lbbd.gov.uk">masuma.ahmed@lbbd.gov.uk</a></td>
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</tbody>
</table>

**Accountable Divisional Director:** Fiona Taylor, Director of Law & Governance

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

**Summary:**

This report is to:

i. Inform the Health and Adults Services Select Committee (HASSC) of the local arrangements for joint health scrutiny and,

ii. Ask the Committee to appoint three HASSC members to the Joint Health Overview and Scrutiny Committee (JHOSC) for the 2017/18 municipal year.

This report and the appended Terms of Reference explain local joint health scrutiny arrangements amongst the boroughs of Barking and Dagenham, Havering, Redbridge, and Waltham Forest, which cover the Outer North East London area.

The Terms of Reference at Appendix 1 state that the JHOSC will consist of three members of each local authority represented, appointed by each borough’s health overview and scrutiny committee. In previous years the Lead and Deputy Lead members of the HASSC have usually been put forward to fill two of the three vacancies.

**Recommendations**

The HASSC is recommended to:

(i) Note the Terms of Reference for the JHOSC;

(ii) Note the matters that were discussed at the last meeting of the JHOSC; and

(iii) Agree to appoint three HASSC members to the JHOSC for 2017/18.

**Reason**

To accord with joint health scrutiny arrangements.
1. **Powers of Health Scrutiny in general**

Regulations under the National Health Service Act 2006 state that local authorities in England have the power to:

- "Review and scrutinise matters relating to the planning, provision and operation of the health service in the area. This may well include scrutinising the finances of local health services.
- Require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny.
- Require employees including non-executive directors of certain NHS bodies to attend before them to answer questions.
- Make reports and recommendations to certain NHS bodies and expect a response within 28 days.
- Set up joint health scrutiny committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority.
- Refer NHS substantial reconfiguration proposals to the Secretary of State if a local authority considers:
  - The consultation has been inadequate in relation to the content or the amount of time allowed.
  - The NHS body has given inadequate reasons where it has not consulted for reasons of urgency relating to the safety or welfare of patients or staff.
  - A proposal would not be in the interests of the health service in its area".  

2. **Joint Health Scrutiny Arrangements**

2.1 The Department of Health Guidance (‘the Guidance’) issued in June 2014 describes two types of joint scrutiny committees; discretionary and mandatory. Discretionary joint committees are set up by local authorities by choice to scrutinise health matters that cross local authority boundaries. Mandatory joint committees are required by regulation to be set up when a relevant NHS body or health service provider consults more than one local authority’s health scrutiny function about substantial reconfiguration proposals.

2.2 In such circumstances, the regulations state that:

- "Only the joint committee may respond to the consultation (i.e. rather than each individual local authority responding separately).
- Only the joint committee may exercise the power to require the provision of information by the relevant NHS body or health service provider about the proposal.
- Only the joint committee may exercise the power to require members or employees of the relevant NHS body or health service provider to attend before it to answer questions in connection with the consultation."  

---

1 Department of Health, Local Authority Health Scrutiny Guidance, 27 June 2014, p12
2 Department of Health, p17
2.3 Individual councils or departments would still be able to respond informally to any consultations but the responsibility to give a formal response would lie with the mandatory JHOSC.

3. **Referrals to the Secretary of State for Health**

3.1 The Guidance makes it clear that the above restrictions do not apply to referrals to the Secretary of State. "Local authorities may choose to delegate their power of referral to the mandatory joint committee but they need not do so. If a local authority had already appointed a discretionary committee, they could even delegate the power to that committee if they choose to. If the local authority has delegated this power, then they may not subsequently exercise the power of referral. If they do not delegate the power, they may make such referrals."\(^3\)

3.2 The London Borough of Barking and Dagenham's Constitution delegates the power of referral to the Secretary of State to the HASSC.

4. **Outer North East London Joint Health Overview and Scrutiny Committee**

4.1 The Outer North East London JHOSC consists of three members from each of the following boroughs:
- Barking & Dagenham
- Havering
- Redbridge and
- Waltham Forest.

The Essex County Council Health Overview and Scrutiny Committee is permitted to appoint one member to the JHOSC.

4.2 **Background to the JHOSC**

The Outer North East London JHOSC was established by the health overview and scrutiny committees of the above boroughs, exercising their powers under section 7 of the Health and Social Care Act 2001 and the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002. This legislation, together with directions issued by the Secretary of State for Health in 2003, required all local authorities affected by what they considered to be 'substantial variations' in local health services to form a 'joint health overview and scrutiny committee' to consider those changes.

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

5.1 The Terms of Reference at Appendix 1 describe the remit and governance of the JHOSC. These state that the JHOSC will consist of three members of each local authority represented, appointed by each borough’s health overview and scrutiny committee. In previous years the HASSC has agreed to appoint its Lead and Deputy Lead members to fill two of the three vacancies and if the HASSC agrees to do the same at its meeting on 21 June 2017, it would need to appoint one further member. If more than three nominations are received, a vote will be conducted to determine the appointments.

\(^3\) Department of Health, p17
5.2 There are typically four JHOSC meetings a year with the four boroughs taking turns to host each meeting. The chair of the health scrutiny committee from the hosting borough chairs the JHOSC meeting. The meetings are clerked by Anthony Clements, Principle Committee Officer at the London Borough of Havering, who charges the boroughs for his support in proportion to the number of members they may appoint to the Committee.

5.3 Four JHOSC meetings have been scheduled for the 2016/17 municipal year as listed below. The latter three will be put to the first meeting for agreement.

- 4pm, 18 July 2017 – Barking & Dagenham
- 4pm, 10 October 2017 – Redbridge
- 4pm, 16 January 2018 – Havering
- 4pm, 27 March 2018 – Waltham Forest

6. Update on issues discussed at the last JHOSC

6.1 The last JHOSC meeting was hosted by Waltham Forest on 18 April 2017. The following matters were discussed at this meeting:

**Statements by members of the public**

The Committee was addressed by the Honorary Secretary of the City & Hackney branch of the British Medical Association who raised concerns over accountability and the Sustainability and Transformation Plan (STP). The Chairman of the meeting suggested these could be responded to at a future meeting and that these concerns should also be raised at the forthcoming meeting of the equivalent committee covering Inner North East London.

**Integrated urgent care and NHS 111 procurement update**

Officers explained that urgent care services including the NHS 111 service were currently in the process of being re-procured across the seven North East London boroughs. It was planned for NHS 111 to be the first point of contact for urgent care needs.

Changes under the new service would include GPs and other clinicians being based within the NHS 111 service itself. Engagement had taken place with clinicians and was now under way with patient reference groups and other public representatives. The contract was expected to be of a large value. The Joint Committee felt that the not for profit sector should be involved in the NHS 111 contract.

**Outcome of Barking, Havering and Redbridge University Hospitals' NHS Trust Care Quality Commission inspection**

The Deputy Chief Nurse for BHRUT confirmed that following the recent CQC inspection, the Trust had exited special measures. The inspection had been targeted on certain services including paediatrics, outpatients and accident & emergency. Waits for treatment had improved and there were now only three people who had waited more than a year for treatment. A lot of overseas recruitment of nurses had taken place but it had proved difficult to keep recruits in post long term. The Trust was looking to further develop its nursing associates scheme and it would also begin training its own nurses in partnership with the University of East London.
Whilst the Trust aimed to receive ‘good’ and ‘outstanding’ ratings for all services assessed, officers accepted that a lot of work remained in order for this to be achieved.

The decision to close A & E at King George Hospital had been taken in 2011 and broader planning around this was currently being reviewed. The decision to only have public Board meetings on a bi-monthly basis allowed more time to be spent on delivering improvements but officers would report back to the Trust the Committee’s concerns that a greater degree of transparency was required. Officers agreed to share information on the number of deaths in A&E at the Trust over the last two years.

**Primary medical services contract update**

The review of the Primary Medical Services (PMS) contract for GPs had been initiated by NHS England in 2014. Following a pause, CCGs had been asked by NHS England to restart the review in November 2016, on the basis of only a local offer with no London-wide offer. Around one third of Practices across Barking & Dagenham, Havering and Redbridge (BHR) were subject to the PMS contract. The new contract was required to be in place by the end of October 2017 and officers accepted this was a tight timescale.

All local GP Practices had now been inspected by the CQC although the outcomes of inspections were awaited for approximately 25% of cases. Six local GP practices had been placed in special measures with around 30 receiving a rating of ‘requires improvement’. All Practices in this position were offered support and GP networks for collaborative working were being established across BHR. Officers accepted that there were significant problems facing primary care in North East London.

It was agreed that a letter should be sent on behalf of the Committee summarising its concerns that issues such as workforce, capacity and health inequalities should be included within the PMS contract review.

**Spending NHS money wisely consultation**

Local health services faced a financial challenge with £55 million in savings having to be found across the Barking & Dagenham, Havering and Redbridge CCGs. Essential services such as cancer, emergency services and mental health services would be protected. Some savings had already been made.

The current consultation, which was due to run until 18 May 2017, sought the views of stakeholders and the public on reducing or stopping funding of services such as IVF, cosmetic procedures, over the counter medicines, bariatric weight loss surgery and sterilisation. It was clarified that the ceasing of cosmetic procedures would not apply to cases of post-cancer reconstruction, trauma or severe burns. For services such as mole or cyst removal, exceptions could still be made if for example a clinician felt these had a significant impact on an individual and/or there was a clinical need for removal. Some bariatric surgery would also still be available if agreed clinical criteria were met.
No decisions had been made as yet. The consultation document had been widely distributed to GPs, Councils, community groups etc. Drop-in sessions had also taken place in each borough.

Final decisions on the proposals would be taken by the CCG governing bodies towards the end of June and Equality Impact Assessments would be completed for all changes proposed. Members felt that more explicit guarantees were needed and that each of the proposed changes needed a thorough Equalities Impact Assessment in order to assure that there was no disproportionate effect on those least able to cope with the changes. It was agreed that these comments, together with the need for clinically approved procedures to still be available as required, should form the Committee’s response to the consultation.

6.2 The minutes of all the JHOSC meetings held during 2016/17 are available on http://democracy.havering.gov.uk/ieListMeetings.aspx?CommitteeId=273

7. Financial and Legal Implications

There are no financial or legal implications arising directly from this report.

Background Papers Used in the Preparation of the Report:

Barking and Dagenham Council Constitution
http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=626&MId=9710&Ver=4&Info=1

Local Health Scrutiny Guidance 2014, Department of Health:

List of appendices:

Appendix 1 Joint Health Overview and Scrutiny Committee’s Terms of Reference
Establishment of the JHOCS

1. The Outer North East London Joint Health Overview and Scrutiny Committee (the JHOSC) is established by the Overview and Scrutiny Committees having health responsibilities of the London Borough Councils of Barking & Dagenham, Havering, Redbridge and Waltham Forest (“the borough OSCs”) in accordance with s.190-191 of the Health and Social Care Act 2012 and consequential amendments and the Local Authority (Overview and Scrutiny Committees Healthy Scrutiny Functions) Regulations 2002.

Membership

2. The JHOSC will consist of three Members appointed of each of the Borough OSCs.

3. In accordance with section 21(9) of the Local Government Act 2000, Executive Members may not be members of an Overview and Scrutiny Committee.

4. The Essex County Council may nominate one full Member for the Joint Health Overview and Scrutiny Committee. Thurrock Borough Council Health Overview and Scrutiny Committee may nominate an observing Member of the Joint Health Overview and Scrutiny Committee. The Councils of the Borough of Brentwood and District of Epping Forest may also each nominate an observing Member.

5. Appointments made to the JHOSC by each participating London borough OSC will reflect the political balance of the borough Council, unless a participating borough OSC agrees to waive the requirement and this is approved by the JHOSC.

Attendance of Substitute Members

6. If a Member is unable to attend a particular meeting, he or she may arrange for another Member of the borough OSC to attend as substitute, provided that a Member having executive responsibilities may not act as a substitute. Notice of substitution shall be given to the clerk before the commencement of the meeting.

Role and Function of the JHOSC

7. The JHOSC shall have the remit to review and scrutinise any matter, including substantial variations, relating to the planning, provision and operation of health services that affect two or more boroughs in Outer North East London. The JHOSC will have the right to respond in its own right to all consultations on such matters, both formal and informal.
8. In fulfilling its defined role, as well as reviewing documentation, the JHOSC will have the right to do any or all of the following:

   a. Request information or to hold direct discussions with appropriate officers from each of the following organisations or their successor bodies:

      Barking and Dagenham Clinical Commissioning Group (CCG)
      Havering CCG
      Redbridge CCG
      Waltham Forest CCG
      NHS England
      North East London Commissioning Support Unit
      Barking, Havering and Redbridge University Hospitals NHS Trust
      Barts Health NHS Trust
      North East London NHS Foundation Trust
      North East London Community Services
      London Ambulance Service NHS Trust

      as well as any other NHS Trust or other body whose actions impact on the residents of two or more Outer North East London Boroughs;

   b. Co-operate with any other Joint Health Overview and Scrutiny Committee or Committees established by two or more other local authorities, whether within or without the Greater London area;

   c. Make reports or recommendations to any of the NHS bodies listed above and expect full, written responses to these;

   d. Require an NHS or relevant officer to attend before it, under regulation 6 of the Regulations, to answer such questions as appear to it to be necessary for the discharge of its functions in connection with a consultation;

   e. Such other functions, ancillary to those listed in a to d above, as the JHOSC considers necessary and appropriate in order to fully perform its role.

   Although efforts will be made to avoid duplication, any work undertaken by the JHOSC does not preclude any individual constituent borough Overview and Scrutiny Committee from undertaking work on the same or similar subjects.

Co-optees

9. The JHOSC shall be entitled to co-opt any non-voting person as it thinks fit or appropriate to assist in its debate on any relevant topic. Each borough Healthwatch organisation for Barking & Dagenham, Havering, Redbridge and Waltham Forest shall be entitled to nominate one co-opted (non-voting)
member of the JHOSC. The power to co-opt shall also be available to any Working Groups formed by the JHOSC.

Formation of Working Groups

10. The JHOSC may form such Working Groups of its membership as it may think fit to consider any aspect or aspects of its work. The role of such Groups will be to consider the matters referred to it in detail with a view to formulating recommendations on them for consideration by the JHOSC. The precise terms of reference and procedural rules of operation of any such Groups (including number of members, chairmanship, frequency of meetings, quorum etc) will be considered by the JHOSC at the time of the establishment of each such Group; these may differ in each case if the JHOSC considers it appropriate. The meetings of such Groups should be held in public except to the extent that the Group is considering any item of business from which the press and public could legitimately be excluded under the Access to Information legislation.

Meetings of the JHOSC

11. The JHOSC shall meet formally at such times, at such places and on such dates as may be mutually agreed, provided that five clear days’ notice is given of the meeting. The Committee may also meet informally as and when necessary for purposes including, but not limited to, visiting appropriate sites within the boroughs or elsewhere.

12. Meeting venues will normally rotate between the four Outer North East London boroughs.

13. Meetings shall be open to the public and press in accordance with the Access to Information requirements. No tape or video recorders, transmitters, microphones, cameras or any other video recording equipment shall be brought into or operated by any person at a meeting of the JHOSC unless the Chair of the meeting gives permission before the meeting (this exclusion will not apply to the taping of the proceedings by officers responsible for producing the minutes). When permission is given, a copy of any tape made must be supplied to the London Borough of Havering, in its role as Administrator.

Attendance at Meetings

14. Where any NHS officer is required to attend the JHOSC, the officer shall be given reasonable notice in advance of the meeting at which he/she is required to attend. The notice will state the nature of the item on which he/she is required to attend to give account and whether any papers are required to be produced for the JHOSC. Where the account to be given to the JHOSC will require the production of a report, then the officer concerned will be given reasonable notice to allow for preparation of that documentation.

15. Where, in exceptional circumstances, the officer is unable to attend on the required date, and is unable to provide a substitute acceptable to the JHOSC,
the JHOSC shall in consultation with the officer arrange an alternative date for attendance.

16. The JHOSC and any Working Group formed by the JHOSC may invite other people (including expert witnesses) to address it, to discuss issues of local concern and/or to answer questions. It may for example wish to hear from residents, stakeholders and members and officers in other parts of the public sector and shall invite such people to attend.

17. The JHOSC shall permit a representative of any other authority or organisation to attend meetings as an observer.

Quorum

18. The quorum for the JHOSC shall be four, provided there is present at least one Member from at least three of the London borough OSCs. For meetings involving the writing or agreeing of a final report of the Committee, the quorum shall comprise at least one representative from each of the four London borough OSCs.

Chair and Vice Chair

19. Each meeting will be chaired by a Member from the host borough on that occasion.

Agenda items

20. Any member of the JHOSC shall be entitled to give notice to the Clerk of the Joint Committee that he/she wishes an item relevant to the functions of the JHOSC to be included on the agenda for the next available meeting. On receipt of such a request (which shall be made not less than five clear working days before the date for despatch of the agenda) the relevant officer will ensure that it is included on the next available agenda.

Notice and Summons to Meetings

21. The Clerk of the Joint Committee will give notice of meetings to all members. At least five clear working days before a meeting the relevant officer will send an agenda to every member specifying the date, time and place of each meeting and the business to be transacted, and this will be accompanied by such reports as are available.

22. Any such notice may be given validity by e-mail.

23. The proper officer of each Council shall ensure that public notice of the meeting is displayed in accordance with the customary arrangements of that Council for giving notice of Committee etc. meetings.
Reports from the JHOSC

24. Once it has formed recommendations the JHOSC will prepare a formal report and submit it to the relevant bodies. In accordance with the Department of Health Guidance on the Overview and Scrutiny of Health dated July 2003, the JHOSC should aim to produce a report representing a consensus of the views of its members. If consensus is not reached within the JHOSC, minority views will be included in the report.

25. In undertaking its role the JHOSC should do this from the perspective of all those affected or potentially affected by any particular proposal, plan, decision or other action under consideration.

Formal Consultations and Referrals to Secretary of State

26. Under guidance on Local Authority Health Scrutiny issued by the Department of Health in June 2014, only the JHOSC may respond to a formal consultation on substantial variation proposals covering health services in more than one constituent Council area. This power also extends to the provision of information or the requirement of relevant NHS officers to attend before the JHOSC in connection with the consultation.

27. The JHOSC may only refer matters directly to the Secretary of State on behalf of Councils who have formally agreed to delegate this power to it.

Procedure at JHOSC meetings

28. The JHOSC shall consider the following items of business:
   (a) minutes of the last meeting;
   (b) matters arising;
   (c) declarations of interest;
   (d) any urgent item of business which is not included on an agenda but the Chair, after consultation with the relevant officer, agrees should be raised;
   (e) the business otherwise set out on the agenda for the meeting.

Conduct of Meetings

29. The conduct of JHOSC meetings shall be regulated by the Chair (or other person chairing the meeting) in accordance with the general principles and conventions which apply to the conduct of local authority committee meetings.

30. In particular, however, where any person other than a full or co-opted member of the JHOSC has been allowed or invited to address the meeting the Chair (or other person chairing the meeting) may specify a time limit for their contribution, in advance of its commencement which shall not be less than five minutes. If someone making such a contribution exceeds the time limit given the Chair (or other person chairing the meeting) may stop him or her.
31. The Chair (or other person chairing the meeting) may also structure a discussion and limit the time allowed for questioning by members of the JHOSC.

Officer Administration of the JHOSC

32. The London Borough of Havering will be the Lead Authority for clerking and administering the JHOSC. The Clerk of the Committee will be the Principal Committee Officer, London Borough of Havering. Costs of supporting the JHOSC will be shared, in proportion to their representation on the Committee, by the London Boroughs of Barking and Dagenham, Havering, Redbridge, Waltham Forest and by Essex County Council, in cash or in kind.

Voting

33. Members may request a formal vote on any agenda item by informing the Clerk of the Joint Committee at least five working days before a meeting. If it is not possible to give this notice, Members have the right to request a vote at a meeting itself, provided they explain to the meeting why it has not been possible to give the standard notice of this request. The decision on whether to allow a vote, if the standard notice has not been given, will rest with the Chairman of that meeting.

34. Any matter will be decided by a simple majority of those members voting and present in the room at the time the motion was put. This will be by a show of hands or if no dissent, by the affirmation of the meeting. If there are equal votes for and against, the Chair or other person chairing the meeting will have a second or casting vote. There will be no restriction on how the Chair chooses to exercise a casting vote. Co-opted members will not have a vote.

Public and Press

35. All meetings of the JHOSC shall be open to the public and press unless an appropriate resolution is passed in accordance with the provisions of Schedule 17 of the National Health Service Act 2006.

36. All agendas and papers considered by the JHOSC shall be made available for inspection at all the constituent authority offices, libraries and web sites.

Code of Conduct

37. Members of the JHOSC must comply with the Code of Conduct or equivalent applicable to Councillors of each constituent Local Authority.

General

38. These terms of reference incorporate and supersede all previous terms of reference pertaining to the JHOSC.
HEALTH AND ADULT SERVICES SELECT COMMITTEE

21 June 2017

Health and Adult Services Select Committee’s Work Programme 2017/18

Report of Law & Governance

Open report

For decision

Report Author:
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Accountable 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 one option prepared by officers to the HASSC for undertaking a small-scale Scrutiny Review, following a recommendation by the HASSC in 2016/17. This report also suggests other areas which may need to be scrutinised at HASSC meetings in 2017/18. If members are not inclined to undertake a review on Oral Health, they may discuss and agree on another topic for scrutiny review. The option that is chosen for a scrutiny review, together with the other agreed areas for scrutiny, shall constitute the HASSC’s Work Programme for 2017/18.

The following are appended to this report:
- The Committee’s remit as described in the Council's Constitution (Appendix 1);
- An option paper for undertaking a small-scale scrutiny review on Oral Health Care Provision (Appendix 2);
- A draft Work Programme suggesting areas for one-off scrutiny in 2017/18 (Appendix 3);
- The Health and Wellbeing Board’s Forward Plan (Appendix 4).

Recommendations

Members are recommended to:

(i) Discuss whether they wish to undertake a small-scale scrutiny review on Oral Health Care Provision (or another topic identified by members) in 2017/18, and if so, choose a particular focus for the scrutiny;

(ii) Note the Health and Wellbeing Board’s Forward Plan, discuss and agree on whether any of the items listed require pre-decision scrutiny by the HASSC; and
Discuss the draft Work Programme for 2017/18, and having considered whether there are other potential areas for scrutiny which should be included, agree a Work Programme for 2017/18.

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 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 which includes the process of agreeing the contents of the scrutiny review report and the recommendations
6. Sharing the draft report with those involved with the review and finalising the report
7. Asking the relevant decision-maker to respond to the recommendations (for example, the Health and Wellbeing Board or the commissioner) and publicising the report and;
8. Monitoring the impact of the scrutiny review.

Due to there being a fewer number if meetings in the Council Calendar in 2017/18, and the importance of scrutinising local health and adult social care commissioners and providers in relation to a number of other issues (see Appendix 3), the proposal is that the Committee undertakes a small-scale review this year, as opposed to an in-depth one. This will still involve the stages described above; however, the terms of reference and the methods to gather evidence will be more considerably more specific and focussed than that involved in an in-depth review.

Following a recommendation by the HASSC on 1 March 2017, officers have drafted an option paper for a small-scale scrutiny review on Oral Health which is at Appendix 2. At paragraph number 3, the report suggests three potential areas of reference for this review. Should members agree that Oral Health should be the subject matter of the scrutiny review, members will be asked to choose one area of focus from the three identified, to give the review a specific focus, and so that the review can be completed between September 2017 and January 2018.

If there are other areas members wish to undertake a small-scale review on, in place of Oral Health, these will need to be discussed at the meeting and members will need to come to an agreement.
Following agreement by the Committee as to the area for scrutiny review, officers will produce a proposed methodology and time-table for completion and circulate this to members via email for agreement, as the next HASSC meeting is not until September 2017.

(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 on its performance, or undertaking a site visit to a facility to talk to service-users.

The draft Work Programme at Appendix 3 lists other potential areas for one-off scrutiny at HASSC meetings in 2017/18 for members to consider.

The Chair of HASSC, Councillor Chand, has asked that the Forward Plan for the Health and Wellbeing Board (HWB) be included in all HASSC meeting agendas to allow the Committee the opportunity to consider whether pre-decision scrutiny of issues that shall be determined by the Board needs to be undertaken. The HWB Forward Plan is at Appendix 4. Members are asked to state at the meeting if they feel an item on the Forward Plans needs pre-decision scrutiny and the Committee as whole will need to discuss whether the item is a priority for HASSC, in light of a busy proposed work programme.

Having considered the proposed items at Appendix 3 and the HWB Forward Plan, members are asked to consider whether there are any other issues which should be included in the Work Programme.

Members are asked to note that the Work Programme agreed today will remain flexible, to allow the Committee to include important health and adult social-care related matters as they arise, and to remove items from the Work Programme which are no longer considered a priority. The Work Programme will therefore be presented at every HASSC meeting by the Chair so that the Committee may take such decisions.

2. Matters to Consider before deciding items to scrutinise

When deciding what matters should be scrutinised (whether it is in the form of a one-off item, scrutiny review or pre-decision scrutiny), 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 1.
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. Implications

3.1 There are no legal implications arising directly as a result of this report.
3.2 The cost of the scrutiny review will need to be met from existing Council resources.

Background Papers Used in the Preparation of the Report:

None.

List of Appendices

Appendix 1 The HASSC’s remit as described in the Council's Constitution
Appendix 2 Option paper for undertaking a small-scale scrutiny review on Oral Health
Appendix 3 Draft Work Programme 2017/18
Appendix 4 The Health and Wellbeing Board’s Forward Plan
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 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).
Title: Options for Health Scrutiny – Oral Health Promotion Programmes

Report of the Director of Public Health

Open Report

Report Author: Paul Starkey, Health Improvement Advanced Practitioner

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Accountable Divisional Director: Matthew Cole, Director of Public Health

Accountable Director: Anne Bristow, Corporate Director, SD&I

Summary:

In January 2017, an oral health promotion strategy was taken to the Council’s Health and Wellbeing Board. The strategy states that based on the evidence of need for oral health services, the recommendation is to focus on children (pre-school and school age), young people and adults whose economic, social, environmental circumstances or lifestyle place them at high risk of poor oral health or make it difficult for them to access dental services.

The Key Priorities (as set out in the strategy)

Priorities for oral health promotion and service delivery in Barking and Dagenham are to:

A. Promote and protect oral health by raising awareness about oral health;
B. Improve diet and reduce consumption of sugary food and drinks, alcohol and tobacco (and thereby improve general health as well);
C. Encourage people to go to the dentist regularly;
D. Address inequalities in oral health;
E. Improve access to local dental services particularly for priority groups;
F. Improve oral hygiene;
G. Promote the provision of preventive dental care;
H. Increase early detection of mouth cancer and dental decay;
I. Increase exposure to fluoride.

Three options for inquiry

- **Option one is to scrutinise oral health in early years.** Target the most deprived communities populated with young families which will offer the best opportunity to tackle dental disease in children which is where the greatest difference can be made. There is potential for scrutiny of the oral health messages and signposting given by professionals who have contact with these families, e.g. community paediatricians, health visitors, children’s centre staff and nursery staff.

- **Option two is to scrutinise oral health in children and adults with learning disabilities.** Scrutiny of dental services that serve special educational needs may
help to understand how we could improve the oral health of this group. This would mean less costly complex treatment later on, with all the attendant anxiety that it would also bring.

Option three is to scrutinise the level of training that is provided to the wider workforce who support oral health improvement in individuals with learning disabilities in Barking and Dagenham. Scrutiny around the training that professionals working with the young and learning disabilities currently have and then to identify any gaps in their knowledge, training and the messages they are giving.

Recommendation

The Committee is recommended to discuss and choose one line of inquiry from the three options presented in the report.

Reason(s)

Barking and Dagenham Council has a statutory responsibility to provide, or commission an appropriate service to secure the provision of oral health surveys, oral health promotion and oral health improvement as part of overall population health improvement. Good oral health is important for general health and wellbeing. On the other hand, poor oral health can affect an individual’s ability to eat, speak, smile and socialise normally due to embarrassment about the appearance of one’s teeth and it can also restrict food choices. Poor oral health can increase the gravity of existing health conditions and it can also be an indicator of neglect or difficult social circumstances.

1. Introduction and Background

1.1 Oral health refers to the physical condition and hygiene of an individual’s teeth, gums, supporting bone and soft tissues of the mouth, tongue and lips. The World Health Organisation defines good oral health as being free from diseases and disorders that affect the oral cavity. Good oral health is important for general health and wellbeing and development. In contrast, poor oral health can affect an individual’s ability to eat, speak, smile and socialise normally due to embarrassment about the appearance of one’s teeth and can restrict food choices. Poor oral health can aggravate existing health conditions. It can also be an indicator of neglect or difficult social circumstances. Oral health problems include gum (periodontal) disease, tooth decay (dental caries), tooth loss and oral cancers.

1.2 In 2012/13 dental extraction was the highest cause of hospital admissions for children in London. In Barking and Dagenham 310 children were admitted to hospital for dental extractions with 40% in the 5 - 9 year age group. This represented 0.5% of the 0 -19 year old population, similar to that for London.

1.3 Data published in March 2017 by the Faculty of Dental Surgery at the Royal College of Surgeons shows that hospitals in England are treating thousands of very young children each year that need baby teeth removed. The figures show that there were 9,206 extractions carried out on children aged 4 and younger between April 2015 and March 2016. A decade earlier, the figures were closer to 7,400 extractions. The faculty reported that these alarming figures are the result of very young children consuming a diet that is far too high in sugar.
2. Issues

2.1 With data for London and England at 13.6% and 11.7% respectively, oral health was found to be much worse in 3-year-old children in Barking and Dagenham. For those with disease, each child had on average 3.49 decayed, missing or filled teeth compared to 3.11 for London and 3.08 for England. There were higher rates of dental abscess at 1.9% compared to 0.5% for London.

2.2 In 2012/13 dental extraction was the highest cause of hospital admissions for children in London. In Barking and Dagenham 310 children were admitted to hospital for dental extractions with 40% in the 5-9 year age group. This represented 0.5% of the 0 -19 year old population, similar to that for London.

3. Areas of options for review

3.1 The Committee is asked to consider one of three areas of scrutiny initiatives that would contribute to improving the oral health of people that are resident in Barking and Dagenham. They are recommended with strong evidence of effectiveness in the document Local authorities improving oral health: commissioning better oral health for children and young people (Public Health England 2014).

3.1.1. Option 1 - Oral health in early years

Option one is to scrutinise oral health in early years. Dental diseases can have a considerable impact on a child’s general health and wellbeing. Poor dental health is associated with being underweight and a failure to thrive. It also affects a child’s ability to sleep, speak, play and socialise with other children. Children with dental problems may not be able to gain the full benefit of their education due to increased school absenteeism as the result of hospital appointments, leading to decreased academic performance. Therefore, to focus on improving dental health in a child’s early years will have a multi factorial positive effect on their wellbeing and prospects.

Barking and Dagenham has more dental capacity compared to London and England and there has been a steady increase in the number of children accessing dental services in Barking and Dagenham from 2011 to 2014. However, lack of attendance at dental appointments and other factors such as poor diet and over consumption of sugary food and drink, combined with poor oral hygiene is likely to have a direct correlation with social deprivation. Therefore, to target the most deprived communities populated with young families offers the best opportunity to tackle dental disease in children and is where the greatest difference can be made. There is potential for scrutiny of the oral health messages and signposting being given by professionals who have contact with these families e.g. community paediatricians, health visitors, children’s centre staff and nursery staff.

3.3 Option 2 - Oral health and special educational needs

Option two is to scrutinise oral health in children and adults with learning disabilities. The 2010 survey found that people with learning disabilities had more missing teeth, fewer filled teeth and more untreated diseased teeth than the general adult population surveyed. This suggests that, when people with learning disabilities do
access dental services, they are more likely to have teeth extracted instead of restorative treatment such as fillings or crowns due to the extent of the oral health problem.

Those who have a learning disability and/or physical impairment may have reduced manual dexterity which increases their difficulty in cleaning their teeth properly; they may also have reduced understanding of the importance of dental health and the factors that affect it.

Some scrutiny of dental services that serve special educational needs may help to understand how we could improve the oral health of this group. This would mean less costly, complex treatment later on, with all the attendant anxiety that it would also bring.

3.4 **Option 3 - Oral health training and the wider professional workforce**

Option three is to scrutinise the level of training that is provided to the wider workforce who support oral health improvement in individuals with learning disabilities in Barking and Dagenham. Scrutiny may be required around the training that professionals working with the young and learning disabilities currently have and then to identify any gaps in their knowledge, training, and the messages that they are providing. The target groups for scrutiny would be health visitors, school nurses, children’s centre staff, Community/Nursery Nurses, foster care and child minder leads and carers of older or vulnerable people. If there was a case for improving training this would aid the drive to reduce early onset of dental disease among children through using people that work with early years by providing the knowledge and skills to enable them to deliver consistent evidence informed oral health interventions within their work role.

4. **Legal Implications**

Implications completed by Dr. Paul Field, Senior Governance Lawyer

4.1 The Health and Social Care Act (2012) conferred the responsibility for health improvement, including oral health improvement to local authorities. This Select Committee’s terms of reference establish its function to scrutinise any matter relating to the planning, provision and operation of the health services in the borough. The proposals are in keeping with this Committee’s function.

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


Implementing the oral health strategy in Barking and Dagenham

**List of appendices:**

Appendix 1 – Oral Health Promotion Strategy
LONDON BOROUGH OF BARKING AND DAGENHAM

IMPROVING ORAL HEALTH IN BARKING AND DAGENHAM

ORAL HEALTH PROMOTION STRATEGY 2016 – 2020
CONTENTS

Executive summary
1. Improving oral health in Barking and Dagenham – our vision
   • Policy context and related plans
2. Introduction – What is oral health?
3. Oral health needs in Barking and Dagenham
   • Oral health needs of children and young people
   • Oral health needs of adults
4. Priorities for oral health promotion and service delivery in Barking and Dagenham
5. Effective interventions for improving oral health
6. The Delivery Plan
7. Delivering the Plan
8. Action Plan
Appendix A (of Oral Health Scrutiny Options Report)

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Jeanette Shaw (Oral Health Practitioner – NELFT)
Desmond Wright (Consultant in Dental Public Health – Public Health England)

Appendices

A - Policy and guidance
B - Effective interventions and outcomes for improving oral health
C - Overview of local oral health services
D - Commissioning map
E - Clinical governance
F - Oral Health Promotion Action Plan
1. IMPROVING ORAL HEALTH IN BARKING AND DAGENHAM – OUR VISION

The London Borough of Barking and Dagenham has set out an all-encompassing vision for the delivery of health and care services: *One borough; one community; London’s growth borough*. Within this vision is the ambition for children and adults who are resident in Barking and Dagenham to have the best possible oral health.

This strategy sets out the ambition to measurably improve the oral health of the resident population by 2020 especially for children and vulnerable adults. This will be achieved by increasing the uptake of regular oral healthcare, reducing inequalities in oral health and ensuring equitable access to dental services in the borough. Key priorities within the strategy are:

- Promoting positive oral health practice at individual level and healthy lifestyles in order to prevent and reduce risk factors to oral health;
- Implementing evidence-based oral health interventions that equitably improve oral health outcomes;
- Integrating the oral health strategy into local community health programmes in order to achieve maximum health impact with limited resources.

POLICY CONTEXT AND RELATED PLANS

Barking and Dagenham has a statutory responsibility to provide, or make arrangements to secure the provision of oral health surveys, oral health promotion and oral health improvement as part of overall population health improvement\(^1\). Barking and Dagenham is responsible for improving the oral health of local people including the commissioning of oral health promotion initiatives and oral health surveys as part of Public Health England’s (PHE) dental public health intelligence programme. This is supported by the dental public health expertise within PHE. NHS England is responsible for commissioning primary care and hospital dental services.

The strategy to improve oral health has been developed in line with the findings of the Joint Strategic Needs Assessment, the key priorities of Barking and Dagenham’s Health and Wellbeing Strategy and the Ambition 2020 outcomes. Key national policy and related local strategies that inform the commissioning and delivery of oral health services are summarised in Appendix B. Recently

\(^{1}\) Statutory Instrument 2012 No. 3094: Dental Public Health functions – Section 4
published oral health guidance (PHE 2014\textsuperscript{2}, NICE 2014, LGA, 2014) will assist Barking and Dagenham to ensure that interventions and activities are evidence-based and meet the diverse needs of local people. The guidance advocates both universal approaches with general advice and support for all residents, together with additional targeted interventions aimed at those people at higher risk of developing oral health problems.

**Delivering the strategy in partnership**

Barking and Dagenham’s oral health improvement responsibility is underpinned by collaborative working with key partners and stakeholders as part of the Oral Health Strategy Group. The strategy has been developed by Barking and Dagenham’s Public Health Team, Leisure Services, Children’s Services, Drug and Alcohol Action Team, North East London NHS Foundation Trust and PHE in partnership with the local NHS and local dentists.

\textsuperscript{2} Commissioning Better Oral Health was published by the Department of Health and Public Health England in June 2014

\textsuperscript{3} http://www.who.int/topics/oral_health/en
2. INTRODUCTION

WHAT IS ORAL HEALTH?

Oral health refers to the physical condition and hygiene of an individual’s teeth, gums, supporting bone and soft tissues of the mouth, tongue and lips. The World Health Organisation defines good oral health as being free from diseases and disorders that affect the oral cavity. Good oral health is important for general health and wellbeing and development. In contrast, poor oral health can affect an individual’s ability to eat, speak, smile and socialise normally due to embarrassment about the appearance on one’s teeth and can restrict food choices. Poor oral health can aggravate existing health conditions. It can also be an indicator of neglect or difficult social circumstances. Oral health problems include gum (periodontal) disease, tooth decay (dental caries), tooth loss and oral cancers.

THE NATIONAL PICTURE

Prevalence of oral health problems in children in England

Tooth decay is the most common oral disease affecting children and young people in England. Tooth decay (dental caries) occurs when oral bacteria produce acids that gradually soften the enamel, leading to cavities in the teeth. Differences in the prevalence levels within the age range for children are as follows:

Under 5s - In 2014 nearly 28% of five year olds in England had experience of tooth decay (in comparison to 31% in 2008) and, although the oral health of children has been improving, significant inequalities remain. Across local authorities in England there is significant variation, ranging from 13% to 53% of five year olds experiencing tooth decay, with these children having on average three teeth affected. Those living in deprived communities have poorer oral health than people living in more affluent communities, as do those in vulnerable population groups including those with disabilities.

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3 Public Health England 2014 Local authorities improving oral health: commissioning better oral health – An evidence-informed toolkit for local authorities
http://www.local.gov.uk/documents/10180/5854661/L14-352+Tackling+Poor+oral+health+in+children/3dd8097f-35b7-42ba-b3c7-186266da82db
Appendix A (of Oral Health Scrutiny Options Report)

Over 5s - In March 2015 the results of the 5th Decennial National Oral Health Survey were published. Key findings included:

- Reductions in the extent and severity of dental decay in permanent teeth for 12 and 15 year old children compared to 2003.
- Persistence of oral health inequalities with 26% of 15 year olds eligible for free school meals having severe or extensive dental decay compared to 12% of 15 year olds who were not eligible.
- More than a third (35%) of the parents of 15 year olds reported that their child’s oral health had impacted on family life in the last six months; 23% of the parents of 15 year olds took time off work because of their child’s oral health in that period.
- Overall, 45% of 12 year olds and 28% of 15 years olds reported that they were not happy with the appearance of their teeth and would like to have them straightened.

Risk factors and impact on health and wellbeing for children

Tooth decay (dental caries) is caused when oral bacteria produce acids that gradually soften the enamel, leading to cavities in the teeth. Sugar plays a key role in tooth decay because it fuels the acid formation by oral bacteria. Acidic food and drinks can be just as harmful as they can wear away the tooth enamel and cause tooth surface loss, making them more prone to decay and sensitivity.

Children’s primary (baby) teeth are more susceptible to decay than permanent (adult) teeth owing to differences in their chemical composition and physical properties. In particular, primary teeth have thinner and often less resilient enamel that does not provide as much protection from bacteria. Infants and toddlers primary teeth can also be affected by an aggressive form of decay called early childhood caries. The disease is associated with the frequent consumption of sugary drinks in baby bottles or sipping cups as it occurs in the upper front teeth and spread rapidly to other teeth.

More than 30% of children in England did not see an NHS dentist between 2012 and 2014. Approximately 46,500 children and young people under 19 were admitted to hospital for a primary diagnosis of dental caries in 2013–14. These numbers were highest in the 5 to 9 year-old age group, which showed a 14% increase between 2010–11 and 2013–14, from 22,574 to 25,812. The second highest admissions in 2013–14 were for tonsillitis, with approximately 11,500 cases, making dental caries by far the most common reason for children aged between 5 and 9 to be admitted to hospital.

5 RCS Faculty of Dental Surgery 2015: The state of children’s oral health in England
Oral diseases can have a considerable impact on a child’s general health and wellbeing. Poor oral health is associated with being underweight and a failure to thrive. It also affects a child’s ability to sleep, speak, play and socialise with other children. Children with dental problems may not be able to gain the full benefit of their education due to increased school absenteeism as the result of hospital appointments, leading to decreased academic performance.

**Prevalence of oral health problems in adults in England**

- In 2009, 94% of the combined populations of England, Wales and Northern Ireland were dentate, that is had at least one natural tooth.
- 58% of adults said that they had tried to make an NHS dental appointment in the previous three years. Of these adults, 92% successfully received and attended an appointment.
- 75% of adults said that they cleaned their teeth at least twice a day and a further 23% of adults said that they cleaned their teeth once a day.
- The mean number of teeth amongst dentate adults was 25.7, with the majority of dentate adults (60 per cent) having between 27 and 32 teeth. Dentate adults had an average of 17.9 sound and untreated teeth but this varied hugely with age.

People are not only living longer but also retaining their natural teeth into old age. Changes that can occur over time in the gum tissues expose vulnerable root surfaces to the oral environment and thus, potentially to the decay process. Therefore while older people are still at risk of dental decay, gum disease and teeth wear, they are also at increased risk of developing root decay and oral cancer. The treatment needs of older people can be complex with long-term conditions, systemic disease and medication compounding oral risk factors, such as dry mouth, making oral hygiene and treatment more difficult.

**Risk factors and impact on health and wellbeing: adults**

The main barriers to adults and older people accessing dental services are low perception of need / oral health not given a priority, poor general health and difficulty in travelling to a practice, cost or fear of cost of dental treatment, poor nutrition, effects of dementia, decreased salivary flow and problems with dexterity (affecting use of a toothbrush).

Poor oral health, whether it is chronic or acute, may impact on nutritional intake, disrupt routine sleep patterns and affect quality of life and general health. Pain / discomfort, difficulty eating, limited food choice and lack of sleep may sometimes lead to increased agitation and anxiety, particularly in older people.
Chronic health conditions such as cardiovascular disease, aspiration pneumonia and mouth cancers can also increase the risk of poor oral health. Whilst people over 50 years of age are more at risk of developing oral cancer the incidence of oral cancer in younger adults has been increasing in recent years. Alcohol consumption, smoking and chewing tobacco are all risk factors for oral cancer and these risks are increased when two or more of these habits are present.

**POPULATION GROUPS AT RISK OF POOR ORAL HEALTH**

Whilst it is important to give advice and support to the whole population as to how to maintain good oral health, it is recognised that certain populations are at increased risk of poor oral health, and therefore may be in need of targeted approaches. This may be due to physical, social, environmental and lifestyle circumstances that impact on their ability to maintain good oral hygiene, consume a healthy diet or access dental services.

Vulnerable populations include those:

- Who are socially isolated or excluded or are geographically isolated;
- Who are older and frail especially those living in nursing or residential care who are often dependent on others for their diet, personal care and access to health services;
- Who have a learning disability and / or physical impairment or where reduced manual dexterity increases difficulty in cleaning their teeth properly;
- Who have a mental health condition - tend to have fewer natural teeth, more untreated decay and more gum disease than the general population;
- Who have specific clinical conditions, such as diabetes, congenital heart problems;
- Pregnant women;
- Who are from lower socioeconomic groups;
- Who live in a disadvantaged area;
- Who smoke heavily or misuse substances (including alcohol);
- Who have a poor diet;
- Who are from certain Black, Asian and minority ethnic groups identified with higher prevalence of oral health problems;
- Who are homeless or frequently move, such as traveller communities, refugees and asylum seekers;
- Who are children of parents or carers with the above risk factors;
- Who are in long-term institutional care including looked after children and those who are, or who have been, in care and older people in residential care homes.
Vulnerable groups often have unmet oral health needs. Co-morbidities, progressive medical conditions, dementia and increasing frailty all contribute to more complex oral health problems and difficulties in accessing primary care dental services or lead to infrequent contact with oral health services.
3. ORAL HEALTH NEEDS IN BARKING AND DAGENHAM

The oral health needs assessment conducted in 2015 identified the following oral health needs among residents of Barking and Dagenham:

ORAL HEALTH OF CHILDREN AND YOUNG PEOPLE: KEY POINTS

3 year olds

A local oral health survey of 3 and 4 year old children in Barking and Dagenham was carried out in 2010. The findings are summarised below:

- 9% of children had experienced pain in the teeth, mouth or jaws;
- 28% had experienced dental disease and 91% of this was untreated;
- 41% of those with decay had visited a dentist in the previous 12 months;
- There were marked inequalities among ethnic groups with high rates of decay and untreated disease in Asian children;
- Asian children were less likely to have their teeth brushed twice a day than White and Black children and there were low rates of attendance among Black children.

Barking and Dagenham participated in a national oral health survey of 3-year-old children in 2013. Compared to the local survey the results showed that oral health had improved with 18% experiencing dental disease. With figures for London and England at 13.6% and 11.7% respectively, oral health is much worse in 3-year-old children in Barking and Dagenham. For those with disease each child had on average 3.49 decayed, missing or filled teeth compared to 3.11 for London and 3.08 for England. There were higher rates of dental abscess at 1.9% compared to 0.5% for London.

5 year olds

A national survey of five-year-old children was carried out in 2012. The results of this survey show that the oral health of children in

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Appendix A (of Oral Health Scrutiny Options Report)

England continues to improve with the percentage of children who had experienced decay falling from 30.9% in 2008 to 27.9% in 2012. The percentage of children with active untreated decay also fell from 27.5% in 2008 to 24.5% in 2012. London showed no improvement with the percentage with decay experience or active untreated decay remaining the same at 32.9% and 29% respectively.

Five-year-old children in Barking and Dagenham had higher rates of tooth decay experience compared to London and England.

Older children

The findings of a national oral health survey of 12 and 15 year old children were published in March 2015. The sample was too small to report data at borough level but the headline findings were as follows:

- Reduction in the extent and severity of tooth decay in permanent teeth but large proportion of children continue to be affected by dental disease;
- Children from lower income families are more likely to have oral disease;
- 51% of 12 year olds and 60% of 15 year olds were satisfied with the appearance of their teeth and the majority were positive about their oral health;
- 23% of parents said they had taken time off work because of their child’s oral health in the previous six months;
- More than three quarters of older children reported brushing their teeth twice a day.

Hospital admissions for dental extractions for children

In 2012/13 dental extraction was the highest cause of hospital admissions for children in London. In Barking and Dagenham 310 children were admitted to hospital for dental extractions with 40% in the 5-9 year age group. This represented 0.5% of the 0-19 year old population, similar to that for London.

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Access to dental services in Barking and Dagenham

Barking and Dagenham has more dental capacity compared to London and England. There are 27 dental practices including community/special care dental clinics. There are more dentists per 100,000 of the population (52) than London (51) and England (44). There are also more Units of Dental Activity (UDA) per 100,000 of the population (178,206) compared to London (149,280) and England (165,798).

In March 2014, 60% of children resident in Barking and Dagenham accessed dental services in the previous 24 months, similar to London but lower than the figure for England. There has been a steady increase in the number of children accessing dental services in Barking and Dagenham from 2011 to 2014.

Population averages can mask inequalities in oral health. There are marked inequalities in children’s oral health, with a strong association between oral health and social deprivation.

ORAL HEALTH OF ADULTS: KEY POINTS

The findings of the local 2010 oral health survey (summarised below) revealed that the dental health status of adults living in Barking and Dagenham was similar or better than the average figures for England:

- The possession of 21 or more natural teeth is used to define a minimum functional dentition to ensure good oral health. In Barking and Dagenham, 94% of adults had a functional dentition, compared to 91% in London and 86% in England;
- 63% of those surveyed were satisfied with the appearance of their teeth;
- 54% had decayed teeth compared to 28% in London and 30% in England;
- 20% had evidence of advanced gum disease compared to 10% for London;
- 64% reported that they brush their teeth twice a day compared to 77% for London;
- 50% attend for dental care only when in emergency compared to 35% for London;
- 65% access NHS dental treatment, 20% go private and 13% utilise a mixture of services.
In addition to clinical indicators of dental problems, insight work revealed the impact of poor oral health on residents’ general wellbeing. In Barking and Dagenham, 47% of adults who had their own teeth reported having experienced one or more oral problems that had an impact on some aspect of their life compared to 37% for London and 39% for England. The most frequently experienced problem was dental pain, followed by psychological impacts such as low self-esteem and confidence.

Between 2010 and 2012 the age standardised rate per 100,000 of the population for oral cancer in Barking and Dagenham was 9.2 compared to 13.5 for London and 13.2 for England\(^8\).

**Access to dental services in Barking and Dagenham**

In March 2014:

- 52% of adults living in Barking and Dagenham accessed dental services in the previous 24 months compared to 44% for London and 51% for England.
- There has been a steady increase in the number of adults accessing dental services in Barking and Dagenham with the level of service use higher than that for London and England.
- There is very little variation in child and adult access rates in Barking and Dagenham wards. Approximately 12% of children and adults who are resident in Barking and Dagenham access dental services in other boroughs.

**VULNERABLE GROUPS**

The 2010 survey found that people with learning disabilities had more missing teeth, fewer filled teeth and more untreated diseased teeth than the general adult population surveyed. This suggests that, when people with learning disabilities do access dental services, they are more likely to have teeth extracted instead of restorative treatment such as fillings or crowns due to the extent of the oral health problem.

A report published by Public Health England (PHE) entitled Tackling poor oral health in children – Local government’s public health role (2014) shows that tooth decay is the most common oral disease affecting children and young people in England. Furthermore, tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2012-13\(^8\).  

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\(^8\) Public Health England. Dental health: Admission to hospital for extraction of one or more decayed primary or permanent teeth 0 to 19 year olds, 2011/12 and 2012/13. [http://www.nwph.net/dentalhealth/extractions.aspx](http://www.nwph.net/dentalhealth/extractions.aspx)
The prevalence of gum diseases increases with age and in older adults is more commonly seen in females. People aged 75 and above and people with dementia are at increased risk of gum disease because of poor oral hygiene and the inability to maintain self-care. A high prevalence of gum disease in older adults should be of concern because it directly increases the patient’s risk of developing root decay, as well as tooth loss with resulting deficient masticatory ability, nutrition and speech, which can affect a person’s quality of life\textsuperscript{19}.

Reported oral health related quality of life is worse in the population with serious mental illness and in one study 80\% of adults with serious mental illness reported having one or more dental impacts compared to 39\% from the general population the most frequently reported impact being pain in the mouth. Fear and anxiety, in conjunction with the added issue of dental teams reluctant in treating patients with mental illness, has resulted in high levels of mentally ill people failing to seek a dental practitioner. Fear and anxiety of attending the dentist may have significant quality of life consequences, especially on an individual who is already coping with a mental illness\textsuperscript{20}.

This demonstrates the need for early interventions and more comprehensive preventive dental and oral health procedures for the general population and vulnerable groups in particular.
4. KEY PRIORITIES FOR IMPROVING ORAL HEALTH IN BARKING AND DAGENHAM

Defining oral health priorities in Barking and Dagenham

An oral health partnership strategy group was established in 2015. The group utilised the needs assessment to make recommendations for local priorities and develop the high-level oral health strategy incorporating community-based interventions and activities. The strategy includes universal actions for all local communities and actions targeted to address the needs of the most vulnerable groups.

Based on the evidence of need for oral health services, the recommendation was to focus on children (pre-school and school age), young people and adults whose economic, social, environmental circumstances or lifestyle place them at high risk of poor oral health or make it difficult for them to access dental services.

THE KEY PRIORITIES

Priorities for oral health promotion and service delivery in Barking and Dagenham are to:

A. Promote and protect oral health by raising awareness about oral health;
B. Improve diet and reduce consumption of sugary food and drinks, alcohol and tobacco (and thereby improve general health as well);
C. Encourage people to go to the dentist regularly;
D. Address inequalities in oral health;
E. Improve access to local dental services particularly for priority groups; F. Improve oral hygiene;
G. Promote the provision of preventive dental care;
H. Increase early detection of mouth cancer and dental decay;
I. Increase exposure to fluoride.
5. EFFECTIVE INTERVENTIONS FOR IMPROVING ORAL HEALTH

Evidence-based interventions for improving oral health

This section outlines the interventions and activities that have evidenced effectiveness in achieving the key objectives of preventing poor oral health, improving oral health and reducing oral health inequalities in the UK. Some of these interventions may involve a universal approach whilst others may be targeted to address oral health needs in specific population groups and geographic areas. Key outcomes from the recommended interventions are also summarised in the outcome triangles in Appendix C. The evidence base will inform the interventions and activities included in the strategy delivery plan.

Effective interventions for improving oral health in children

The following measures are identified as being effective in improving oral health in children:

<table>
<thead>
<tr>
<th>IMPROVE DIET AND REDUCE THE CONSUMPTION OF SUGARY FOODS, DRINKS, ALCOHOL AND TOBACCO</th>
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<tbody>
<tr>
<td>• Healthy food and drink policies in childhood settings</td>
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<tr>
<td>• Influencing local and national government policy and fiscal policy in relation to food, infant feeding, smoking and alcohol (risk factor approach)</td>
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<tr>
<th>INCREASE THE AVAILABILITY OF FLUORIDE</th>
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<tr>
<td>• Targeted provision of toothbrushes and toothpaste</td>
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<tr>
<td>• Targeted community-based fluoride varnish programmes</td>
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<tr>
<td>• Fluoridation of public water supplies</td>
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<table>
<thead>
<tr>
<th>IMPROVE ORAL HYGIENE</th>
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<tr>
<td>• Targeted peer (lay) support groups and peer oral health workers</td>
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<tr>
<td>• Oral health training for the wider professional workforce</td>
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<tr>
<td>• Supervised tooth-brushing in targeted childhood settings</td>
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<tr>
<td>• Integration of oral health into targeted home visits by health and social care workers</td>
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<table>
<thead>
<tr>
<th>ADDRESS INEQUALITIES IN ORAL HEALTH</th>
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</table>
Appendix A (of Oral Health Scrutiny Options Report)

**Oral Health Promotion Strategy**

- Integration of oral health into targeted home visits by health and social care workers
- Targeted provision of toothbrushes and toothpaste (e.g. postal or through health visitors)
- Targeted community-based fluoride varnish programmes
- Supervised tooth-brushing in targeted childhood settings

**INCREASE ACCESS TO DENTAL SERVICES**

There is only weak evidence to suggest that intensive home visits by dental co-ordinators may increase access to dental service. It is therefore the responsibility of all services to seize opportunities to:

- Signpost parents to primary dental care, and
- Ensure that information is available on how to access dental care, and the associated costs/eligibility for support with healthcare costs.

**Table 1: Evidence-based interventions for improving oral health in children (NICE 2014)**

<table>
<thead>
<tr>
<th>Effective Interventions for improving oral health in adults and vulnerable adults</th>
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<tbody>
<tr>
<td>With regard to adults and vulnerable adults effective interventions include training of the wider professional workforce including skills training for carers. Other programmes include targeted provision of high strength fluoride toothpaste and mouth cancer screening for people who are at high risk. Overarching strategic outcomes to determine the effectiveness of the programmes include a change in the oral health related quality of life and reduction in active dental caries and gum disease are listed in Appendix C.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Oral Health Promotion Strategy</th>
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<tbody>
<tr>
<td>Encourage dental teams to give dietary advice in dental practice as this promotes good oral health.</td>
</tr>
<tr>
<td>Encourage tooth brushing twice daily with a fluoride toothpaste in order to prevent dental decay and gum disease in adults.</td>
</tr>
<tr>
<td>Support behavioural interventions as they contribute to dental anxiety reduction and result in improved dental attendance in adults.</td>
</tr>
<tr>
<td>Support programmes using more innovative approaches than the medical/behavioural model as they have more potential for achieving longer-term behaviour changes.</td>
</tr>
<tr>
<td>The use of tailored approaches based on active participation and addressing social cultural and personal norms offer longer-term changes in behaviour compared with simple one off interventions.</td>
</tr>
<tr>
<td>Develop oral health promotion programmes combined with skills training for carers as this can benefit older adults.</td>
</tr>
<tr>
<td>Encourage the use of high concentration fluoride toothpaste and fluoride varnish as this can prevent or reverse tooth decay in older adults.</td>
</tr>
<tr>
<td>Where appropriate encourage dentists to use the traumatic restorative technique (ART) as this is an effective method of treating root caries in older adults.</td>
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</tbody>
</table>

Table 2: Evidence-based interventions for improving oral health in adults

National guidance for oral health in care homes should be implemented including oral health assessments and development of individual oral health care plans for residents.  

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9 NICE will be publishing guidance on oral health for adults in care homes in July 2016.
APPENDIX A - POLICY AND GUIDANCE

A number of policy documents have been issued in relation to improving oral health and commissioning dental services for children and adults.

National policy drivers

The Government made a commitment to improve oral health and dentistry with a drive to:
• Improve the oral health of the population, particularly children
• Introduce a new NHS dental contract based on registration, capitation and quality
• Increase access to primary dental care services

Public Health England advice\textsuperscript{11} and NICE guidelines (PH55)\textsuperscript{12} were issued in 2014 to support local authorities and their partners in their role to improve health in local communities. Recommendations include:

• Ensuring that oral health is a health and wellbeing priority and included in the
• Conduct an oral health needs assessment, using a range of oral health epidemiological data sources
• Develop an oral health strategy
• Ensure that frontline health and social care staff can give advice on the importance of oral health;
• Promote a whole school approach to oral health in primary and secondary schools.

Public Health Outcomes Framework (2013-16) - The PHOF encourages the prioritisation of oral health improvement by including a measure of the oral health of five-year-old children as a key indicator. PHOF indicator 4.2 measures the ‘\textit{mean severity of tooth decay in children aged five years based on the mean number of teeth per child sampled which were either actively decayed or had been filled or extracted decayed/missing/filled teeth (d3mft)}’. Local authorities use this indicator to monitor and evaluate children’s oral health improvement programmes\textsuperscript{13}

\textsuperscript{10} NHS England 2014; Department of Health 2010
\textsuperscript{12} Oral health: local authorities and partners; October 2014 https://www.nice.org.uk/guidance/ph55
Appendix A (of Oral Health Scrutiny Options Report)

**NHS Outcomes Framework** (2014-15) includes indicators related to patients’ experiences of NHS dental services (4aiii) and access to NHS dental services (4.4ii).¹⁴

**The Children and Young People's Health Outcomes Framework** (2014) and strategy recommends that an integrated and partnership approach be adopted to improve health outcomes for children and young people and includes the indicator to measure tooth decay in children aged 5.

**Local policy**

Barking and Dagenham has a statutory responsibility to ‘provide, or make arrangements to secure the provision’ of oral health surveys and oral health promotion and oral health improvement as part of overall population health improvement¹⁵. This is supported by the dental public health expertise within Public Health England. NHS England is responsible for commissioning primary care and hospital dental services.


Ambition 20/20  https://www.lbbd.gov.uk/council/priorities-and-strategies/vision-and-priorities/overview/

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Appendix A (of Oral Health Scrutiny Options Report)


Oral health promotion approaches for dental practitioners. NICE public health guideline - Publication expected October 2015 http://www.nice.org.uk/Guidance/InDevelopment/GID-PHG60

APPENDIX B - EFFECTIVE INTERVENTIONS AND OUTCOMES FOR IMPROVING ORAL HEALTH

Effective Interventions and outcomes for improving oral health in children

Overarching outcomes for children

- Changes in tooth decay levels in 5 year old children (Public Health Outcomes Framework Indicator 4.2)
- Reduction in decay rates in the most deprived areas
- Reduced hospital admissions for tooth extractions
- Change in the number (%) of children reporting toothaches and pain

Figure 1: Effective interventions and outcome measures for oral health improvement programmes for children and young people (overleaf)
Appendix A (of Oral Health Scrutiny Options Report)

Overarching Strategic Outcomes

Health Outcome
- Change in tooth decay levels in five-year-old children (population)

Health Outcome
- Reduction in tooth decay rates in the most disadvantaged areas in the local authority

Health Outcome
- Reduced hospital tooth extractions

Quality of Life outcome
- Change in number (%) of children reporting toothaches and pain/discomfort

Intermediate Outcomes

Parents' change in oral health knowledge and self-efficacy

Health and social care professionals change in oral health knowledge and oral health literacy

Change in food choices in early years settings and schools

Change in reported tooth brushing behaviour because of supervised tooth brushing schemes

Change in reported use of fluoridated toothpaste because of postal toothpaste schemes

Parents' change in oral health knowledge and self-efficacy

Number (%) of targeted schools with a supervised tooth brushing scheme

Number (%) of targeted children reached by postal toothpaste and brush schemes

Percentage of targeted children reached by community fluoride varnish programmes

Planning policies restricting unhealthy food outlets near schools and early year settings in place

Service outcomes

Number of the peer-led oral health support groups established to vulnerable groups

Number (%) of the children's workforce who have received annual oral health training

Number of schools with a policy including restrictions on added sugars

Percentage of targeted children reached by community fluoride varnish programmes

Community-Based Preventive Services
- Targeted Community-based Fluoride varnish programmes
- Targeted provision of toothbrushes and toothpastes

Healthy Public Policy
- Influencing local and national government policies

Recommended Interventions

Community Action
- Targeted peer (lay) support groups / peer oral health workers
- Supporting consistent evidence informed oral health information
- Oral health training of the wider professional workforce
- Integration of oral health into health and social care worker visits

Supportive Environments
- Supervised tooth brushing in targeted childhood settings
- Healthy Food and Drink Policies in Childhood Settings
- Fluoridated Water Supply

Community-Based Preventive Services
- Targeted Community-based Fluoride varnish programmes
- Targeted provision of toothbrushes and toothpastes

Healthy Public Policy
- Influencing local and national government policies
Appendix A (of Oral Health Scrutiny Options Report)

Key performance indicators for children

- Number (%) of the children’s workforce including health visitors and school nurses who have received annual oral health training
- Number (%) of schools with an oral health indicator for the healthy schools programme
- Number (%) of targeted children reached by a fluoride varnish programme
- Number (%) of targeted children reached by a supervised brushing programme
- Number (%) of targeted children reached by the brushing for life programme
- Number (%) of targeted children reached by the brushing for life programme

Intermediate outcomes for children

- Change in the number (%) of CYP workforce incorporating oral health messages into work programmes
- Number (%) of targeted children receiving two fluoride varnish applications per year
- Parents change in oral health knowledge and self efficacy
- Health and social care professionals change in oral health knowledge and oral health literacy
- Change reported in tooth brushing behaviour because of supervised tooth brushing programme
- Planning policies restricting unhealthy food outlets near schools and early year settings in place

Future outcomes for children and young people

- Every child and young resident of Barking and Dagenham to be registered with a dentist (by 2020?)

Effective Interventions for improving oral health in adults and older adults

Figure 2: Effective interventions and outcome measures for oral health improvement programmes for adults and older adults (overleaf).
Effective interventions
Table 1: Evidence-based interventions for improving oral health in adults (NICE 2014) (see page 17).

Supporting consistent evidence informed oral health information
- Oral health training for the wider professional workforce including skills training for carers as this can benefit older adults
- Integration of oral health into targeted home visits by health and social care workers

Community based preventive programmes
- Targeted use of high strength fluoride toothpaste and fluoride varnish for at risk adults and older adults
- Targeted screening for oral cancer for adults and older adults who are at high risk
- Encourage dental professionals to deliver tobacco cessation interventions as they may be effective in helping tobacco users to quit

Supportive environments
- Standards for care homes for older people should reflect an oral health assessment and oral care plan
- Standards for care homes for older people should reflect the impact of healthy food choices and sugar consumption on the maintenance of good oral health

Community action
- Targeted peer (lay) support groups/peer oral health workers

Healthy public policy
- Influencing local and national government policies

Expected outcomes
- Change in reported use of high strength fluoride toothpaste
- Health and social care professionals change in oral health knowledge and oral health literacy
- Change in the reported oral health of older adults as a result of systematic use of oral health assessments and development & implementation of oral health care plans
Future outcomes for adults
• Every adult resident in Barking and Dagenham to be registered with a dentist (by 2020)

Key performance indicators
• Number (%) of health and social care programmes with oral health messages
• Number (%) of carers who have received oral health training
• Number (%) of frail adults who have received an oral health assessment and care plan
• Number (%) of targeted older adults who have received high strength fluoride tooth paste or fluoride varnish
• Number of peer-led oral health support groups established to support vulnerable adults and older adults
• Number of mouth cancer awareness sessions delivered
• Number of targeted adults screened for mouth cancer
• Number of adults and older adults referred to tobacco cessation services
APPENDIX C - OVERVIEW OF LOCAL ORAL HEALTH SERVICES

Dental services in Outer North East London

Programme 1: Infant and Primary Schools

This is a signposting and information oral health programme consisting of a mail out pack which includes:
• Information on how to set up/develop a School Snack Policy
• Laminated Dental First Aid Poster – What to do if an adult tooth is knocked out – Helping to reduce dental injuries.
• Catalogue to loan resources that support school teaching of dental health.
• Appropriate dental health web sites for teaching/education.
• List of local NHS dentists
• Pro forma for referral into the Community Dental service explaining criteria for referral.

Target: parents, teachers, Sencos, Healthy Schools Co-ordinators and school support staff.

Programme 2  Senior Schools

A signposting and information programme consisting of a mail pack which includes:
• Laminated Dental First Aid Poster – What to do if an adult tooth is knocked out. This simple advice can prevent a teenager requiring a denture by their own tooth being implanted correctly, it will also help reduce dental injuries
• List of local NHS dentists
• Pro forma for referral into the Community Dental service explaining criteria for referral.

Target: students, teachers, Sencos, Healthy Schools Co-ordinators and school support staff.

Programme 3  New Intake Children - Reception year

An information welcome starter card for children starting school.

Target: Reception class children and their families, teachers, Senco’s and school support staff.
Programme 4  Dental Programme for Special Educational Needs Schools

A school tooth brushing programme is set up and maintained by the oral health team in Special Educational Needs Schools. The aim of the programme is to have daily supervised tooth brushing at school in addition to any tooth brushing that happens at home. Training is provided for all staff involved. Equipment provided includes toothbrush holders and covers, toothpaste at optimum fluoride level, toothbrushes and appropriate labelling, poster to be displayed near brushing area.

Target: Children attending Special Educational Needs schools, and staff.

Programme 5  Early Years – Children Centres and Nurseries promoting good oral health

The programme involves a variety of oral health initiatives that will facilitate the national drive to reduce dental disease among children. Using children’s centres and nurseries our local strategic objective is to improve oral health outcomes for the more vulnerable groups in our communities by focusing on children living in communities of relative deprivation, and children with learning difficulties.

The programme involves training staff in Children’s Centres and identifying a nominated lead for oral health. The oral health lead for Children’s Centres is responsible for identifying and nominating Oral Health Champions that will be assigned to individual children’s centre/cluster/managers. Oral health champion’s (OHC) are responsible for

- Implementing the standardisation of the oral health leaflets throughout all centres
- Responding to oral health enquiries from families attending centres
- Sign-posting to local GDP/community dental service
- Oral health sessions, displays/campaigns for the centre.
- Working with clinical teams to arrange outreach check-up programmes for all red and amber families and signposting green families to General Dental Practitioners.

Target: families attending Children Centres, Children’s Centre staff.
Appendix A (of Oral Health Scrutiny Options Report)

Programme 6  Oral health training for all who work with Early Years

This training programme facilitates the national drive to reduce early onset of dental disease among children using people who work with early years.

Training objectives are to enable participants to
• Recognise the factors that contribute to poor oral health
• Understand how good oral health contributes to overall health and wellbeing
• Understand that dental diseases are mainly preventable
• Understand the role of fluoride in prevention
• Realise the importance of early and regular dental attendance
• Apply information learnt to promote oral health within their work role

Target: Health Visitors, School Nurses Health Visitor teams, School Nurse Teams, Children Centres, Community/Nursery Nurses, Foster Care and Child Minder Leads.

Programme 7  Vulnerable Adults programme

This programme is an oral health training schedule for any staff or people who work with vulnerable adults, including older people and people with learning disabilities.

Target: Staff and carers from Care and Nursing Homes, Residential homes, Day centres for older cared for adults, adults with learning disabilities. District nurses, Adult speech and language therapists.

Programme 8  Vulnerable Adults Signposting programme

A poster campaign which aims to raise awareness of the signs and symptoms of oral cancer, and encourage early presentation.

Programme 9  Work programmes for vulnerable adults

A training programme delivered to adults with learning disabilities or adults who experience mental health problems. Each session is tailored to meet the needs of the participants

Target: vulnerable adults

Programme 10  Substance & Alcohol Misuse team oral health training

A training programme which aims to raise awareness of oral health issues pertaining to substance misuse and alcohol users. This includes

- Increasing knowledge of the oral health issues and barriers to accessing care, experienced by people that abuse alcohol/substances.
- Awareness of oral health messages
- Ability to provide tailored oral health information for clients
- Awareness of the early warning signs of oral cancers, and those groups who have an increased risk of developing the disease.
- Ability to signpost people to access dental care/out of hours emergency dental care.

Target: People who use Substance & Alcohol Misuse services and staff

Programme 11  Support National Campaigns

National Smile Month - May – June
Oral Cancer Awareness Month – November
Stop Smoking Campaigns
Supports other national events such as Parkinsons Week, Action on Stroke Month, Older People’s Day and Alzheimer’s Day.

Programme 12  Support Local Campaigns

Includes Stop Smoking events, NELFT Health and Wellbeing day, Autism Awareness Month/Day.
APPENDIX D - COMMISSIONING MAP FOR DENTAL SERVICES IN BARKING AND DAGENHAM

NHS England London region is responsible for the commissioning of all clinical dental services. They commission the following dental services:

- General dental services – high street dentists
- Community dental services – dental services for the vulnerable and people with special needs
- Out of hours urgent care dental services – dental services for evenings, weekends and bank holidays
- Primary care specialist dental services – dental services for people requiring complex endodontics (root canal), periodontics (gum disease) and prosthodontics (dentures, crowns and bridges)
- Hospital dental services

Local authorities are responsible for the commissioning of the following non-clinical oral health services:

- Oral health improvement programmes
- Oral health surveys as part of local and national epidemiology programmes
APPENDIX E - CLINICAL GOVERNANCE

Dental care in Barking and Dagenham is provided by Dental Professionals who must be registered with the General Dental Council and meet their standards.

There are nine principles they must follow:

- Put patient’s interests first
- Communicate effectively with patients
- Obtain valid consent
- Maintain and protect patients’ information
- Have a clear and effective complaints procedure
- Work with colleagues in a way which is in patients’ best interests
- Maintain, develop and work within professional knowledge and skills
- Raise concerns if patients are at risk
- Make sure personal behaviour maintains confidence in them and the profession

The Care Quality Commission inspectors use professional judgement, supported by objective measures and evidence, to assess dental services against five key questions:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C (Caring)</td>
<td>Staff involve and treat people with compassion, kindness, dignity and respect.</td>
</tr>
<tr>
<td>R (Responsive)</td>
<td>Services are organised so that they meet people’s needs.</td>
</tr>
<tr>
<td>E (Effective)</td>
<td>People’s care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.</td>
</tr>
</tbody>
</table>
Appendix A (of Oral Health Scrutiny Options Report)

<table>
<thead>
<tr>
<th>W</th>
<th>Well-led - the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Safe - people are protected from abuse and avoidable harm.</td>
</tr>
</tbody>
</table>

Useful websites

General Dental council [www.gdc-uk.org](http://www.gdc-uk.org)


Website details for Management of Dental Trauma [www.dentaltraumaguide.org](http://www.dentaltraumaguide.org)


Faculty of General Dental Practice [http://www.fgdp.org.uk/](http://www.fgdp.org.uk/)

Care Quality Commission [www.cqc.org.uk](http://www.cqc.org.uk)
## Appendix F – Oral Health Promotion Action Plan

<table>
<thead>
<tr>
<th>No.</th>
<th>Area of work</th>
<th>Action</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Parenting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td></td>
<td>Provide oral health resource packs at antenatal classes in Children’s Centres</td>
<td>Children’s Services</td>
</tr>
<tr>
<td>1.2</td>
<td></td>
<td>Develop educational oral health programmes for parenting classes</td>
<td>Children’s Centres</td>
</tr>
<tr>
<td>2.</td>
<td>Infancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td></td>
<td>Ensure oral health input into infant feeding guidelines</td>
<td>NELFT</td>
</tr>
<tr>
<td>2.2</td>
<td></td>
<td>Distribute free toothbrushes and toothpastes to every child in the borough at 8 months (to include weaning/drinking cups) and focus on children up to 2 years</td>
<td>Children’s Services</td>
</tr>
<tr>
<td>3.</td>
<td>Pre-school</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td></td>
<td>Place an emphasis on parents through Children’s Centres and other Early Years settings and promote the values of good oral health through knowledge and oral health behaviours and promoting self care</td>
<td>Children’s Centres</td>
</tr>
<tr>
<td>3.2</td>
<td></td>
<td>Develop supervised tooth brushing protocol</td>
<td>NELFT</td>
</tr>
<tr>
<td>3.3</td>
<td></td>
<td>Supervised tooth brushing sessions targeted at special schools and areas in the borough where there is the greatest need</td>
<td>NELFT</td>
</tr>
<tr>
<td>3.4</td>
<td></td>
<td>Develop oral health booklet for pre-schoolers</td>
<td>Children’s Services</td>
</tr>
</tbody>
</table>
### 3.5
Establish an accreditation process for early years settings that offer healthy food/snack policies and daily supervised tooth brushing

**Children’s Services**

### 4. School
4.1 All schools offered opportunity to be involved in supervised tooth brushing programme

**Education Services**

4.2

4.3 Develop oral health education resource for schools

**PHE**

### 5. Raising Awareness
5.1 Develop communication plan to support National Smile Month and Mouth Cancer Awareness annual campaigns

**Communications and Marketing**

5.2 Actively participate in annual National Smile Month and Mouth Cancer Awareness annual campaigns, the British Dental Association’s ‘Make a meal of it’ campaign (damage done to the oral health of children by sugary and acidic food and drink)

**Communications and Marketing**

### 6. Training
6.1 Conduct oral health workshops for all front line staff including early years settings

**NELFT**

6.2 Incorporate oral health input into early years training programmes provided in the borough

**NELFT**

### 7. Vulnerable Groups
7.1 Ensure the oral health needs of newly arrived children in the borough are identified and met through collaborative working

**Children’s Services**
## Oral Health Promotion Strategy

<table>
<thead>
<tr>
<th>7.2</th>
<th>Ensure the oral health needs of looked after children in the borough are identified and met through collaborative working</th>
<th>Children’s Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.3</td>
<td>Ensure the oral health needs of disabled children in the borough are identified and met through collaborative working</td>
<td>Children’s Services</td>
</tr>
<tr>
<td>8.0</td>
<td><strong>Older People</strong></td>
<td></td>
</tr>
<tr>
<td>8.1</td>
<td>Ensure that preventive packages are developed. Including older people living independently, in assisted housing and those in nursing and residential homes.</td>
<td>Adults Care and Support</td>
</tr>
<tr>
<td>Meeting date</td>
<td>Agenda items</td>
<td>Officer/ Presenter</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Weds 20 September</td>
<td>NELFT - Update on Improvement Journey&lt;br&gt;Health Checks Performance Update&lt;br&gt;Results of Inspections undertaken by the Care Quality Commission on Local Adult Social Care Services -Quarter 1&lt;br&gt;JHOSC update</td>
<td>Melody Williams, NELFT&lt;br&gt;Matthew Cole&lt;br&gt;Chair</td>
</tr>
<tr>
<td>Mon 13 November</td>
<td>BHRCCG’s outcome of ‘Spending NHS money wisely’ consultation&lt;br&gt;BHRUT – update on referral to treatment times and A&amp;E performance&lt;br&gt;Sustainability and Transformation Plans and Accountable Care Partnership - updates&lt;br&gt;JHOSC Update</td>
<td>TBC, BDCCG&lt;br&gt;TBC&lt;br&gt;Chair</td>
</tr>
<tr>
<td>Date</td>
<td>Item</td>
<td>Updates</td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Weds 10 January</td>
<td>The challenges in adult social care</td>
<td>LBBD - TBC</td>
</tr>
<tr>
<td></td>
<td>Primary Care Update</td>
<td>BDCCG</td>
</tr>
<tr>
<td></td>
<td>Results of Inspections undertaken by the Care Quality Commission on</td>
<td>TBC</td>
</tr>
<tr>
<td></td>
<td>Local Adult Social Care Services – Quarter 2</td>
<td>Healthwatch</td>
</tr>
<tr>
<td></td>
<td>Heathwatch update</td>
<td></td>
</tr>
<tr>
<td>Weds 21 February</td>
<td>Mental Health Provision in Barking and Dagenham</td>
<td>TBC</td>
</tr>
<tr>
<td></td>
<td>Monitoring report – Cancer Scrutiny Recommendations and Progress of</td>
<td>TBC</td>
</tr>
<tr>
<td></td>
<td>Action Plan</td>
<td>TBC</td>
</tr>
<tr>
<td></td>
<td>Results of Inspections undertaken by the Care Quality Commission on</td>
<td>Chair</td>
</tr>
<tr>
<td></td>
<td>Local Adult Social Care Services – Quarter 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>JHOSC update</td>
<td></td>
</tr>
</tbody>
</table>
THE FORWARD PLAN

Explanatory note:

Key decisions in respect of health-related matters are made by the Health and Wellbeing Board. Key decisions in respect of other Council activities are made by the Council’s Cabinet (the main executive decision-making body) or the Assembly (full Council) and can be viewed on the Council’s website at http://moderngov.barking-dagenham.gov.uk/mgListPlans.aspx?RPId=180&RD=0. In accordance with the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 the full membership of the Health and Wellbeing Board is listed in Appendix 1.

Key Decisions

By law, councils have to publish a document detailing “Key Decisions” that are to be taken by the Cabinet or other committees / persons / bodies that have executive functions. The document, known as the Forward Plan, is required to be published 28 days before the date that the decisions are to be made. Key decisions are defined as:

(i) Those that form the Council’s budgetary and policy framework (this is explained in more detail in the Council’s Constitution)
(ii) Those that involve ‘significant’ spending or savings
(iii) Those that have a significant effect on the community

In relation to (ii) above, Barking and Dagenham’s definition of ‘significant’ is spending or savings of £200,000 or more that is not already provided for in the Council’s Budget (the setting of the Budget is itself a Key Decision).

In relation to (iii) above, Barking and Dagenham has also extended this definition so that it relates to any decision that is likely to have a significant impact on one or more ward (the legislation refers to this aspect only being relevant where the impact is likely to be on two or more wards).

As part of the Council’s commitment to open government it has extended the scope of this document so that it includes all known issues, not just “Key Decisions”, that are due to be considered by the decision-making body as far ahead as possible.

Information included in the Forward Plan

In relation to each decision, the Forward Plan includes as much information as is available when it is published, including:

• the matter in respect of which the decision is to be made;
• the decision-making body (Barking and Dagenham does not delegate the taking of key decisions to individual Members or officers)
- the date when the decision is due to be made;

**Publicity in connection with Key decisions**

Subject to any prohibition or restriction on their disclosure, the documents referred to in relation to each Key Decision are available to the public. Each entry in the Plan gives details of the main officer to contact if you would like some further information on the item. If you would like to view any of the documents listed you should contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: tina.robinson@lbbd.gov.uk.

The agendas and reports for the decision-making bodies and other Council meetings open to the public will normally be published at least five clear working days before the meeting. For details about Council meetings and to view the agenda papers go to [http://moderngov.barking-dagenham.gov.uk/ieDocHome.asp?Categories](http://moderngov.barking-dagenham.gov.uk/ieDocHome.asp?Categories) and select the committee and meeting that you are interested in.

The Health and Wellbeing Board’s Forward Plan will be published on or before the following dates during the Council municipal year, in accordance with the statutory 28-day publication period:

<table>
<thead>
<tr>
<th>Edition</th>
<th>Publication date</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2017 edition</td>
<td>13 February 2017</td>
</tr>
<tr>
<td>May 2017 edition</td>
<td>10 April 2017</td>
</tr>
<tr>
<td>July 2017 edition</td>
<td>5 June 2017</td>
</tr>
<tr>
<td>September 2017 edition</td>
<td>7 August 2017</td>
</tr>
<tr>
<td>November 2017 edition</td>
<td>9 October 2017</td>
</tr>
<tr>
<td>January 2018 edition</td>
<td>18 December 2017</td>
</tr>
<tr>
<td>March 2018 edition</td>
<td>12 February 2018</td>
</tr>
<tr>
<td>June 2018 edition</td>
<td>14 May 2018</td>
</tr>
</tbody>
</table>
Confidential or Exempt Information

Whilst the majority of the Health and Wellbeing Board’s business will be open to the public and media organisations to attend, there will inevitably be some business to be considered that contains, for example, confidential, commercially sensitive or personal information.

This is formal notice under the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 that part of the meetings listed in this Forward Plan may be held in private because the agenda and reports for the meeting will contain exempt information under Part 1 of Schedule 12A to the Local Government Act 1972 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it. Representations may be made to the Council about why a particular decision should be open to the public. Any such representations should be made to Alan Dawson, Democratic Services Manager, Civic Centre, Dagenham, Essex RM10 7BN (telephone: 020 8227 2348, email: committees@lbbd.gov.uk).

Key to the table

Column 1 shows the projected date when the decision will be taken and who will be taking it. However, an item shown on the Forward Plan may, for a variety of reasons, be deferred or delayed.

It is suggested, therefore, that anyone with an interest in a particular item, especially if he/she wishes to attend the meeting at which the item is scheduled to be considered, should check within 7 days of the meeting that the item is included on the agenda for that meeting, either by going to http://moderngov.barking-dagenham.gov.uk/ieListMeetings.aspx?CId=669&Year=0 or by contacting contact Tina Robinson, Democratic Services Officer, Civic Centre, Dagenham, Essex, RM10 7BN (telephone: 020 8227 3285, email: tina.robinson@lbbd.gov.uk).

Column 2 sets out the title of the report or subject matter and the nature of the decision being sought. For ‘key decision’ items the title is shown in **bold type** - for all other items the title is shown in normal type. Column 2 also lists the ward(s) in the Borough that the issue relates to.

Column 3 shows whether the issue is expected to be considered in the open part of the meeting or whether it may, in whole or in part, be considered in private and, if so, the reason(s) why.

Column 4 gives the details of the lead officer and / or Board Member who is the sponsor for that item.
<table>
<thead>
<tr>
<th>Health and Wellbeing Board: 5.7.17</th>
<th><strong>Domestic and Sexual Abuse Strategy : Community</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The report will present the Board with the draft Domestic and Sexual Abuse Strategy.</td>
</tr>
<tr>
<td></td>
<td>The Board will be asked to discuss and approve the Domestic and Sexual Abuse Strategy.</td>
</tr>
<tr>
<td></td>
<td>• Wards Directly Affected: All Wards</td>
</tr>
<tr>
<td>Open / Private (and reason if all / part is private)</td>
<td>Open</td>
</tr>
<tr>
<td>Sponsor and Lead officer / report author</td>
<td>Mark Tyson, Commissioning Director, Adults' Care &amp; Support (Tel: 020 8227 2875) (<a href="mailto:mark.tyson@lbbd.gov.uk">mark.tyson@lbbd.gov.uk</a>)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health and Wellbeing Board: 5.7.17</th>
<th>Older People’s Housing Strategy - Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Board will be asked to consider and discuss the Older People’s Housing Strategy.</td>
</tr>
<tr>
<td></td>
<td>• Wards Directly Affected: All Wards</td>
</tr>
<tr>
<td>Open / Private (and reason if all / part is private)</td>
<td>Open</td>
</tr>
<tr>
<td>Sponsor and Lead officer / report author</td>
<td>Mark Tyson, Commissioning Director, Adults' Care &amp; Support (Tel: 020 8227 2875) (<a href="mailto:mark.tyson@lbbd.gov.uk">mark.tyson@lbbd.gov.uk</a>)</td>
</tr>
</tbody>
</table>
### Health and Wellbeing Board: 5.7.17

<table>
<thead>
<tr>
<th>Contract</th>
<th>Tender for the award of a contract for the provision of Three-Borough Integrated Sexual Health Services: Financial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The contract for Integrated Sexual Health services will expire on 30 September 2018.</td>
</tr>
<tr>
<td></td>
<td>The Board will be asked to approve the procurement strategy for the joint competitive procurement of this service with the London Boroughs of Havering and Redbridge from 1 October 2018 to 30 September 2021, with the option for the Council to extend the contract for a further two-year period, and to the delegation of the award of the contract.</td>
</tr>
<tr>
<td></td>
<td>• Wards Directly Affected: All Wards</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health and Wellbeing Board: 5.7.17</th>
<th>Contract: Tender for the procurement of an integrated Adult and Young People Substance Misuse (Drug and Alcohol) Services: Financial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The current contract for the Substance Misuse (Drug and Alcohol) services will expire on 31 March 2018.</td>
</tr>
<tr>
<td></td>
<td>The Board will be asked to approve the procurement strategy for the competitive procurement of this service from 1 April 2018 to 31 March 2021, with the option for the Council to extend the contract for a further two-year period, and to the delegation of the award of the contact.</td>
</tr>
<tr>
<td></td>
<td>• Wards Directly Affected: All Wards</td>
</tr>
</tbody>
</table>

Open | Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (matthew.cole@lbbd.gov.uk) |

Open | Mark Tyson, Commissioning Director, Adults’ Care & Support (Tel: 020 8227 2875) (mark.tyson@lbbd.gov.uk) |
<table>
<thead>
<tr>
<th>Health and Wellbeing Board: 5.7.17</th>
<th><strong>Contract: Public Health Primary Care Service - Procurement Strategy</strong> : <strong>Financial</strong></th>
<th>Open</th>
<th>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (<a href="mailto:matthew.cole@lbbd.gov.uk">matthew.cole@lbbd.gov.uk</a>)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The current contract for the Public Health Primary Care service will expire on 31 March 2018. The Board will be asked to approve the procurement strategy for the competitive procurement of this service from 1 April 2018 to 31 March 2020, with the option for the Council to extend the contract for a further two-year period, and to the delegation of the award of the contract.</td>
<td>• Wards Directly Affected: All Wards</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health and Wellbeing Board: 5.7.17</th>
<th><strong>Contract: Mental Health Support Procurement Strategy</strong> : <strong>Financial</strong></th>
<th>Fully Exempt</th>
<th>Mark Tyson, Commissioning Director, Adults' Care &amp; Support (Tel: 020 8227 2875) (<a href="mailto:mark.tyson@lbbd.gov.uk">mark.tyson@lbbd.gov.uk</a>)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Board will be asked to approve the proposed strategy to procure mental health support for residents of the Borough.</td>
<td>• Wards Directly Affected: All Wards</td>
<td>It will include information relating to the accommodation of individual residents.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health and Wellbeing Board: 5.7.17</th>
<th><strong>Stepping Up - The Future of Health and Wellbeing Board (H&amp;WB) Integration</strong> : <strong>Community</strong></th>
<th>Open</th>
<th>Mark Tyson, Commissioning Director, Adults' Care &amp; Support (Tel: 020 8227 2875) (<a href="mailto:mark.tyson@lbbd.gov.uk">mark.tyson@lbbd.gov.uk</a>)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A workshop was held on 26 January at which members of the Board and associated individuals from partner organisations considered the progress made in Barking and Dagenham around the integration of health and social care and what was required for the future. The Board will be presented with some of the key findings and have a chance to discuss and agree ways forward in terms of health and social care integration at a Barking and Dagenham level.</td>
<td>• Wards Directly Affected: Not Applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and Wellbeing Board: 5.7.17</td>
<td>Sustainability and Transformation Plan Update</td>
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<td>The Board will be provided with an update on the progress made in the development and delivery of the North East London Sustainability and Transformation Plan (NEL STP).</td>
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<td>• Wards Directly Affected: All Wards</td>
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<td></td>
<td>Open</td>
<td>Mark Tyson, Commissioning Director, Adults' Care &amp; Support (Tel: 020 8227 2875) (<a href="mailto:mark.tyson@lbbd.gov.uk">mark.tyson@lbbd.gov.uk</a>)</td>
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<tr>
<td>Health and Wellbeing Board: 5.7.17</td>
<td>Barking, Havering and Redbridge Transformation Programmes and Governance</td>
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<td>The Board will be provided with an update on the various BHR wide transformation programmes that are ongoing across social care and health, including work related to health devolution and localities as well as other health related work.</td>
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<td>Health and Wellbeing Board: 5.7.17</td>
<td>Better Care Fund Plan for 2017/19: Update</td>
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<td>The Board will be updated on progress towards the development of the Better Care Fund Plan for 2017/19 following the publication of the guidance. The Board will be invited to give feedback on these developments, with the understanding that the full Plan will be brought for the Board’s approval in July 2017.’</td>
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<tr>
<td>Health and Wellbeing Board: 5.7.17</td>
<td>Strategy for Liver Disease in Barking and Dagenham: Community</td>
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<td>Hospital admissions for liver disease, mainly due to excess alcohol consumption, continue to rise year upon year.</td>
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<td>The HWWB Board are asked to agree and support a move to develop a cohesive strategy that addresses this need.</td>
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<td>• Wards Directly Affected: All Wards</td>
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<td></td>
<td>Open</td>
<td>Matthew Cole, Director of Public Health (Tel: 020 8227 3657) (<a href="mailto:matthew.cole@lbbd.gov.uk">matthew.cole@lbbd.gov.uk</a>)</td>
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<tr>
<td>Health and Wellbeing Board: 5.7.17</td>
<td>Care City Update</td>
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<td>The Board will be provided with an update on the work being carried out by Care City.</td>
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- Wards Directly Affected: All Wards

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<tr>
<th>Health and Wellbeing Board: 5.7.17</th>
<th>London Health Devolution Agreement</th>
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<td>The Board will be presented with a report setting out the agreed London Health Devolution Agreement, including potential opportunities for Barking &amp; Dagenham and the BHR system to use some of the devolved powers and responsibilities.</td>
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</tbody>
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- Wards Directly Affected: All Wards | Open | Mark Tyson, Commissioning Director, Adults' Care & Support (Tel: 020 8227 2875) (mark.tyson@lbld.gov.uk)
Membership of Health and Wellbeing Board:

Councillor Maureen Worby, Cabinet Member for Social Care and Health Integration (Chair)
Councillor Sade Bright, Cabinet Member for Equalities and Cohesion
Councillor Laila M. Butt, Cabinet Member for Cabinet Member for Enforcement and Community Safety
Councillor Evelyn Carpenter, Cabinet Member for Educational Attainment and School Improvement
Councillor Bill Turner, Cabinet Member for Corporate Performance and Delivery
Anne Bristow, Strategic Director for Service Development and Integration and Deputy Chief Executive
Matthew Cole, Director of Public Health
Frances Carroll, Chair of Healthwatch Barking and Dagenham
Dr Waseem Mohi, Chair of Barking and Dagenham Clinical Commissioning Group (Deputy Chair of the H&WBB)
Dr Jagan John, Clinical Director (Barking and Dagenham Clinical Commissioning Group)
Conor Burke, Accountable Officer (Barking and Dagenham Clinical Commissioning Group)
Bob Champion, Executive Director of Workforce and Organisational Development (North East London NHS Foundation Trust)
Dr Nadeem Moghal, Medical Director (Barking Havering and Redbridge University Hospitals NHS Trust)
Sean Wilson, Interim LBBD Borough Commander (Metropolitan Police)
Ceri Jacob, Director Commissioning Operations NCEL (NHS England - London Region) (non-voting Board Member)