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# HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

| 7.00 pm | Tuesday<br>9 September 2014 | Havering Town Hall |
|---|---|---|

Members 6: Quorum 3

**COUNCILLORS:**

| Conservative Group ( 3) | Residents' Group ( 2) | UKIP Group ( 1) |
|---|---|---|
| Dilip Patel (Vice-Chair)<br>Joshua Chapman<br>Jason Frost | Nic Dodin (Chairman)<br>Gillian Ford | Patricia Rumble |

**Andrew Beesley**
**Committee Administration Manager**

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**anthony.clements@oneSource.co.uk**

## AGENDA ITEMS

**1 ANNOUNCEMENTS**

Details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation will be announced.

**2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS**

(if any) – receive.

**3 DISCLOSURE OF PECUNIARY INTERESTS**

Members are invited to disclose any interests in any of the items on the agenda at this point of the meeting. Members may still disclose an interest in an item at any time prior to the consideration of the matter.

**4 MINUTES** (Pages 1 - 8)

To agree as a correct record the minutes of the meeting held on 24 June 2014 and to authorise the Chairman to sign them (attached).

**5 HEALTHWATCH HAVERING ANNUAL REPORT** (Pages 9 - 50)

To receive a presentation from a senior Healthwatch Havering officer on the Healthwatch Havering Annual Report (attached).

**6 BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST IMPROVEMENT PLAN**

To receive a presentation from the Chief Executive of Barking, Havering and Redbridge University Hospitals Trust (BHRUT) on the Trust improvement plan and other issues.

**7 BREAST CARE SERVICES**

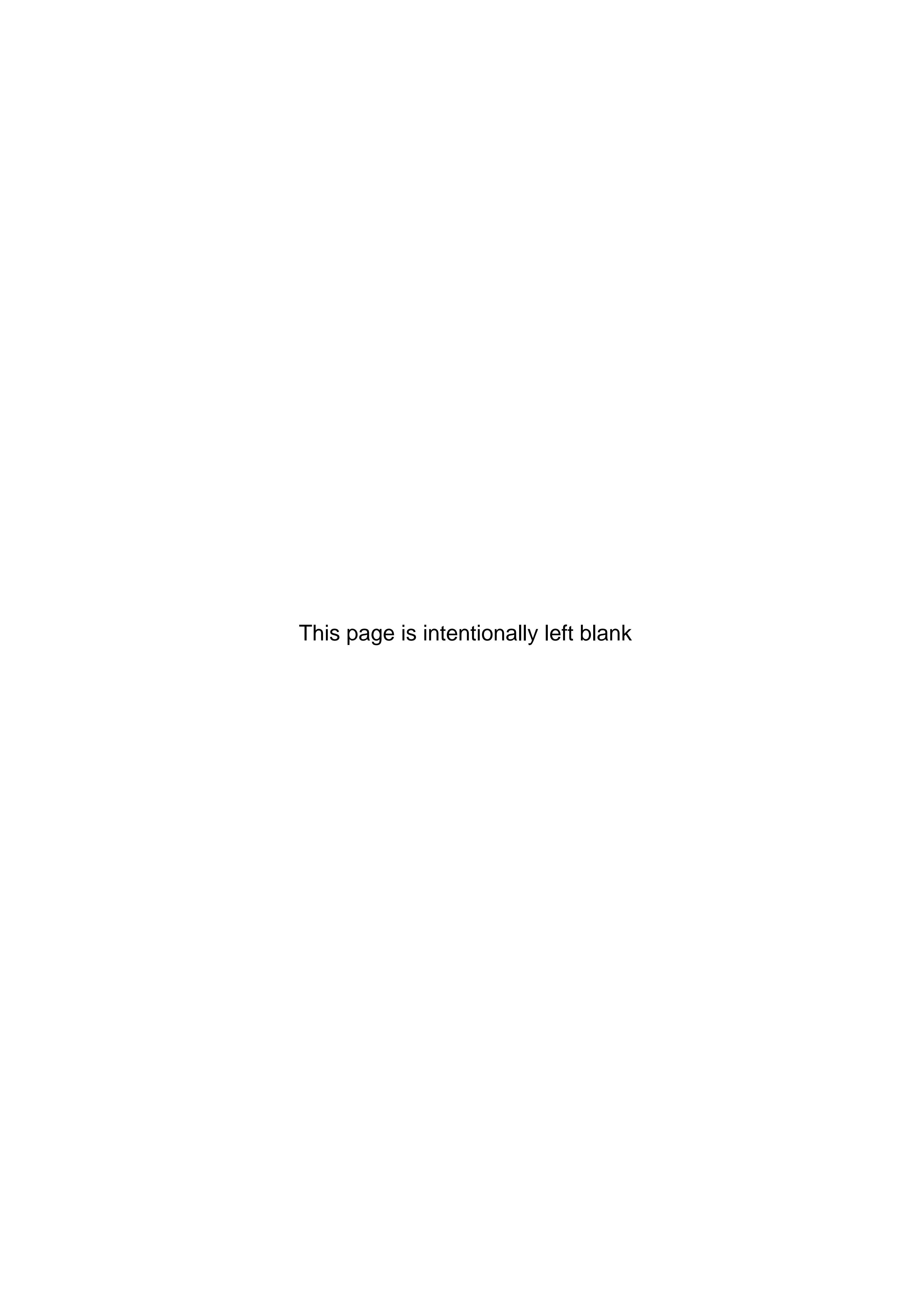
To discuss with BHRUT officers proposed changes to local breast care services.

**8 INTERMEDIATE CARE CONSULTATION** (Pages 51 - 76)

To consider the Committee's response to the current consultation on intermediate care services (consultation document attached).

**9 URGENT BUSINESS**

To consider any item of which the Chairman if of the opinion, by means of special circumstances which shall be specified in the minutes, that the item should be considered as a matter of urgency.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**MINUTES OF A MEETING OF THE**
**HEALTH OVERVIEW & SCRUTINY COMMITTEE**
**Havering Town Hall**
**24 June 2014 (8.15 - 10.20 pm)**

**Present:**

Councillors Nic Dodin* (Chairman), Dilip Patel (Vice-Chair - the Chair at the start of the meeting), Joshua Chapman, Gillian Ford*, Jason Frost* and Patricia Rumble.

*- part of meeting.

Councillor Wendy Brice-Thompson was also present.

There were no apologies for absence.

Also present: Mark Ansell, Acting Director of Public Health, Ian Buckmaster, Healthwatch Havering, Ilse Mogensen, North East London Commissioning Support Unit, Dr Gurdev Saini, Havering Clinical Commissioning Group (CCG) Alan Steward, Havering CCG.

The Vice-Chairman as details of the arrangements in case of fire or other event requiring the evacuation of the building.

1 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

2 **MINUTES**

The minutes of the meeting were agreed as a correct record and signed by the Vice-Chairman.

3 **INTRODUCTION TO SCRUTINY**

The clerk to the Committee gave a presentation covering the role of Overview and Scrutiny and how it was applied in Havering. The presentation also discussed the powers of health scrutiny and the Health Trusts and similar bodies operating in the local area. It was explained that a number of issues would need to be scrutinised on a cross-border basis, in conjunction with neighbouring boroughs.

The Committee **NOTED** the presentation.

4 **LOCAL HEALTH ECONOMY AND INTERMEDIATE CARE**

The Chief Operating Officer of Havering Clinical Commissioning Group (CCG) explained that the CCG, which had been in operation since April 2013 commissioned a large number of services covering areas such as community health, mental health and secondary or hospital care. Services were commissioned across London, not just from the local Hospitals' Trust. The CCG was principally made up of GPs and GPs themselves were mainly accountable to NHS England.

The CCG's overall commissioning budget was £304.7 million per year while annual running costs totalled £6.3 million. The CCG's work was supported by a Commissioning Support Unit that worked across the whole of North East London. The CCG was a statutory body with a governing body elected annually. The governing body included seven GPs, a senior nurse, a secondary care consultant and lay members covering audit and patient involvement. The CCG leadership was accountable to the Members' Committee which included all 49 GP practices in Havering. There was also a Joint Executive Committee working jointly with the CCGs in Barking & Dagenham and Redbridge.

The CCG was also part of the Integrated Care Coalition and was involved, with the Council, in drawing up the Joint Strategic Needs Assessment. The population of Havering was continuing to get older and there was an associated low satisfaction with e.g. access to primary care.

The CCG was focussing on a number of key areas including improved access to urgent and primary care and developing a new model for complex care. This would aim to help the most regular visitors to hospital. A system of integrated case management was also being developed for people with long-term conditions such as asthma and diabetes.

It was also hoped to integrate urgent and emergency care services by combining the contracts for these. It was acknowledged that the BHRUT Hospitals' Trust had been put into special measures and the Trust's improvement plan had been published in the last week.

As part of its focus on elderly people and long-term conditions, the CCG had commissioned a Community Treatment Team. This was a rapid response team that visited people at home who suffered from long-term conditions such as deep vein thrombosis. This could be accessed via the NHS 111 service or through a referral from another health professional. Patients with long-term conditions were also given details of the service. From April 2014, Integrated Health Teams had been introduced for the six GP clusters in Havering. These would co-locate nursing and community therapy teams and would also involve secondary care clinicians in managing long-term conditions. The Government Better Care Fund could also be used to promote integrated care services that were run jointly between the Council and the CCG.

The CCG was committed to having care provided closer to people's homes and services such as dermatology and ophthalmology were being provided in local settings rather than in hospital. This would be applied to more services in 2014/15 including cardiology and diabetes services.

The CCG had received a total of £5.6 million from the Prime Minister's Challenge Fund which was the highest amount nationally. This funding was to be used to transform primary care. It was planned that one GP in each Havering cluster would provide care 8 am to 10 pm, seven days per week. The development of a GP Federation in Havering would assist with this. It was also hoped to develop electronic sharing of care records across GP practices. A map of local health services and GP clusters would shortly be put on the GP website.

As regards intermediate care, the CCG wished to improve the productivity of community-based beds and the trial of Community Treatment Teams would continue across the three local CCGs. Intermediate care helped recovery from illness and prevented admission to hospital or long-term residential care where this was not necessary. Both the Community Treatment Teams and the new Intensive Rehabilitation at Home service had received high satisfaction rates in patient surveys. While these services were on a trial basis at present, the CCG wished to introduce them permanently in Havering. A business case for this change would be considered by the CCG executive that week and this would lead to a consultation exercise on the proposed changes.

The CCG was responsible for commissioning services for children with disabilities although the Council would have a role in this from September 2014. Public Health was also involved in work to discourage parents from taking their children to A&E unnecessarily.

Work was ongoing with social care colleagues on how care funding could be better invested in the community and more details could be provided to the Committee on this. Plans on the impact of personal budgets had recently been shared with the Health and Wellbeing Board.

It was clarified that extended GP opening times would only be for patients needing urgent or emergency treatment. The Chief Operating Officer added that the new GP contract that would commence from 2016 would require GP practices to open 8 am to 8 pm, seven days per week. Feedback from Queen's Hospital had indicated that relatively few attendances at A&E had been due to people being unable to obtain GP appointments.

It was confirmed that there was an out of hours GP service covering Havering although Members reported that telephone guidance given had stated specifically that this was not the case. It was hoped to appoint in the future one contractor for the whole pathway as this would allow a greater consistency of message to be given.

There were a total of 104 rehabilitation beds for Havering residents available at King George Hospital and other sites. The CCG felt it that only 40-60 beds would be needed, provided these were all based at one site. It was planned to start a 12 week consultation on these issues from 7 July.

The Committee **NOTED** the presentation.

5 **COUNCIL CONTINUOUS IMPROVEMENT MODEL - UPDATE ON PUBLIC HEALTH TRANSITION**

The Acting Director of Public Health explained that responsibility for public health had moved from the former Havering Primary Care Trust to the Council in April 2012. Certain functions such as immunisation and health visiting were the responsibility of Public Health England although health visiting was due to transfer to the Council in September 2015.

Public Health was already responsible for a large number of functions such as weight & measurement checks for children, healthcheck provision, some sexual health services and school nursing.

A public health outcomes framework was used which gave Havering data for around 100 indicators covering health improvement, premature mortality and the wider determinants of public health.

The Council received a public health allocation of funding to cover work in this area. While this funding had risen in the last two years, it remained below the target figure. The largest proportion of the public health budget was spent on sexual health and drug & alcohol services.

Public health priorities for Havering had included leading on drug & alcohol and teenage pregnancy work. Work was also undertaken with other Council teams on areas such as fuel poverty and sports development. Public health analysis was also submitted for the Joint Strategic Needs Assessment.

The health protection role of Public Health was developing and a health protection forum had been established with Public Health England. As regards health improvement, smoking cessation and weight management services were available but it was hoped to recruit more volunteers to assist with health improvement work. Other services commissioned by public health included an alcohol liaison service at Queen's Hospital and the reinstatement of vision checks for children in the reception year. Emergency contraception was also provided by Public Health to community pharmacies. Public Health did already have contact with local food banks as it was important to target those in need but this area would be investigated further.

The Committee **NOTED** progress with the issue since the Executive Decision had been taken.

6 **HEALTHWATCH HAVERING - DEMENTIA AND LEARNING DISABILITIES REPORT**

The Director of Healthwatch Havering explained that a series of five meetings had been held during February and March 2014 concerning dementia and learning disabilities. The meetings were attended by a mix of NHS and Social Care officers as well as service users and carers.

It had been found that the rising population in Havering (which was increasing quicker than that of London as a whole) was putting more pressure on the local health and social care economy. The increasing number of elderly people in Havering was also linked to higher numbers of cases of dementia being diagnosed.

Healthwatch had concluded that services for dementia were adequate overall although there was still a lot to do. Learning disability services were however somewhat less advanced. A more contemporary model was needed for both dementia and learning disabilities.

Concerns had been raised that service users and carers did not know where to go for support and were unaware of what services were on offer. Personalised budgets were considered to help in the longer term but it was felt people may find these difficult at first.

The Healthwatch events had led to a number of recommendations including for the review of arrangements for Annual Healthchecks and that steps should be taken to ensure all Havering GPs have training in dementia and learning disability. Areas where under-diagnosis of dementia was occurring should be identified and addressed and Healthwatch also felt there should be prompt referral of dementia patients for services such as optometry, dentistry and hearing checks.

Other recommendations included ending any delay between a diagnosis of dementia and the commencement of treatment and the development of a clear information path for learning disability and dementia. There was also a need for further clarity from the North East London NHS Foundation Trust (NELFT) on the future of Admiral Nurses in Havering.

Healthwatch had also recommended that a ‘One Stop Shop’ should be provided for the benefit of service users and carers and that ‘reachability’ should be introduced as a criterion for measuring services in these areas.

A number of actions had already been taken in response to the Healthwatch report including discussions with NELFT and Age Concern over the position if a person with dementia refuses to attend the memory service or their GP. The CCG was also discussing with NELFT the lack of Admiral Nurses in the borough.

Members welcomed the Healthwatch report and it was confirmed that the current dementia diagnosis rate for Havering was 49%. The national target

was to increase this to 67% in the next two years. Details of the work of the dementia partnership board and of the dementia alliance which was to be launched shortly could also be provided. The Committee felt it was important that the Butterfly Scheme which indicated on a patient's notes if they suffered from dementia continued to be used as widely as possible.

The Committee **NOTED** the Healthwatch report.

7 **COMMITTEE'S WORK PROGRAMME**

It was **AGREED** that a joint meeting should be arranged with the Children & Learning Overview and Scrutiny Committee in order to scrutinise issues relating to children's health. Committee Officers would discuss with both Committee Chairmen a date and agenda for the meeting which would be circulated in due course.

It was **AGREED** that some future meetings of the Committee should focus on specific themes within health services. The next meeting would focus on acute and hospital care. The clerk to the Committee would circulate a revised outline work programme to Members for information.

8 **NOMINATIONS TO JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEES**

It was **AGREED** that Councillors Dodin, Ford and Patel would be the Committee's representatives on the Outer North East London Joint Health Overview and Scrutiny Committee.

It was also **AGREED** that Councillor Dodin would be the lead representative for the Committee on any pan-London scrutiny of issues that may be required during the municipal year.

9 **COUNCIL CONTINUOUS IMPROVEMENT MODEL**

The Committee noted that the Executive Decision on Healthwatch Implementation was now due for review under the Council Continuous Improvement Model. It was **AGREED** that an update on this area should be given at the next meeting.

10 **URGENT BUSINESS**

The Committee **AGREED** that future meetings would commence at 7 pm.

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**Chairman**

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# ANNUAL REPORT, 2013/14

## Making a difference…

*Presented in accordance with*
***"The Matters to be Addressed in Local Healthwatch Annual Reports Directions, 2013"***

*Healthwatch Havering is the operating name of*
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

## What is Healthwatch Havering?

Healthwatch Havering is your new consumer local champion for both health and social care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and are able to employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary. There is also a full-time Manager, who co-ordinates all Healthwatch Havering activity.

**Why is this important to you and your family and friends?**

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforces the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution will be vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

***'You make a living by what you get,***
***but you make a life by what you give.'***
***Winston Churchill***

*CONTENTS*


| | | Page |
|---|---|---|
| Foreword by Anne-Marie Dean, Chairman, Healthwatch Havering | | 3 |
| | | |
| 1 | Making a difference: working with local partners to improve services | 5 |
| 2 | Making a difference: working with local people | 6 |
| 3 | Making a difference: influencing official bodies and others | 7 |
| 4 | Making a difference: public consultation and participation | 9 |
| 5 | Making a difference: Health and Wellbeing | 10 |
| 6 | Developing volunteer participation | 15 |
| 7 | Governance, finance and business support | 17 |
| 8 | Looking forward… | 19 |
| | | |
| Appendix 1: | Involvement with other organisations | 23 |
| Appendix 2: | Enter and View | 25 |
| Appendix 3: | Case studies | 26 |
| Appendix 4: | Governance arrangements | 28 |
| Appendix 5: | Summary statement of Income and Expenditure | 32 |
| Appendix 6: | Directors, Staff and Members | 33 |
| Appendix 7: | Profile of the London Borough of Havering | 36 |


We will be sending copies of this Annual Report to the statutory recipients (including the British Library) and circulating it widely to local health and social care organisations. Printed copies will be available for the public. It will also be available on our website, www.healthwatchhavering.co.uk .

# Foreword

*Anne-Marie Dean, Chairman, Healthwatch Havering*

It is a pleasure to welcome you to our first annual report.

Firstly, I would like to begin by thanking our volunteers, staff and the statutory and voluntary organisations that have supported us in becoming established within Havering. With their help and advice we have become part of the Havering network of health and social care organisations.

Healthwatch Havering is part of a new national concept which gives every individual, in every community, their own local independent consumer champion for health and care. Our umbrella body is **Healthwatch England**, which is part of the Care Quality Commission.

Our job is to champion the needs of children, young people and adults. We know that if we can make things better for the most vulnerable in our communities, we will all benefit. We work for everyone, not just those who shout the loudest.

During the year patients, service users, carers and concerned members of the public have shared with us a number of matters. Our approach is always to listen carefully, build up a detailed

picture gaining a clear understanding of what is important to each individual.

Although we work in partnership with the health and care sector, voluntary and community sector; we are independent, and so we can, and do, when required, speak loudly on behalf of all individuals in Havering and we are not afraid to point out when things have gone wrong.

The strength of our work is entirely based in the strength of our volunteer team. They lead and set the priorities and objectives, based on personal knowledge and the experiences that people and organisations share with us and the national and local agenda. Within our Annual Report we share with you examples of their work and achievements.

We have had a busy and successful year and thank you for your part in helping us to achieve this.

# 1 *Making a difference: working with local partner organisations to improve services*

**The launch of Healthwatch both nationally and in Havering in April 2013 coincided with emerging public concern about standards of care in health and social care settings - the scandals of Mid-Staffordshire Hospital and the Winterbourne House care home were just the two most remarked-upon examples of a series of failings that attracted the attention of the media and other commentators.**

**Safeguarding is at the heart of all we are doing in the Borough. It is often more effective to work informally in the background than stridently to produce formal reports and recommendations.**

Locally, concerns arose following a series of adverse Care Quality Commission (CQC) and other reports about care in Queen's Hospital, Romford and in several residential care homes. Our contacts with the Barking, Havering & Redbridge University Hospitals Trust (BHRUT) and with several care home proprietors have received positive responses.

In late 2013, Queen's Hospital was one of the first in England to be subjected to a new inspection regime by the CQC, as a result of which the hospital was placed in "special measures". Although not directly involved in that decision, we submitted preliminary evidence to the inspection team and we were present by invitation at the meeting at which the CQC announced the findings of the inspection team.

Our Social Care team has been paying close attention to the Borough's care homes and, in particular, those identified by the CQC as being in need of significant improvement. We have not needed to make formal recommendations or representations to the CQC so far but our close working relationship with them both has led to the development of mutual trust and respect that enables us to be informally influential.

More recently, we have worked on services for people with Dementia and for people with a Learning Disability – both areas of growing concern nationally as well as locally. We are developing strong links with both statutory and voluntary agencies operating in those areas, enabling us to be influential without necessarily having to take formal action. We have recently submitted a series of recommendations to commissioners and providers of health and social care services for people with Dementia or for people with a Learning Disability, based on what people who live or work in the Borough have told us through our **"Have your say…"** events on Learning Disability and Dementia.

## *2 Making a difference: working for local people*

**Although Healthwatch Havering has no direct remit to represent, or act as advocate for, individuals or to investigate individual complaints, people in distress do not always appreciate exactly whom to approach for help and contact Healthwatch Havering "because we are here". We have taken the view that we have a general duty of care to help those in distress.**

Generally, we carry out that duty by referring people on to those best placed to help them but, occasionally, a more detailed intervention may be needed. Moreover, of course, an approach from a person in distress may be symptomatic of some underlying systemic failure that *is* within our remit.

An example of possible systemic failure emerged with difficulties in getting appointments at Queen's Hospital:

- a patient who had a life-threatening illness, who needed further medical attention was having trouble getting an appointment
- another was distressed because he had been told by Queen's Hospital that he had only a limited time to contact them to make an appointment for treatment for a respiratory problem but was unable to get though on the telephone, and was concerned that he would miss the slot
- one patient's paperwork for the pain clinic was lost and, despite being in agonising pain, she was told that she would have to go to the back of the queue

In each case, we made representations on the patient's behalf and appointments were promptly arranged for them.

In another case, a patient contacted us having taken her two young sons to be vaccinated at her GP practice – while there, she had a disagreement with the nurse and felt awkward about returning to the practice; she was very worried about not having a GP. We told her to contact NHS England, and we later learned that she had been allocated to another GP within a couple of days.

One man rang the office – his mother had been refused a stair lift on the ground that she lacked mental capacity to use it safely, even though the son was living with her. We referred him to the appropriate staff in Adult Social Care and he later told us that his mother had received her stair lift – his thanks were profuse!

## *3 Making a difference: influencing official bodies and others*

**Healthwatch Havering is a statutory member of the Havering Health & Wellbeing Board. We are also formally represented at meetings of Havering Council's Health, Individuals and Children's Services Overview & Scrutiny Committees and a wide range of other relevant bodies, both local and regional to North and East London.**

A fuller list of the organisations etc. with which we are involved is set out in ***Appendix 1***.

Informal meetings are regularly held with senior managers of Havering Adult Social Care, BHRUT and Havering Clinical Commissioning Group (CCG). A good working relationship has been established with the local officers of the CQC Inspectorate responsible for health and social care facilities in Havering.

After a visit by our Social Care team to a particular, rather large care home, it transpired that their residents shared 8 or 9 GPs: as such a large number could have led to confusion over which GP was responsible for which residents, we contacted the CCG and suggested there should be fewer, designated GPs. As a result, the CCG has designated a single GP for the home instead. This case was recently cited to Healthwatch England as an example of the sort of change for the better that local Healthwatch can be instrumental in achieving[1].

In February, we undertook an announced "Enter & View" visit to a care home in Romford that had given the CQC cause for concern. Our team found that the home had made progress in dealing with the problems identified by the CQC but that there were still issues to be addressed. Our recommendations following the visit led to the home's proprietors employing an additional activities coordinator.

We have developed an ambitious work programme for 2014/15, which will include an investigation of patient-related activity at GP practices (see ***Chapter 8***).

[1] Comments to the Committee of Healthwatch England in February 2014 by Councillor Sir Merrick Cockell, Chairman of the Local Government Association and former Leader, Royal Borough of Kensington & Chelsea

Further details of our Enter & View activities are given in ***Appendix 2***. Some case studies of actions that have led to positive change are given in ***Appendix 3***.

Although strictly outside the scope of this Annual Report, we recently learned that BHRUT had welcomed as positive the feedback we have given them following an Enter & View visit to the Maternity Unit at Queen's Hospital. Their Chairman said, on the record at a Board meeting, that:

> "I am pleased to say that an independent review by Healthwatch into our maternity services was very complimentary. This is a reflection of the Journey of Improvement that has been carried out in BHRUT's maternity services"

Subsequently, BHRUT confirmed their acceptance of our recommendations for further improvement (details are on our website).

We have established a useful working relationship with Healthwatch England, both at national level and in London. During 2013/14, we had no occasion to make any suggestions or proposals to Healthwatch England on matters for investigation (though as publication of this annual report was nearing, we did agree to support a special inquiry proposed by Healthwatch England into hospital and other institutional discharge, based on local work about discharge already carried out – see ***Appendix 3***).

## 4 Making a difference: public consultation and participation

**Healthwatch Havering is developing a role in consulting the public and encouraging their participation in health and social care issues.**

In September, we commissioned the Film Unit of the Media Studies Group of Sixth Formers of a local School, the Coopers' Company & Coborn School, Upminster, to produce a short film of local peoples' thoughts about local health services. This film is available on **You Tube**.

In December, we held a workshop at which the CCG and North East London Foundation Health Trust (NELFT) were able to give presentations about their plans for improving home care services: **New Services Putting Care Closer to Home** was well-attended and generated valuable feedback for the CCG and NELFT in proceeding with their plans.

Over two weeks at the end of February and beginning of March, we held five **"Have your say…** on Learning Disability and Dementia services" events around the Borough. These gave health and social care professionals, service users and carers, and representatives of the voluntary sector an opportunity to discuss health and social care services for people who have Dementia or a Learning Disbaility. The information gathered in the course of those events has proved invaluable and the formal report is now on our website.

Some of our volunteers provided a stand at Havering's **National Women's Day** in March, at Havering College.

We are are represented at the monthly meetings of Havering's **Over-Fifties Forum**, giving us the opportunity to discuss health and social care issues with them on a regular basis.

We are planning to hold more **"Have your say…"** events in the course of 2014/15, probably in mid-summer, late autumn and spring; and we will also hold sessions to follow up the December event on **Putting Care Closer to Home** and the recent **"Have your say on…"** event about services available in Havering for people who have dementia or a learning disability. We have also arranged for the Nursing Director of Havering CCG to address a public meeting on the CCG's response to the Francis Report (about the Mid-Staffordshire Hospital scandal) and its implications for Havering.

## *5 Making a difference: Health and Wellbeing*

**Among the key provisions of the Health & Social Care 2012 was an obligation on local authorities to establish a new statutory executive committee, the Health & Wellbeing Board (HWB).**

The HWB, uniquely in local government, includes as voting members representatives of the relevant CCG and the Chief Executive and chief officers responsible for Public Health, Adult Social Care and Children's Services as well as local Councillors. It is chaired by the Leader of the Council (or his nominee). Most significant, however, from the Healthwatch perspective, is the obligation to appoint a representative of the local Healthwatch to the HWB as a full voting member, since this gives us a key role within the principal health and social care planning and co-ordinating body for the borough.

Since April 2013, Healthwatch Havering has been represented at the Havering HWB by Anne-Marie Dean, its Chairman, who has attended every meeting of the Board, which meets on a monthly basis in the Town Hall, and the vast majority of all the work of the board is undertaken as an open public meeting. There is also a monthly preparation meeting to ensure that the most important issues are prioritised and reports are properly prepared for discussion. When required there are also special meetings where the board has additional development work needed to support main documents and papers such as the Better Care Fund. Healthwatch Havering is an active contributor at all of these meetings.

We have presented an end of year report on our progress to the Board, which included our work plan for 2014/15 and is available on our website.

**The Health and Wellbeing Board established 8 Priorities for 2013/14 and some of the key highlights from a Healthwatch perspective are:**

- *The CQC inspection of Queens Hospital (Priority 7: Reducing avoidable hospital admissions)*

  From the local people's perspective, there had been a growing concern about care standards, the A&E, unsafe discharge of the frail and elderly and some complex concerning complaints.

  Healthwatch submitted a report to CQC on the evidence provided by local residents as part of the formal process. In addition, we worked with the HWB to ensure that it was at the heart of the discussions to support the Hospital to develop detailed integrated plans to help them move forward positively, such as the development of 7 day working and successful recruitment initiatives.

Particular focus has been placed by the HWB on the safer and more effective management of A&E, which reflects the CQC report. The focus is to develop more detailed integrated plans for reducing avoidable hospital admissions.

- Frail and Elderly Members of our community (Priority 5: Better integrated care for the 'frail elderly' population and Priority 1 Early help for vulnerable people)

This work has ranged from the monitoring of patients admitted to A&E to discharge, developing detailed community plans which aim to ensure wherever possible hospital admissions are avoided.

The HWB has overseen the development of the Tri-borough (Havering, Barking & Dagenham and Redbridge) Integrated Care Coalition which sets out plans for the shift of resources from acute to community services, detailed intermediate care plans for long term conditions and comprehensive rehabilitation services run by NELFT.

We supported the work on the Frailty Audit undertaken in A&E by University College Hospital Partners and the outcomes from this audit have significantly influenced the development of services and the training of staff.

As part of our **Have your say…** series of consultation events, we hosted an event at which the CCG and NELFT outlined their Integrated Care programme.

- The Better Care Fund ((Priority 8: Improvement the quality of services to ensure that patient experience and long-term health outcomes are the best they can be)

The Better Care Fund sets out joint strategic aims and the plans to support the implementation of new care models. This is the first time that such an integrated financial joint community action plan has been developed.

The proposed service plans addresses both health and social care and is developed and led by both the CCG and the Council. The total proposed value of the pooled budget for 2014/15 is £6,946,000 and for 2015/16 the budget increases to £18,914,000.

- The Care of Children in our Community (Priority 6: Better integrated care for vulnerable children)

  During the year the HWB has received a number of reports that look at the needs and the welfare of children in our community. These reports have included: Child Death Overview Panel, Looked after Children, Child Protection Processes, the Troubled Families report and the Serious Case Review reports.

  The Safeguarding Borough team have developed a highly effective Multi Agency Safeguarding Hub (MASH), which has gained recognition as a highly effective tool in safeguarding for children and young people across London.

  We in Healthwatch Havering work closely with the Safeguarding team, particularly on the safeguarding of vulnerable adults which is highlighted elsewhere in this Annual Report.

- Joint Strategic Needs Assessment (Supports the development of all the 8 priorities)

  Healthwatch Havering was consulted, and provided recommendations, on the JSNA. These included requesting more detailed data on

    - Carers – age group, area, health group and whether adult or children
    - Accommodation – residents maintained in care and nursing homes, enhanced sheltered accommodation and warden controlled.
    - How the needs of the increased number of residents on the Waterloo estate have their primary care needs met, so that there is not an increased burden on A&E
    - How is the predicted growth in the early year's group being addressed by primary, social and educational teams?
    - The training of health and social care providers in cultural needs and practices, given ethnicity is up from 8% in 2001 to 17% in 2011.
    - More lately, following our **Have your say…** sessions on Learning Disabilities and Dementia, we have requested more detailed information on individuals with learning disability and dementia.

- Dementia Strategy (Priority 2: Improved identification and support for people with dementia)

  The management of people who have dementia and their families has been a yearlong discussion item. The strategy has now been received and approved by the HWB with encouragement for this to be implemented as quickly as possible.

  Our Social Care Team is particularly involved in working with people with dementia in their work with Care Homes and their Enter & View programme.

- Children and Families Bill (Priority 1: Early help for vulnerable people)

  There have been regular updates to keep the HWB informed of the progress being made to develop the proposals expected once the Children and Families Bill has passed by Parliament.

  The Board has particularly focused on Special Educational Needs and Disability (SEND) Project The reports have outlined The Local Offer, Educational Health and Care Plans from 0-25, Joint commissioning and Personal Budgets.

  Our Learning Disability Team is working closely with the Council and local voluntary organisations, parents and schools.

  Our **Have your say…** sessions on Learning Disabilities and Dementia have supported both the Dementia Strategy and development of services for people with a Learning Disability by enabling people who use the services, carers and professionals to help inform the commissioning of services for these vulnerable groups.

- Specialist and Cardiovascular Services (Priority 3: Earlier detection of cancer)

  Throughout the year there have been detailed discussions regarding the provision of specialist cancer services. This has involved detailed presentations from senior clinicians and the clinical working parties tasked with reviewing and providing recommendations for change. The HWB was keen to reinforce support to keep the services, talents and abilities of key staff local to the Queen's Hospital. This work is still on going and is also being covered in detailed by the Havering Council Health Overview & Scrutiny Committee and the Outer London North East Joint Health Overview and Scrutiny Committee (which covers Barking & Dagenham, Havering, Redbridge and Waltham Forest), on both of which we are represented.

Healthwatch expressed the concerns on behalf of patients and their carers that

- Earlier detection was vital and better training of GPs and better public awareness campaigns were necessary
- No patient should have to travel to London for routine tests
- Proper transport arrangements should be made for patients and carers who have to travel to London for regular chemotherapy or other debilitating therapies
- Greatly improved communication/integration is needed between Queen's Hospital and the London hospitals' clinical teams, as patients had shared their concerns regarding 'being lost in the system' and losing valuable time in the treatment programme

- Childhood Obesity (Priority 4: Tackling obesity)

  The Public Health team produced a report and programme for the HWB which was well received. The HWB has requested a more comprehensive approach, which is to include looking at 'best in class' programmes where organisations/countries are able to demonstrate real sustained improvement in the management of childhood obesity.

**As the first year began, a key priority for all members of the HWB was to establish a common base, an agreed understanding of what was happening, how it was happening and to whom, when and why: questions such as how does each member contribute to a positive culture and how do we agree priorities coming from such diverse starting points. These issues have all been discussed in an open and supportive way and, although it has been a challenging year for the Health and Wellbeing Board, a lot has been achieved.**

## *6 Developing volunteer participation*

**The Directors decided early on that the differences of function between the former LINk and Healthwatch Havering meant that a new approach was needed.**

We were clear that we would be looking for particular levels of commitment and participation (which had to be developed, rather than taken for granted) and that time would be needed to achieve that: we also wanted to encourage people who had never been involved in the former LINk to join us.

We therefore took time to develop a model of involvement that we felt would suit our vision for Healthwatch Havering. Although there will always be a place for new members, our structure is designed to make the most of the talents, abilities and experiences of those who have volunteered to join us.

Currently, four Lead Members are in post, and fourteen Active Members have been appointed; in addition, a total of 147 Supporters, including local organisations as well as individuals, are on our mailing list. We are really pleased with the progress that we, as effectively a start-up organisation, have been able to make. Although there remain a number of Lead Member vacancies, those already appointed have begun work on a variety of issues:

* The Social Care Lead Member and members of her team have met the managers and/or proprietors of care homes that have fallen short in CQC report. The team have also written to those care homes that have received good reviews in recent CQC reports
* The Hospital Lead Member and her team have met the Chief Executive and/or other senior managers of BHRUT
* We have participated in a survey on the use of A&E
* Following comments from members of the public, we have begun to review a number of aspects of services provided by or through GP practices
* The newly-appointed Lead Member for people who have a Learning Disability has begun work, particularly in relation to services for young people.

All of our current volunteers have now received, or are due shortly to receive, training about "Enter & View", safeguarding (both adults and children), mental capacity and deprivation of liberty.

Our volunteers have taken leading roles in the **"Have your say…"** sessions, acting as facilitators to lead discussion as well as acting as hosts.

Profiles of our Directors, Staff and Members are shown in ***Appendix 6***.

## 7 Governance, finance and business support

**Statutory responsibility for the conduct of the legal, financial and business affairs of the Company rests upon the three Directors in accordance with the Articles of Association.**

The Directors are clear that it is essential for the volunteers who comprise Healthwatch Havering to play an active role in the direction of the organisation's affairs. As a result, all volunteers wishing to play an active role in Healthwatch Havering are (after providing satisfactory references, completing a Disclosure & Barring Service (DBS, formerly CRB) check and undergoing appropriate training) admitted to membership of the Company; and those members designated as Lead Members serve on the Strategy, Assurance and Governance Board.

Greater detail of the governance arrangements is given in ***Appendix 4*****.**

### Finance

Healthwatch Havering is funded principally by grant from Havering Council in accordance with section 221 of the Local Government & Public Involvement in Health Act 2007, as amended. The Council has a statutory obligation to secure provision of a Healthwatch service and receives specific funds from the Government for that purpose.

It is understood that the Council has passed the bulk of the available finance to Healthwatch Havering.

An abstract from the Annual Accounts is set out in ***Appendix 5***.

### Business support: resilience

It became clear during summer 2013 that the amount of effort required of Healthwatch was, unexpectedly, significantly greater than had been the case with the former Local Involvement Network (LINk). Not only were the commitments expected by official bodies much greater than ever required of the LINk – including statutory membership of the Health & Wellbeing Board and close consultation with the CQC over a range of regulatory functions – but the "back office" functions of running a business required more attention than anticipated, largely because the previous contractor for supporting the LINk had dealt with such issues from its central office, in effect hidden from sight, whereas Healthwatch Havering has to deal with all such matters itself. The financial and other penalties that can be incurred as a result of failure to comply with the statutory requirements of Her Majesty's Revenue & Customs, Companies

House and other regulatory bodies can be considerable and demand constant attention.

In consequence, the time required of the Chairman and Company Secretary was much greater than anticipated; accordingly, both are now engaged for 21 hours per week and remunerated accordingly (see ***Appendix 4***). Moreover, the workload of the volunteer Lead Members has grown; as volunteers, their time is more limited and, to ease the pressure on them, two part-time posts, of Administrative Assistant and Community Support Assistant, reporting to the Manager, have been created to ensure that the Members are given the support they need to be effective.

Short profiles of the Directors, Staff and Lead Members are given in ***Appendix 6***.

## Business support: office accommodation and equipment

Initially, office accommodation for the Manager was provided at the CarePoint premises in High Street, Romford. Unfortunately, that arrangement proved disappointing as no permanent base could be made available there and the facilities that could be used were very limited. A possibility of accommodation in the Harold Wood Polyclinic was pursued but proved impossible to achieve in a realistic timescale. An office was therefore taken on commercial terms in Morland House, Romford. The room initially available there proved inadequate for our needs but in November we were able to move to a much larger room, ideal for our purposes, but an unforeseen additional expense.

As an entirely new organisation, Healthwatch Havering had to acquire new office equipment. Equipment transferred from the LINk proved to be obsolete and inadequate for our purposes, and had to be replaced. In addition, it was necessary to obtain a range of IT services, including a website, email system, land-line telephone system, mobile telephones, PCs, printers, wireless local network and a photocopier.

## 8 Looking forward…

**An Annual Report inevitably looks back upon the year past. We do, however, have ambitious plans for the coming year and feel it appropriate to give a flavour of them here.**

### Our Key Priorities for 2014/2015

We have identified 6 key priorities for 2014/15, reflecting areas where we have been alerted to concerns or there are changes in service provision, and which will support the overall health and wellbeing of people.

- End of Life Care
- Frail and Elderly Care within the Emergency department
- Access to Primary Care
- Access to Health checks and immunisation
- Continue the programme of Care Home visits
- To identify a project working with Young People

### How we will approach the Key Priorities

We have been developing dedicated programmes of work to enable us to get a comprehensive understanding of

- Ways in which we can jointly measure and define good care,
- The rights of people and how these are supported
- The challenges and opportunities within the health and social care environment
- Joint approach to collecting and sharing information and overall provision

We will manage the process by

- Setting priorities for six months ahead;
- Reviewing them on a monthly basis, adjusting as necessary to accommodate any new issues or concerns e.g. feedback from public forums
- Sharing evidence and information with our partners

- Where appropriate, making immediate contact to ensure urgent concerns are shared and known.

### *Social Care Work stream*

Developing networks across the Borough

- Bi-monthly Borough Safeguarding Meetings since January 2014
- Three-weekly Borough Quality Assurance Team meetings since November 2013
- Regular meetings with Care Home Providers commenced in August 2013
- Quarterly meetings with local CQC team

Enter and View programme for Care Homes

- Number of homes visited from December to March 2014 = 3 1 Enter & View, 2 informal)
- Number planned for April 2014 to September 2014 = 15 (5 every two months)

Extending this role 2014/15

- Discuss and develop locally the CQC's work on 'End of Life' care
- More extensive training on Dementia
- Establish a better understanding of 'Domiciliary Care'

### *Hospital Services Work stream*

Developing networks across the Borough

- Meetings with the Deputy Director of Nursing at Queen's hospital
- Member of St. Francis Hospice board
- Key high profile meetings – CQC, Coroner Reports
- Attendance at the Outer North East London Health Joint Overview & Scrutiny Committee on Acute Service reconfiguration in respect of Cardiac and Cancer services

Enter and View programme for Hospital Services

- Visits to Queen's Hospital will commence once the Trust has published its proposals to respond to the 'Special Measures' position
- Queen's Hospital Maternity Unit visit in early April

Extending this Role for 2014/2015

- Care of the Frail and Elderly in the Emergency Department
- Discharge processes once the new joint Borough arrangements have been in place for 6 months
- Alcohol and Drug recovery programme
- End of Life Pathway
- Review of the waiting times for Chemotherapy services

### ***Learning Disabilities Work stream*** **(***this role began in February 2014***)**

Developing Networks across the Borough

- Member of the Learning Disability Health Pathway Group at BHRUT
- Member of the Learning Disability Partnership board
- Member of the Children with Disabilities and Special needs forum

Enter and View programme for Learning Disability services

- Planned visits will commence in Autumn 2014
- There will be joint visits undertaken between the Learning Disabilities team and the Social Care team, with a particular emphasis on Dementia

Extending this role in 2014/2015

- To ‘shadow’ the key members of the Boroughs Learning Disabilities team
- To visit as many providers/users and organisations as possible to enable us to map the provision
- Determine the level of provision and consultation with users, carers and families by and with NELFT
- Investigate issues which are raised by people about the health and social care provision e.g. the provision of yearly health checks

### *Other work streams*

We will be developing other work streams during the year as and when the opportunity arises. For example, we are in the process of setting up a team to visit GP surgeries.

### *Knowing the patch…*

The London Borough of Havering is one of the largest of the London Boroughs – see the profile in ***Appendix 7***. This profile has informed, and will continue to inform, our work priorities and programmes.

# Appendix 1: Involvement with other organisations

**Healthwatch Havering is a member of, or is represented at meetings of, a range of local, regional and national bodies, both statutory and voluntary.**

Healthwatch Havering is a statutory member of the Havering Health & Wellbeing Board.

We are also formally represented at meetings of Havering's Overview & Scrutiny Committees: Health; Individuals; and Children's Services. We also have a co-opted member on the Outer North East London Joint Health Overview & Scrutiny Committee (which brings together the Health OSCs of Havering, Barking & Dagenham, Redbridge and Waltham Forest, and is also attended by representatives of the Healthwatches of those boroughs).

In addition, Healthwatch Havering is a member of, or is represented at meetings of:

* Barking, Havering & Redbridge University Hospital Trust Learning Disability Health Pathway
* Children with Disabilities and Special Needs Strategy Group
* CQC Dementia Advisory Group (a national body)
* Havering Adult Services Quality Assurance Team
* Havering CCG Voluntary and Community Sector Health and Social Care Forum
* Havering Dementia Action Alliance
* Havering Safeguarding Adults Board
* Havering Winterbourne Steering Group
* Local Government Association (LGA) Healthwatch Local Peers meetings
* NHS England (London)'s pan-London Quality Surveillance Group (representing North East London)
* North East London Quality Surveillance Group
* PLACE Inspection Teams for Queen's Hospital and King George Hospital, Chadwell Heath
* St Francis Hospice Clinical Governance Group
* St George's Hospital Site Steering Group (currently in abeyance)
* University College Hospital Partners – developing services for frailty in North East London
* Urgent Care Board for Barking & Dagenham, Havering and Redbridge (which also includes the three CCGs, Boroughs, BHRUT and NHS England)

Informal meetings are regularly held with senior managers of the Adult Social Care Quality & Assessment Team, BHRUT and CCG on a regular basis and a good working relationship has been established with the local officers of the CQC Inspectorate responsible for health and social care facilities in Havering, with regular meetings programmed to discuss matters of mutual interest (including discussion about care homes that are cause for concern); and we attended the CQC Quality Summit at Queen's Hospital, prior to the publication of the CQC report on their Autumn 2013 inspection of BHRUT (which led to the hospital being placed in special measures).

We have developed a network of strong working relationships with health and social care providers and commissioners. Using those networks has enabled us to obtain relevant information without the need to resort to use of statutory powers.

Our Lead Member for Dementia represented Healthwatch nationally on an Advisory Group set up by the CQC in respect of proposed changes in the way that they inspect care homes providing for people with dementia.

# *Appendix 2: Enter and View*

**The power to carry out "Enter and View" visits to health and social care premises is the most powerful tool available to local Healthwatch organisations. The law allows entry to almost all premises where publicly-funded health or social care is provided, including not only hospitals and residential care homes, but also GP surgeries, pharmacies, dental surgeries and opticians' practices. Enter and view visits may be both announced and unannounced. Reports of all our Enter & View visits are checked for factual accuracy with the management of the establishment visited and published on our website.**

Healthwatch Havering considers that, to be effective, the power to enter and view should be:

- Used appropriately – neither as mere routine nor as a last resort, nor as a licence for simple curiosity or nosiness;
- Used sparingly: in particular, unannounced visits should be made only where there are serious concerns about a particular establishment; and
- Exercised only by Healthwatch members who have acquired essential skills by undergoing training in safeguarding, mental capacity and deprivation of liberty.

We recognise too that Enter and View visits can be disruptive of an establishment's proper routine and, potentially, a source of anxiety for management, staff and residents or patients.

For all those reasons, in the year under review, only one enter and view visit was undertaken, as it took time to ensure that all those members undertaking such visits had been properly trained.

| Date of visit | Establishment visited | | Reason for visit | Announced or unannounced? |
|---|---|---|---|---|
| | Name | Type | | |
| 17/2/14 | Barleycroft | Residential care | Concerns raised by CQC | Announced |

In addition to formal Enter & View visits, several informal visits were made in the course of the year to residential care homes in order to discuss particular issues. As the year closed, a similar informal visit had been arranged to a GP practice in the borough about which members of the public had raised concerns with us.

Since the year end, we have carried out a number of Enter & View visits, details of which are available on our website.

# Appendix 3: Case studies

**The following "case studies" are examples of the sort of activity that we have carried out during the year, with the aim of making a difference…**

## Care Homes:

- Following our "Enter & View" visit to Barleycroft, one of our recommendations was that they improve their activities arrangements for residents. The Manager has told us that they now have two activity co-ordinators.

- We carried an informal visit to a care home and learned that 8 or 9 GPs were assigned to the home, each dealing with a handful of residents, a clearly unsatisfactory and inefficient situation. We contacted the CCG (which responded promptly) and, as a result, there is now a single GP caring for all of the residents, holding a surgery there weekly.

## Queen's Hospital:

- Following the inquest into the death of a pregnant woman in the Maternity Unit at Queen's Hospital as a result of inappropriate surgical intervention, we met senior representatives of BHRUT and asked a number of questions, most importantly, why there was no process in place for the supervision of the junior medical staff. BHRUT has now put measures in place to avoid a recurrence of the problems that had arisen in that case and the Trust had welcomed our feedback.

## Annual Health Checks:

- We learned at one of our **"Have your say…"** sessions that many people with a Learning Disability were finding it hard to have an annual health check. This was mentioned at a later session attended by a GP representative of the CCG, who undertook to look into the issue. The CCG subsequently wrote to all GPs in the borough reminding them that these checks should be undertaken and offering training; and suggesting that "a hub" could be set up where such checks could be dealt with in a single location.

## One-Stop Shop for Learning Disability

- During discussion at another **"Have your say…"** session, it transpired that NELFT were looking for a site for a "one stop shop" for people with a Learning Disability; a senior officer from Adult Social Care, hitherto unaware of this need, was able to facilitate investigation of a suitable site.

## Dementia services

- At another **"Have your say…"** session, members of the Age Concern dementia team expressed concern that, although they had been in the past, they were no longer being invited to some meetings that NELFT held about dementia patients. Representatives of NELFT who were present said that they would look into this and, if possible, reinstate the Age Concern attendance.
- As a result of what we learned during the **"Have your say…"** sessions, we have recommended that NELFT review the provision of Admiral Nurses, with a view to increasing their cover, and that the CCG ensure that all GPs have the right level of training and expertise to treat appropriately their patients who have dementia or a learning disability.
- Subsequently, we have become members of the Havering Dementia Action Alliance, and intend to use our activities, such as Enter & View visits, to ensure that due recognition is given to the needs of people who have dementia.

## Orchard Village Medical Centre

- The Centre was closed as it had been flooded but local people complained that information was available about alternative facilities only by actually visiting the Centre. We contacted the CCG which then arranged to put up a notice on its website indicating that the Centre was closed and that patients should contact the Harold Wood Polyclinic.

## *Appendix 4: Governance arrangements*

**Healthwatch Havering is, in legal terms, a company limited by guarantee called Havering Healthwatch Limited[2]. As a company limited by guarantee, it has no shareholders and is prohibited by law from distributing any financial surplus (or profit) generated in the course of its business to individuals.**

This form of business entity satisfies the requirements of the Local Government & Public Involvement in Health Act 2007, as amended by the Health & Social Care Act 2012, and various orders and regulations made under those Acts (all referred to here as "the governing legislation"), which is the legal basis for Healthwatch nationally.

Havering Healthwatch Limited was incorporated in February 2013, having been set up by Havering Council, which then invited the three individuals who are now the directors to take over the company and to move it forward in forming Healthwatch Havering. The legal and business affairs of Havering Healthwatch Limited are directed by the Management Board of the three directors (see below). This is the statutory Board of Havering Healthwatch Limited.

Membership of Havering Healthwatch Limited is open to anyone resident or working in Havering who has satisfied the Board that they are qualified for admission.

"Qualified for admission" means obtaining a satisfactory Disclosure & Barring Service certificate and satisfactorily completing a series of relevant training sessions. Membership of the company confers rights of voting at general meetings as provided for in the Company's Articles of Association. Members guarantee to contribute £1 in the event of the Company being wound up with outstanding debt.

There is also a Strategy, Governance and Assurance Board, comprising the directors, the Manager and those members of the Company who have been designated Lead Members. This Board oversees the work of Healthwatch Havering, deciding the strategic direction of its activities and holding the Management Board to account for its stewardship of the Company's resources.

### *Lead and Active Members*

The governing legislation envisages that the bulk of Healthwatch activity will be undertaken by volunteers, both those who work as healthcare professionals (legally termed "volunteers") and members of the public who have an interest in health and social care issues (legally termed "lay persons"), supported by professional administrators. Across England, different Local Healthwatch organisations have adopted different approaches to ensuring that volunteers and lay persons are engaged directly in the governance of their organisation as well as undertaking Healthwatch activity generally. Havering Healthwatch has chosen not to distinguish

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[2] Healthwatch Havering is the operating name of Havering Healthwatch Limited, a company limited by guarantee, registered in England and Wales under No. 08416383. The Registered Office is Morland House, 12-16 Eastern Road, Romford RM1 3PJ

between the different types of voluntary effort and so terms all who participate in its activities as "Members"

Healthwatch Havering decided early on to give its Members a stake in the organisation by admitting them as members of the company.

There are two categories of member (but all are members of the Company):

**Lead Members** who commit on average at least five hours a week to Healthwatch activity. Each is responsible for a discrete area of activity, and either leads a team of volunteers or has an over-arching responsibility for facilitating issues common to several, or all, teams.

**Active Members** who commit on average at least two hours a week to Healthwatch activity. They are the members of the teams (and may, if they wish, belong to more than one team) and undertake the majority of Healthwatch activity.

### *Supporters*

Healthwatch Havering recognise that there are many people who have an interest in health and social care matters who, for one reason or another, do not wish to, or cannot, commit to giving regular time but are able to respond to enquiries, give information and occasionally help out at events.

Such people are not regarded as volunteers and are not members of the company but are termed "supporters". They play no part in the governance of the organisation.

### *The Management Board*

The Management Board comprises the three Directors who, acting collectively as the statutory Board, are responsible for ensuring the company's compliance with the various legal requirements for running a business, including company law, taxation (income and corporation), accountancy, health & safety and, of course, the legal framework for Healthwatch (including authorising members to undertake enter and view visits). In accordance with arrangements made by Havering Council, each Director is paid a basic fee of £5,000 per annum, in return for which they commit to a minimum of five hours per week, supervising the organisation generally. Two of the Directors also have executive responsibility as Chairman and Company Secretary respectively, for which they are additionally remunerated; the third Director is non-executive.

The Directors are supported by the (full time) Manager, Community Support Assistant and an Administrative Assistant (both part time), all of whom are salaried employees.

## *The Strategy, Governance and Assurance Board*

The Strategy, Governance and Assurance Board brings together the Management Board and the Lead Members and is responsible for setting the broad policy direction for the organisation. Active Members may be invited to attend Board meetings from time to time.

Among other issues, the Board receives monthly finance updates and reports about the numerous meetings at which Healthwatch Havering is represented.

The Board not only holds the Management Board to account for its stewardship of the Company's resources but considers matters such as the Work Programme, reports of Teams' activities and publication of the Annual Report.

## *Policies and standard operating procedures*

The Management Board decided early on that it was important that Healthwatch Havering should have a series of agreed policies and operating procedures to guide its activities and to ensure that volunteers were aware of the scope – and the constraints – of its activities.

The following policies have been formally adopted:

- **Attendance at conferences and events outside London**
- **Complaints Procedure**
- **Declaration of Interests Guidance**
- **Equality & Diversity**
- **Escalation Procedure for complaints**
- **Expenses**
- **Health and Safety**
- **Safeguarding**
- **Use of IT**
- **Volunteer**
- **Whistle Blowing**

A comprehensive handbook for volunteers has been produced.

Every member is issued with a photo-identity card which includes their Disclosure & Barring Service certificate number and, on the reverse, a statement of their statutory right to be involved in Enter and View visits.

Members are encouraged to claim all out-of-pocket expenses and Lead Members are issued with a mobile phone at Healthwatch Havering's expense for use on Healthwatch business. Oyster cards are available to cover the cost of travel on public transport.

### *The "Healthwatch" logo and trademark*

Havering Healthwatch Limited has a licence agreement with Healthwatch England governing use of the Healthwatch logo and trademark.

The Healthwatch logo is used widely for Healthwatch Havering activity. It is used on:

- The Healthwatch Havering website
- This Annual Report
- Publications such as reports of public consultation events and Enter & View visits
- Reports to official bodies, such as the Health & Wellbeing Board and Overview & Scrutiny Committees
- Official stationery, including letterheads and business cards
- Members' identity cards
- Newspaper advertisements
- Flyers for events

# Appendix 5: Summary statement of Income and Expenditure

**This Appendix is summarised from the Annual Accounts of Havering Healthwatch Limited. A copy of the full set of Annual Accounts is available from the Company on request, and may be viewed on the Healthwatch Havering website.**

| | £ | £ | £ | £ |
|---|---|---|---|---|
| **INCOME** | | | | |
| **Havering LBC: Main grant, 2013/14** | **117,359** | | | |
| **Havering LBC: Supplementary grants, 2013/14** | **9,184** | | | |
| **Havering LBC: Supplementary grant, 2014/15** | **12,000** | | | |
| **Miscellaneous receipts** | **376** | | | **138,919** |
| **EXPENDITURE** | | | | |
| **1 COSTS OF MANAGEMENT** | | | | |
| **Administration costs** | | | | |
| Office expenses, insurance and fees | 9,532 | | | |
| Office rent (including refundable deposit) | 10,340 | | | |
| Mileage, travel and subsistence | 2,118 | 21,990 | | |
| **Payroll** | | | | |
| Fees and salaries | 74,181 | | | |
| Employers' NICs and pension contribution | 8,629 | | | |
| Payroll administration | 1,829 | 84,639 | 106,629 | |
| 2 **COSTS OF VOLUNTEERING** | | | | |
| **Volunteers' out of pocket expenses reimbursed** | | 809 | | |
| **Publicity** | | 1,476 | | |
| **Recruitment expenses** | | 1,096 | | |
| **Equipment and supplies** | | 2,079 | 5,460 | |
| 3 **COSTS OF TRAINING AND DEVELOPMENT** | | | 1,902 | |
| 4 **COSTS OF PUBLIC CONSULTATION AND EVENTS** | | | 3,624 | **117,615** |
| **5 AT BANK** | | | | |
| Carried forward to 2014/15 | | 7,443 | | |
| 2014/15 supplementary grant (received in 2013/14) | | 12,000 | | |
| 2013/14 Corporation Tax provision (due 31 December 2014) | | 1,861 | | **21,304** |
| | | | | **138,919** |

# Appendix 6: Directors, Staff and Members

**Healthwatch Havering is led by a combination of Directors of the Company, staff and volunteer Lead Members.**

## Directors and Manager

### Executive Chairman and Director: Anne-Marie Dean

Anne-Marie has over thirty years' experience working in the NHS. She has been a Chief Executive and Board Director of an acute hospital and Director of Commissioning of a former PCT. Her career has included eight years' experience as a Director of a private sector organisation working in both health and social care. As well as being Chairman of Healthwatch she is a volunteer for St. John Ambulance at its National HQ, and is also a Non-Executive Director of a mental health and social care trust.

### Executive Director and Company Secretary: Ian Buckmaster

Ian is a Chartered Secretary who, until he retired in March 2013, had worked for nearly 40 years in Havering Council's Democratic Services. In his time there, Ian had been clerk to the Social Services Committee, various Health Committees and the Housing Committee, as well as the full Council and Cabinet. He is an expert in governance and is responsible for Healthwatch Havering's legal, business and financial affairs. He is also District President of St John Ambulance for East London.

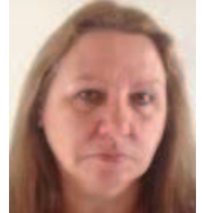
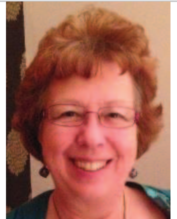
### Non-Executive Director: Hemant Patel

Hemant is a pharmacist, and has for many years been the Secretary of the North East London Pharmaceutical Committee, which represents pharmacists across the region. He has served four terms as President of the Royal Pharmaceutical Society of Great Britain, and is a member of the steering group of the NEL Public Pharmacy Partnership.

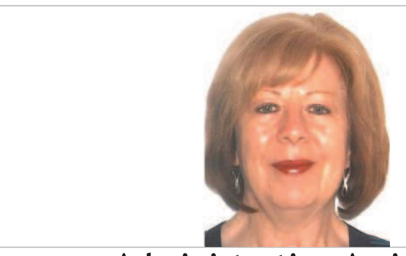
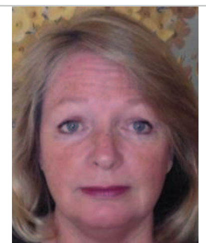
### Manager: Joan Smith

Joan began her working life as a police officer with the Metropolitan Police, at Stoke Newington. When she left the police, she went to work in the City, in banking, staying there for some 25 years. In 2009, she became Organiser of Havering Local Involvement Network (LINk), and transferred to Healthwatch Havering when it took over from the LINk.

## Lead Members

| Lead Member, Hospitals: Debbie Baronti | |
|---|---|
|  | Debbie has over 20 years' experience in NHS management, including 10 years at Assistant Director level with NHS Havering. She is currently employed by a CCG in South London. |
| **Lead Member, Social Care: Christine Ebanks** | |
|  | Christine began her career in the NHS as a cadet nurse in 1970 and then trained as a State Registered Nurse at Harold Wood Hospital. In 1975, she started midwifery training at Barking and Ilford Maternity Hospitals, and then served as a midwife until retirement in March 2013, working initially in hospitals and, from 1989, in as a community midwife in Havering. |
| **Lead Member, Learning Disability: Alan Jones** | |
| | Alan is a former Detective Inspector, having served with the Metropolitan Police for 30 years. In 2002, when posted to Romford, he became responsible for the Vulnerable Persons Unit, was Chair of the Multi-Agency Public Protection Arrangements and sat on the Elder Abuse Panel. After retiring from the police, Alan worked for the Mayor of London. Previously Chair of Victim Support Havering, he has also worked for Havering Samaritans. Currently, he volunteers with the Citizens' Advice Bureau and is a member of the Independent Monitoring Board at ISIS Prison, Belmarsh. |
| **Lead Member, Dementia Services: Cliff Reynolds** | |
| | Cliff joined Age Concern Havering following early retirement from the Financial Services industry in 2002. At Age Concern, he was as Information, Advice and Advocacy Manager providing support to older people and their carers. In that role, he provided advocacy support for elderly people in care homes. Cliff is Chair of Havering Over 50's Forum, and was Vice Chair of the Havering LINk until it was replaced by Healthwatch in 2013. |
| **Facilitator, Communication and Design: Irene Buggle** | |
| | Following a 30-year career holding management positions in an organisation providing market research, marketing and editorial for the pharmaceutical industry, since 2007 Irene has been co-director of a consultancy providing information solutions about that industry to the NHS, media and others, both public and private. |

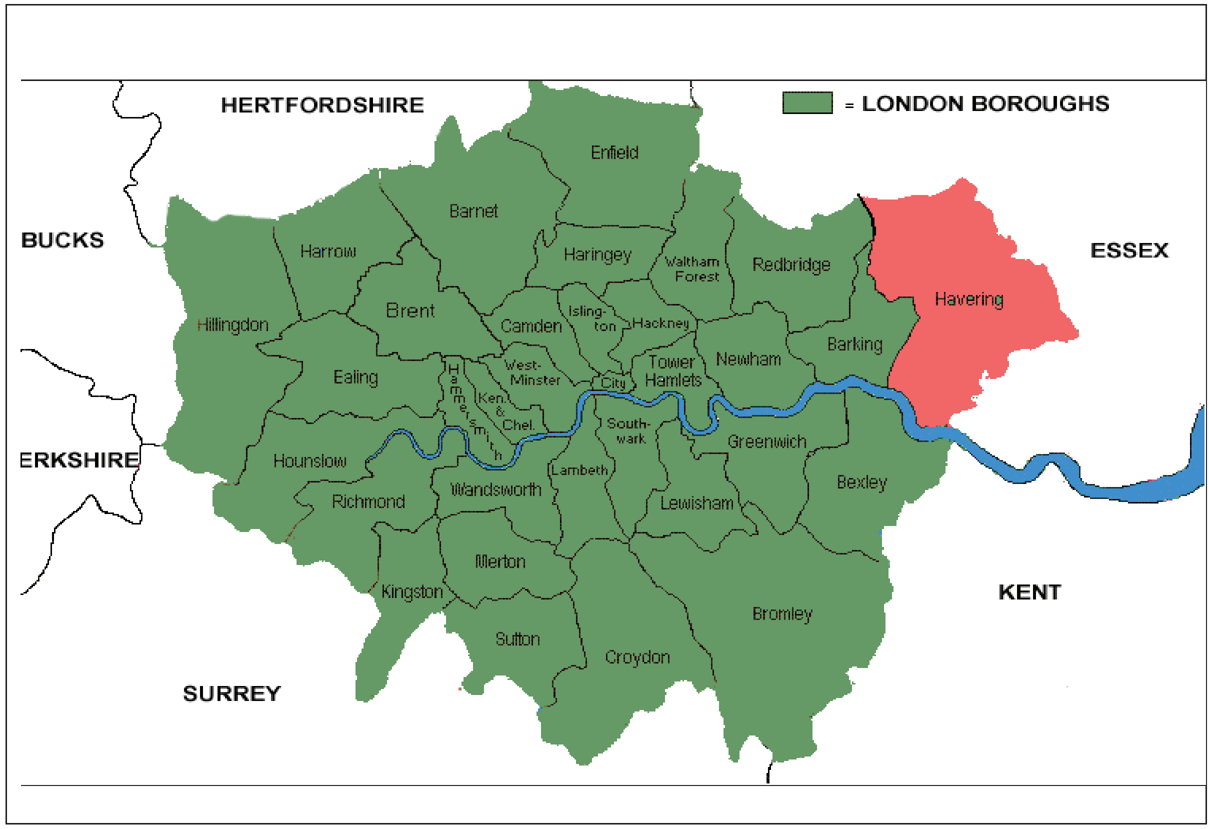
## Staff

|  |  |
|---|---|
| **Administrative Assistant: Carole Howard** | **Community Support Assistant: Beverley Markham** |

## Members

| | | | |
|---|---|---|---|
| Nike Adenmosun | Pierrett Burden | Jenny Ggregory | Donal Hayes |
| Emma Lexton | Terry Matthews | Diane Meid | Dianne Old |
| Lorna Poole | Lucy Sanya | Adrienne Saunderson | John Skillman |

# *Appendix 7: Profile of the London Borough of Havering*




**The London Borough of Havering was formed in 1965 by the amalgamation of the Borough of Romford and the Urban District of Hornchurch (although the present boundaries differ slightly from the original, as a result of subsequent boundary reviews). It is the third largest of the London Boroughs, and the easternmost, and one of the least built-up, with around 50% of its area designated as green belt, of which a significant part is given over to agriculture or outdoor leisure.**

Despite its “leafy borough” appearance, however, the borough has pockets of considerable deprivation: within a couple of miles of each other are wards among the most prosperous in England, and others among the least prosperous.

For many years, the borough has had a disproportionately large, and growing, population of people over 50. This was recognised as a trend likely to affect the provision of health and social care services as long ago as the early 1980s, and has continued without break ever since; the borough has the highest proportion of people aged 85 or over in Greater London and one of the highest such proportions in the whole of England. The proportion of residents from an ethnic minority has also risen markedly since 2000.
Paradoxically, the borough is also experiencing high growth in the proportion of the population aged 18-24; again, that growth (albeit from a much smaller percentage of the population) is among the highest in both Greater London and England.

The following information is extracted from the Havering Joint Strategic Needs Assessment[3]:

It is estimated that 236,100 people currently live in Havering. Greater London Authority population projections estimate that:

- By 2016, Havering's population will have grown by 5.4% (12,699 people), compared to 5.2% in London
- By 2021, Havering's population will have grown by 11.5% (27,095 people), compared to 8.6% in London
- By 2026, Havering's population will have grown by 14.1% (33,314 people), compared to 10.7% in London

243,508 people are registered with a GP in Havering (GP list population). The GP list population is larger than Havering's estimated population, which could be due to factors such as residents from neighbouring Boroughs being registered with Havering GPs, or patients moving away and not informing their GP.

There are 54,018 people aged 0-18 in Havering, 23% of Havering's population; 36% of the population are aged 50+ (85,999 people); and 21% of the population are of retirement age (60+ females, 65+ males; 49,122 people).

Of the 236,100 Havering residents:

- 52% are female
- 48% are male

The greater number of females than males in Havering's population may in part be explained by the longer life expectancy of females: 55% of the 50+ population are female and 45% male; but in the very elderly (aged 75+), 61% are female and 39% male, with 72% of the most elderly (90+) being female.

Among young people and middle aged adults (aged less than 65), there is a fairly even proportion of males and females at most ages. However, for children and young adults (up to age 33), there is often a greater proportion of males than females by up to several percent. Between the ages of 34 to 65, the proportion of females is often greater than the proportion of males by up to several percent.

In terms of deprivation, Havering is ranked 177th out of 326 local authorities for deprivation (1st being most deprived, 326th being least deprived). However, there are pockets of deprivation, with two small areas of Havering falling into the 10% most deprived areas in England and 11 small areas in Havering falling into the 20% most deprived areas in England.

[3] As published on the Council's website **www.haveringdatanet/research/jsna.htm** – permission to reproduce these findings is gratefully acknowledged

Havering's current population is less ethnically diverse than London overall, with the greatest diversity being among young people:

| | 0-15 | | | 16-64M/59F | | | 65M/60+F | | |
|---|---|---|---|---|---|---|---|---|---|
| Ethnicity | Havering | London | England | Havering | London | England | Havering | London | England |
| White | 83% | 62% | 83% | 88% | 69% | 86% | 96% | 83% | 96% |
| Mixed | 4% | 8% | 4% | 1% | 3% | 2% | 0% | 1% | 0% |
| Asian or Asian British | 6% | 14% | 8% | 5% | 14% | 7% | 2% | 8% | 2% |
| Black or Black British | 5% | 13% | 3% | 4% | 10% | 3% | 1% | 6% | 1% |
| Other | 1% | 2% | 1% | 1% | 4% | 2% | 1% | 2% | 0% |

It is estimated that between 2011 and 2016, Black African and Black Caribbean groups will be the fastest growing ethnic groups in Havering, and will increase faster than in London or outer London Boroughs overall:

| | % Growth 2016 Havering | % Growth 2016 Outer London | % Growth 2016 Greater London | % Growth 2021 Havering | % Growth 2021 Outer London | % Growth 2021 Greater London |
|---|---|---|---|---|---|---|
| All Ethnicities | 5% | 4% | 5% | 12% | 7% | 9% |
| White | 4% | 1% | 3% | 9% | 1% | 4% |
| Black Caribbean | 22% | 8% | 5% | 42% | 13% | 8% |
| Black African | 33% | 16% | 11% | 61% | 25% | 18% |
| Black Other | 21% | 13% | 10% | 41% | 23% | 18% |
| Indian | 11% | 8% | 8% | 21% | 13% | 13% |
| Pakistani | 11% | 12% | 11% | 20% | 19% | 19% |
| Bangladeshi | 10% | 16% | 9% | 18% | 27% | 17% |
| Chinese | 14% | 12% | 13% | 27% | 19% | 21% |
| Other Asian | 17% | 11% | 11% | 33% | 19% | 18% |
| Other | 21% | 19% | 17% | 39% | 31% | 29% |
| Black and Minority Ethnicities | 21% | 12% | 10% | 40% | 20% | 17% |

The Borough is served by

- Havering London Borough Council
- Havering Clinical Commissioning Group
- Barking, Havering & Redbridge University Hospitals NHS Trust
- North East London Foundation Health Trust

## Participation in Healthwatch Havering

We need local people, who have time to spare, to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering. To achieve this we have designed 3 levels of participation which should allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

**We are looking for:**

### Lead Members

To provide stewardship, leadership, governance and innovation at Board level. A Lead Member will also have a dedicated role, managing a team of members and supporters to support their work.

### Active members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

### Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

## Interested? Want to know more?

Call our Manager, Joan Smith, on **01708 303 300**;
or email **enquiries@healthwatchhavering.co.uk**

*Healthwatch Havering is the operating name of*
*Havering Healthwatch Limited*
*A company limited by guarantee*
*Registered in England and Wales*
*No. 08416383*

*Registered Office:*
*Morland House, 12-16 Eastern Road, Romford RM1 3PJ*
*Telephone: 01708 303300*

*Email: enquiries@healthwatchhavering.co.uk*

*Website: www.healthwatchhavering.co.uk*

Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

Agenda Item 8

# Making intermediate care better

**in Barking and Dagenham, Havering and Redbridge**

# Foreword from the clinical directors

As doctors, we want to help people live as healthily as possible, making sure they get the right care, when they need it. As local GPs, we've always known what our patients need and want. Now we're also in a position to lead changes that we believe will make a real difference to local people.

We've always known that people don't want to go into hospital unless they really have to and that if they do, they want to come home again as soon as they can. We also know that they are likely to recover better outside hospital, in a familiar place, close to their family and friends - as long as they also have the right care and support from nurses, therapists and care workers. That's what we want to make happen.

In the past we haven't done as well as we could to provide care for people at home. We've known for some time that in other areas they do things differently and people generally recover more quickly. We wanted to learn from them and provide a different, better sort of care, but we didn't want to make any permanent changes until we knew that they really were an improvement and until we'd heard what patients thought of them. We have looked at evidence from the UK and overseas which shows better results for patients and want to implement this locally. We're pleased to see that the trials of the new community treatment team and the intensive rehabilitation service have helped more people to get care and treatment outside hospital.

We are also pleased to hear from patients and carers that they've appreciated this support at home. This success means we're now in a position to talk about what we do in the longer term.

This document explains what we want to do. Please do read about our proposals, ask us if anything's not clear and let us know what you think about what we want to do.

It's your NHS and we want you to help shape it locally.

**Dr Jagan John**, clinical director, integrated care, Barking and Dagenham Clinical Commissioning Group

**Dr Gurdev Saini**, clinical director, frail elders, Havering Clinical Commissioning Group

**Dr Mehul Methukia**, clinical director, integrated care, Redbridge Clinical Commissioning Group

"I couldn't have got a better service if I went private."

# Introduction

**This document talks about intermediate care in Barking and Dagenham, Havering and Redbridge. It explains what we have been doing during the past year to try out new ways of working and what we would like to do in the future to make those services better.**

We have set out different options and what we think would be the best option and why. We want to know your views, whether you agree or disagree, and if there is anything else you want us to consider.

We want to establish permanently the new intermediate care services that we have been trialling, which would mean that more people could receive care in their own homes. We also want to merge the three existing community rehabilitation units into one unit, on the King George Hospital site in Goodmayes. We believe this would result in better, more individual care that would help people to recover more quickly.

These services are currently provided by North East London NHS Foundation Trust (NELFT), and we intend for these services to continue to be provided by NELFT.

We would especially like to hear from local residents, people aged 65 years and over (as most of the people who use intermediate care services are in this age group), carers, health professionals and our partners in the community and voluntary sectors about whether they think our proposals would improve intermediate care services for local people.

**Intermediate care** means services that provide people with specialised care from nurses, therapists and other professionals, without them needing to go to (or stay longer in) hospital. These services can be provided in different places - people's own homes, community rehab units or residential homes, for example.

Our new intermediate care services are the **community treatment team (CTT)** – a team of doctors, nurses, physiotherapists, social workers and others who together care for people at home having a health or social care crisis at home – and the **intensive rehabilitation service (IRS)**, a team of physios, occupational therapists, healthcare assistants and others offering intensive physio and other therapy in a patient's home.

**Rehabilitation** means helping people to recover after an illness or injury. **Community rehabilitation (or rehab) units** are buildings with beds for people who don't need to be in hospital any more, but can't go home because they need intensive 24 hour support and care.

# How to make your views known

**There are a number of ways in which you can give your views:**

Visit our websites and fill in the online questionnaire

Complete the questionnaire at the end of this document and send it back to us

Write a letter to
FREEPOST I Y 426
ILFORD
IG1 2BR

Email: haveyoursay@onel.nhs.uk

Call: 020 3688 1089

**All comments must be received by 5pm, Wednesday 1 October 2014.**

**How to find out more**

If you want to find out more about our work to improve intermediate care before you comment, you can visit the intermediate care page on our websites. Or call us and we can send information to you.

We will be out and about in Barking and Dagenham, Havering and Redbridge talking to people about our proposals – the dates and times for these events are below, and you can also find the latest information on our websites.

If you would like someone to come and talk to your community group about our proposals, please email **haveyoursay@onel.nhs.uk** or call **020 3688 1089**.

**Barking and Dagenham** – Thursday 11 September, 4-7pm
Barking Learning Centre
2 Town Square
Barking IG11 7NB

**Havering** – Thursday 21 August, 4-7pm
Romford Central Library
St Edwards Way
Romford RM1 3AR

**Redbridge – Thursday 31 July, 4-7pm**
Redbridge Central Library
(formerly Ilford Central Library), Clements Road
Ilford IG1 1EA

**Our websites:**

www.barkingdagenhamccg.nhs.uk/intermediatecare
www.haveringccg.nhs.uk/intermediatecare
www.redbridgeccg.nhs.uk/intermediatecare

# Background to the proposals

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (CCGs) have been working together with the local councils and local health service providers to improve health and social care services for local people. We want to make services more joined up with each other and focused on what individual people need, not on what is convenient for the services.

We need to improve people's experience of care and make sure it's the best quality, so we know we are delivering the right care, in the right place, at the right time.

We need to make sure the health and social care system is 'future proof'. We know the population is growing and getting older. We need a system that will care better for people now and can also care for more people in years to come.

We must ensure that services are efficient and deliver value for money.

**As part of this work, we have been focusing on improving local intermediate care services.**

"This is an outstanding brilliant service, what you have done in 21 days is unbelievable. My mum was in hospital for 13 weeks and was nowhere near where she is today with her walking. My mum is now able to walk which I never thought would happen."

# So what is intermediate care?

Intermediate care helps people get better quicker without needing to go to hospital, and also helps get people out of hospital and back home, sometimes after a stay in a community rehab unit.

These services are most often needed by older people, for example if they have a fall and hurt themselves which makes them less mobile and less able to care for themselves. They can also be needed by younger people, though, if they have an ongoing health problem that sometimes flares up making them unwell and needing help. We do not include specialist care for people who have had a stroke when we talk about intermediate care.

Historically, local people needing this kind of care have generally been cared for in beds at community rehab units when they could have been cared for at home, if the right services were in place to help them. This means that there are more intermediate care beds across our area compared with other areas.

This is an old-fashioned way of providing care and it does not take into account people's individual needs. The results for patients are generally not quite as good as if care was provided in other ways. For example, it often takes longer for people to recover fully. Being in a bed makes patients more likely to get an infection and to lose their independence.

People tell us they want to be cared for and supported in their own homes. We know people locally have been spending longer in community rehab units than people do elsewhere, and this can make it much harder for them to return home and live independently. By providing home-based services, patients recover more quickly and have a good experience of care.

To find out more about the evidence behind this, visit our websites:

www.barkingdagenhamccg.nhs.uk/intermediatecare
www.haveringccg.nhs.uk/intermediatecare
www.redbridgeccg.nhs.uk/intermediatecare

By caring for people at home where possible we would prevent most people from having to go into a community rehab unit.

Of course, there are times when people *do* need to stay in a community rehab unit – for example they're not mobile enough to go home – and we would make sure that they can do this and the care they get there is excellent.

By improving the way we look after people in a community rehab unit and making sure they get personalised, focused care, with access to a range of therapies, patients would need to spend less time there.

To be clear, both the care at home and the care in a bed at a community rehab unit are intermediate care.

# What are the new services we have been trialling?

We have been trialling two new services to help people to stay at home.

**Community treatment team (CTT)**
This is a team of doctors, nurses, physiotherapists, social workers and others who together care for people at home so that they either don't need to go into hospital or return home from hospital sooner.

The CTT started in Barking and Dagenham and Havering in January 2013, where it ran from 8am - 8pm, seven days a week. In November 2013, the service was expanded to include Redbridge, and the hours across the three boroughs were extended for an additional two hours a day, until 10pm.

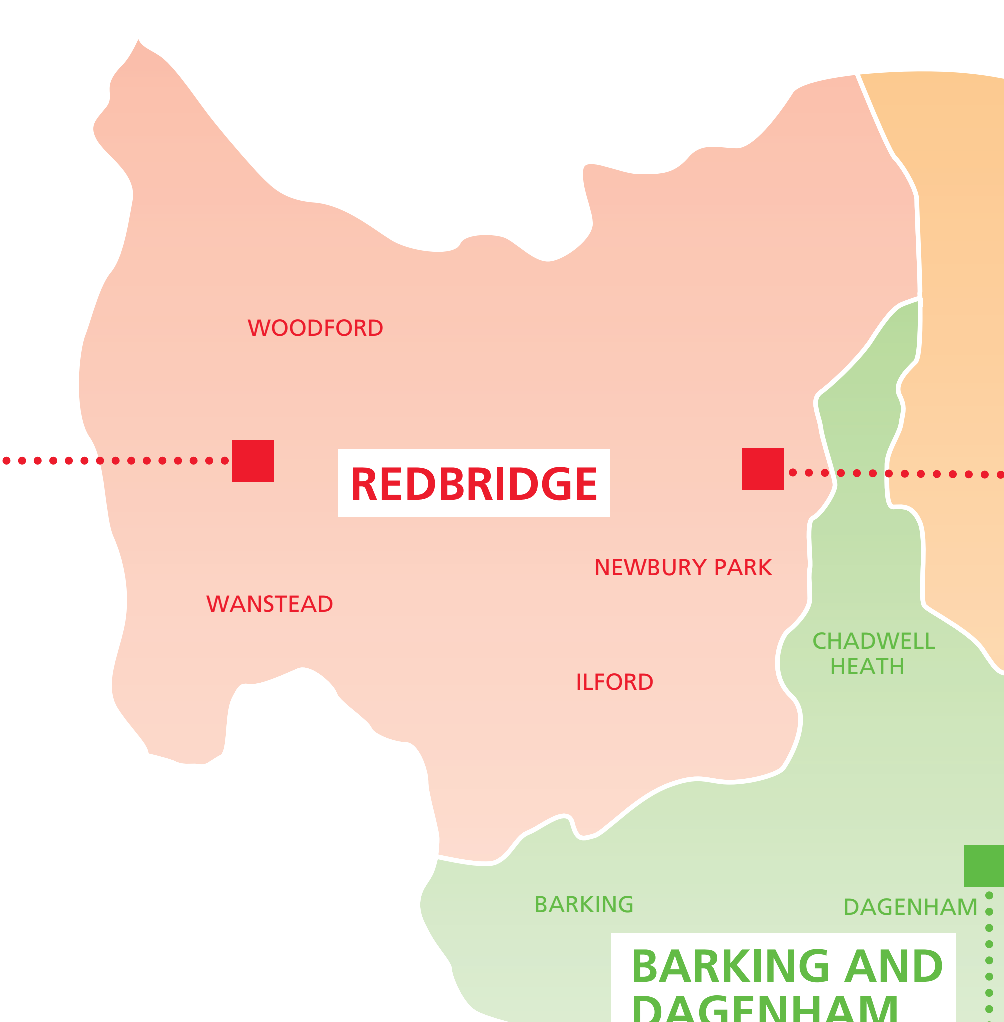
**Intensive rehabilitation service (IRS)**
This is a team of physios, occupational therapists, healthcare assistants and others offering intensive physio and other therapy in a patient's own home, with up to four visits a day depending on the patient's needs. The service operates from 8am - 8pm, seven days a week.

**What do patients think of these services?**
Patient satisfaction rates for both the new services have been consistently high across the three boroughs since the trials began. On a scale of 1-10, with 10 being 'very satisfied' with the service, CTT has averaged 8.7 and IRS 9.0 out of 10. You can see some of the comments patients have made about the services throughout this document.

"The patient is getting about now and is able to go up and down the stairs, can go the length of his footpath and manage a big step with little difficulty, something he could not do previously."

# Community rehab units

**At the moment there are three community rehab units used by people from Barking and Dagenham, Havering and Redbridge.**




### Heronwood and Galleon Unit in Wanstead

**Capacity and facilities:** 48 beds, in two wards. Physiotherapy gym, dining room and day room.

**Public transport:** Average links. Two bus routes are within five minutes' walk. Nearest underground station is 10-15 minutes' walk.

**Parking:** Free limited parking on site for staff and visitors. Limited parking in residential streets.

### Grays Court in Dagenham

**Capacity and facilities:** 26 beds, in single rooms, some of which have en-suite facilities but which are too small for equipment like hoists and wheelchairs. Physiotherapy gym, day rooms, dining area, consultation rooms.

**Public transport:** Poor links. Nearest bus route is 10 minutes' walk away. Nearest underground station is 20 minutes' walk.

**Parking:** Free limited parking on site, used by staff and visitors. Limited parking on residential streets.

### Foxglove Ward (King George Hospital) in Goodmayes

**Capacity and facilities:** 30 beds, in one ward (with another ward identified for expansion). Day room, physiotherapy gym on ward and access to a larger hospital gym. Access to other hospital services and facilities.

**Public transport:** Good links. Four bus routes stop in King George grounds. Nearest station is 15 minutes' walk.

**Parking:** Large on-site carpark for staff and visitors. Charges apply.

ROMFORD

HAVERING

HORNCHURCH

UPMINSTER

RAINHAM

Intermediate care services used to be provided at St George's Hospital in Hornchurch, but this site was closed for health and safety reasons in October 2012 and remains closed.

Anyone who needs care in a community rehab unit is offered the next available bed in any of the three units. This might not be the one closest to where they live. This is so they can get access to rehabilitation as quickly as possible, which should help to speed up their recovery. If they prefer to wait for a bed at another unit, they can do so, but generally people want to start their rehabilitation quickly.

# Bed numbers: now and in the future

There is capacity for 104 community rehab beds across these three sites. However at the moment these beds are not all being used as there is no need for them. From looking at how the services have been operating recently and particularly since the trial of new services began, we have worked out that we would only need between 40-61 community rehab beds over a year if the home-based CTT and IRS were both running all the time. This is because most people would receive care in their own home and so would not need a community rehab bed.

When working this out, we have taken into account the fact that more beds are generally needed over the winter months.

This means if we did not reduce the numbers of available beds, at any one time during a year there would be between 43 and 64 unused community rehab beds. It costs hundreds of thousands of pounds to keep these available, whether they are occupied or not, in building upkeep, electricity and so on. We also need to duplicate staffing across the sites.

## Case study: Sunita stays in a community rehabilitation unit

**Sunita is a 77 year old woman who is unsteady on her feet and is in hospital following a fall. She also has a chest infection.** She no longer needs to be in the hospital, but she's not mobile enough to go home, and she is afraid of falling over again. CTT and IRS won't be enough for her – she needs help to move around safely, but she also needs 24 hour care. Sunita is referred to a community rehab unit. A nurse from the unit comes out to visit her, assesses her to make sure that the unit is the right place for her to go. It is and she's offered the next available bed.

While in the unit, Sunita receives 24 hour nursing care, physio and occupational therapy. The team regularly assess her and set her small but achievable goals to build her confidence and make sure she is progressing. After two and a half weeks, Sunita is feeling confident enough to go home, and the unit team supports this. They plan how she will manage after leaving. IRS staff visit her on the ward and once she's back home and develop an intensive rehab plan for her. The district nurses and the social care team also review Sunita's needs and provide the support she needs to stay at home safely, with the support of her family.

Sunita is happy to go home, pleased that she will have the support she needs to continue to recover. She is feeling stronger and more confident.

# Why we want to change the way we offer intermediate care

We want people to get better care and to recover more quickly. We want them to be able to stay at home, if at all possible, because that's what patients and their families want. Keeping people at home helps them to stay independent for longer and it reduces the risk of them picking up a new infection and becoming more unwell.

We want to make sure that we are using NHS money in the best possible way. This means spending our budget on services that would help patients the most. It means making sure that we are running services as efficiently as possible, saving money where we can so we can reinvest it in different and better services.

Since introducing CTT and IRS on a trial basis, we have found that a lot of beds in community rehab units are not now being used, because the teams care for people in their own homes (in the first six months of the trial, 29 beds weren't used). During the trial we have found that people are able to access care and support sooner. We know that for the majority of people care at home is the right thing, they do not need to go to hospital or a community rehab unit, and they recover as well, and in some cases better and quicker at home. Patients who have used the new services have told us they have had a very good experience and received high-quality care.

"Everybody wants to go home from hospital – as soon as they are ready and able to."

"I could not have managed without the support from the team."

## Case study: Reg is helped at home by the Community Treatment Team

**Reg is 55 years old. He lives on his own and he has Chronic Obstructive Pulmonary Disease (COPD) which sometimes makes it hard for him to breathe.**

Reg visits his GP a lot about his COPD because he's not confident about managing it and he's ended up in A&E in the past. His GP tells him about the local community treatment team (CTT), who can help him to manage his condition.

Reg has struggled to breathe all day but tries to manage with his existing medication. By 4pm, Reg is finding it harder to breathe and this triggers a panic attack. (Panic attacks can be very frightening and intense, but they are not dangerous and won't cause you any physical harm).

Instead of calling 999, as he would have in the past, he calls the CTT. The administrator asks him some questions and tells him how long it will be before someone calls him back. He's called back within 10 minutes as his case is a priority because it is clear he is having difficulty breathing. (The CTT will contact all patients within two hours). A senior nurse asks him questions about how he's feeling. Because of what he says, she allocates his case to a community nurse who arrives at his house within two hours. Reg is thankful that he can receive help at home as, like lots of people, he finds hospitals stressful, which generally makes him feel worse.

The nurse does various tests and notes his temperature has gone up and his oxygen levels are outside the normal range. They talk through his medical history and what medication he is on. The nurse advises Reg that he should now start taking the medication he has for when he has an attack. They discuss how he can manage his shortness of breath, and she carries out a blood test to rule out any further medical concerns. The CTT continues to monitor Reg's progress over the next two to three days and they keep his GP informed.

The nurse also refers Reg to the specialist respiratory team who will work with him in the longer term to help him manage his condition, looking in detail at the medication he's on and working with a physio and occupational therapist.

Reg feels much more confident about managing his COPD in the future, and knows he can always call the CTT if he needs them.

# What are the options for intermediate care?

We looked at the possibilities for improving intermediate care services for local people then drew up a list of five options. We then looked at the advantages and disadvantages of each option.

- What would be best for patients and help them to recover as quickly as possible?
- What would be easiest for patients and carers to help them live their normal lives where possible?
- How well does each option fit in with all the other local health and social care services and any plans there might be to develop those in the future?
- Could we afford to pay for the services in each of the options and are some options more or less expensive than others?

We have to make sure that we spend our limited NHS money in a way that makes sure we get the most we can for local people. We do not have enough money to spend on everything that everyone wants and if we spend more on one service then we have less to spend on another. That's why it's really important that we get the balance right.

As well as thinking about how much it would cost to run the services in the future, we thought about how much it would cost to make any changes. This would include the cost of any changes that we might need to make to modernise buildings, for example.

When we evaluated the options, we took into account both non-financial and financial criteria and we weighted these 60:40, meaning the financial aspects were not as important as things like quality of care and patient experience. Detail of these processes and the evidence behind our thinking, including information on finances and the pre-consultation business case is on our websites:

www.barkingdagenhamccg.nhs.uk/intermediatecare
www.haveringccg.nhs.uk/intermediatecare
www.redbridgeccg.nhs.uk/intermediatecare

"Walks well now, able to walk with a stick."

**The five options we considered in detail were:**

## Option 1: Stay as they are now

CTT and IRS – same number of beds – beds on three sites

This option means things would not change from how they are now. There would be the same number of beds on the same sites and there would be the new CTT and IRS services that we have been trialling.

Under this option, patients would benefit from the popular home-based care services which help patients to recover more quickly. They would also have more choice if they needed care in a community rehab unit as there would be three community rehab units offering care.

Under this option, there would be unused beds in the community rehab units because more people would be cared for in their own homes. This means money would be wasted.

This option would not be affordable because it is the most expensive option. We would not be able to pay for the new home-based services while still running the same number of beds across three community rehab units. We managed to find additional money to pay for the trial but we cannot carry on running both home-based and bed-based services at this level in the long term.

## Option 2: Go back to before the trial

No IRS – No CTT in Redbridge and reduce CTT hours in BD and Havering – same number of beds – beds on three sites

This option means we would go back to how things were before we started trialling the new services. That means there would be no IRS in any of the boroughs and no CTT in Redbridge. The CTT in Barking and Dagenham and Havering would reduce their hours again, by two hours a day. There would be the same number of beds on the same sites.

Under this option patients in all areas would get a reduced service, particularly in Redbridge. The reduction in services would be in the home-based services that patients and carers really like and which help people to recover more quickly.

This option is not affordable in the longer term. No IRS (and no CTT in Redbridge) to support other services would mean longer waits for the services that do exist. That would make those services less productive and patients would take longer to leave hospital. That would be more expensive in the long term than what we are proposing.

"We're extremely happy with the service and have recommended to our friends already."

## Option 3: New services and three sites

### CTT and IRS – fewer beds – beds on three sites

This option means we would have the new home-based services (CTT and IRS) in all boroughs and we would still have three community rehab units. There would be fewer beds overall though because we would take out the ones that aren't needed.

Under this option patients would benefit from the popular and effective home-based services. Those who needed to stay in a community rehab unit would still be able to choose from the three current units (although they might have to wait for a bed if they wanted a specific unit, as they do now).

Having beds on a number of sites has some disadvantages. It is harder to ensure the same consistency and quality of care. If beds are spread over a number of sites, we need more staff than if they are all on one site. The workforce is less flexible if we are running a number of units.

This option is not the most affordable option because we would have to pay all the costs of keeping three community rehab units open, even if we weren't using all the space in each building.

## Option 4: New services and two sites

### CTT and IRS – fewer beds – beds on two sites

This option means we would have the new home-based services (CTT and IRS) in all boroughs. We would reduce the number of community rehab units to two and we would reduce the overall number of beds.

Under this option patients would benefit from the popular and effective home-based services. Those who needed to stay in a community rehab unit would be able to choose from two units (although they might have to wait for a bed if they wanted a specific unit, as they do now).

Having beds on a number of sites has some disadvantages. It is harder to ensure the same consistency and quality of care. If beds are spread over a number of sites, we need more staff than if they are all on one site. The workforce is less flexible if we are running a number of units.

We considered all combinations of which two sites could stay open, but for the reasons explained above, did not feel this option would provide high quality care. For a detailed description of this process, see the pre-consultation business case on our websites:

www.barkingdagenhamccg.nhs.uk/intermediatecare
www.haveringccg.nhs.uk/intermediatecare
www.redbridgeccg.nhs.uk/intermediatecare

This option is more affordable than options 1-3, but it doesn't offer the best value for money because we would still have to run two separate units on two separate sites.

## Option 5: New services and one site

**CTT and IRS – fewer beds – beds on one site at King George Hospital**

This option means we would have the new home-based services (CTT and IRS) in all boroughs. We would reduce the number of community rehab units to one at King George Hospital and we would reduce the overall number of beds.

Under this option patients would benefit from the popular and effective home-based services. Those who needed to stay in a community rehab unit would be able to.

This option would be the most affordable because we would pay for the new services with the money that we saved by reducing bed numbers and by reducing the number of sites from three to one. It would also be the best value for money as we would reduce duplication (for example paying to run three buildings).

This is also the best option clinically – it would allow us to deliver a better service, with better results for patients. Clinicians tell us the safest way to provide high-quality care is by having a service in one place rather than in a number of smaller units, as this means patients get better more quickly. Running one unit would mean we could use staff much more efficiently and flexibly and patients would have better access to specialist therapy and nursing support.

This option is our preferred option and we explain why in the following section.

### Summary of options

| Option | Is there a community treatment team? | Is there an intensive rehab service? | How many beds overall? | How many community rehab units? |
|---|---|---|---|---|
| **1** | Yes | Yes | 104 | 3 |
| **2** | Yes, with reduced hours (Barking and Dagenham and Havering)<br>No (Redbridge) | No | 104 | 3 |
| **3** | Yes | Yes | 40-61 | 3 |
| **4** | Yes | Yes | 40-61 | 2 |
| **5** | Yes | Yes | 40-61 | 1 |

# What do we think would be best in the future?

We want to be able to continue the new services that we have been trialling – the community treatment teams in all three boroughs for 14 hours a day, and the new intensive rehabilitation service, because the trial has been very successful. We have had really good feedback from patients and carers about the services – they think they are an improvement.

As much as possible, patients have been helped to stay at home, which has helped them to get better quicker and to stay independent.

We also want to make sure that we have the right number of beds for people who do need to stay in a community rehab unit. We want those beds to have the right supporting services around them.

After thinking about the advantages and disadvantages of all the options, **we think option five is the best option**. This is because we think it would result in the best and safest care.

Option five would mean:

- **We would continue to run the community treatment team and the intensive rehabilitation service that we have been trialling.**

  This means most people would get care at home and would not need to travel or stay in hospital. They would be able to lead as normal a life as possible and stay close to family and friends. We know that helping people to stay out of hospital means they are more able to stay independent for longer. Those people who do need to go into hospital would be helped to return home more quickly than in the past. This is because people who have been helped by these services think they are much better than going into hospital.

- **We would reduce the total number of beds across the three boroughs to between 40 and 61.**

  This means that we would always have 40 beds and we would always be able to increase the number of beds up to a maximum of 61, depending on how many people need a bed at a time. We do not think we would ever need more than 61 beds at any one time. This is because fewer people would need a bed because they are being cared for at home and those who do need a bed for a while would not have to stay in the unit for as long.

- **We would move all the beds onto one site**

  Having a service in one place rather than in a number of smaller units, means patients get better more quickly. It is much easier to make sure care is of consistent quality and clinicians say this is the safest way to provide care (rather than on two or three sites).

  We could use staff much more efficiently and flexibly and we would cut down on duplication of tasks, which would mean staff would have more time to spend with patients. A single larger rehab unit is much better able to cope with fluctuations in demand. Patients would have better access to specialist therapy and nursing support. The links with CTT and IRS would be better than if they were dealing with a number of units.

  We realise that moving from three sites to one would make it harder for some people to visit a relative or friend, but we think the benefits to patients should make it worthwhile. For example, patients will go home sooner than they do now. Some people are already travelling – people in Havering travel to Redbridge to visit Foxglove ward. We think this can be offset by the majority of people being seen in their own home, and not needing to travel.

- **We would locate the service on the King George Hospital site.**

  This location is fairly central to the three boroughs, there are good, well-established transport links and car parking is available on the site.

  Locating the service on this site means it could link in with other health services where necessary. There is enough room here to be able to have up to the maximum number of beds that we think we might need at any one time. There is not enough room on either of the other two sites for 61 beds.

  It would mean that we would no longer need two community rehab units – Heronwood and Galleon unit in Wanstead and Grays Court in Dagenham.

  We do not own either of these sites, so we cannot make decisions about what would happen to them, but we would work with the owners and other local stakeholders to help them decide how best to use the sites.

  For information on the advantages and disadvantages of the different sites, look at the 'Community rehab units' section.

"The service has made a massive difference to my mobility. I would not have been able to recover to the level I have."

## Case study: Doreen goes home from hospital with the help of the Intensive Rehabilitation Service

**Doreen is an 86 year old widow living by herself. She has high blood pressure, rheumatoid arthritis and walks with a stick but is otherwise in good health.**

One day, Doreen falls down her stairs and can't get up, so her neighbour calls 999. An ambulance takes her to Queen's Hospital where an x-ray shows she's broken her leg. She has her leg set under anaesthetic, and spends three weeks recovering on an orthopaedic ward.

While she is in hospital, Doreen has physiotherapy to work on her strength and mobility and an occupational therapist helps her to practise tasks like washing and dressing and moving about safely.

When Doreen no longer needs to be in hospital, instead of going to a community rehab unit, she is referred to the Intensive Rehabilitation Service (IRS). Staff from the service talk to the hospital therapists, nurses and doctors and to Doreen about her situation - how she is recovering, and what kind of care she needs to complete her recovery at home.

Once Doreen is back home, the IRS team visit her and talk to her about her goals. She wants to be able to climb her stairs safely, and walk to her neighbour's house, so between them they work out a plan to help her achieve this.

This involves up to 21 days of intensive rehabilitation at home. She is visited twice a day every day and receives care from a physio, occupational therapist, rehabilitation assistants and a nurse. As Doreen becomes more confident moving around, the team does more with her – helping her to manage the steps in her back garden.

The team reviews Doreen's progress throughout her rehabilitation and looks at what other help she needs. Both they and Doreen think she has recovered well, thanks to the intensive support. They let Doreen's GP know about her progress so she can follow up and refer Doreen to other services such as district nursing. They also talk to the council's social care team to make sure she has someone to help her do her shopping

Doreen feels safe to continue to live in her own home, with the support of NHS and council services.

# Questions and answers

### How did you decide on the preferred option?

The executive committees of the three CCGs set up a steering group with senior doctors and managers (including the nurse director and finance director) from all three boroughs. This group developed and appraised the options against a set of criteria, coming up with a recommended preferred option. The governing bodies of the three CCGs then considered what they had done, and agreed we should consult the public and other stakeholders on that preferred option.

### When would you make these changes?

If agreed, we would need to talk to Barking, Havering and Redbridge University Hospitals NHS Trust, which owns King George Hospital, to agree when we would be able to start to use more space. We'd need to take the time to make any changes properly, at minimum disruption to patients, so any move would probably take place in the 2015/16 financial year.

### Have you factored population changes into the planning?

Yes. We always use the most up-to-date population information and projections to make sure that we plan appropriately for current and future needs.

### Isn't this just all about saving money?

No. The reason we want to make changes is because we think we can make things better for patients so they recover more quickly and most of the time recover in their own homes. We have also had great feedback on the services – patients like them. This is about spending money where it will have the greatest impact and result in the best care and results for patients.

But anything we do has to be affordable. We have a limited NHS budget and if we spend more on one service then we have to cut what we spend on something else.

### What if I want to recover in a bed at a community rehabilitation unit, not at home?

If you wanted to recover in a bed at a community rehab unit, we would talk to you about why you wanted to do this. If we thought you would recover more quickly at home we would explain why. We would discuss any social care needs you might have and we would talk to you about how we could help you remain independent. Of course, anyone who is in clinical need of a bed would get a bed.

### Why can't we keep three community rehab units?

Clinicians tell us the safest way to provide high-quality care is by having a service in one place rather than in a number of smaller units, as this means patients get better more quickly. Running one unit would mean we could use staff much more efficiently and flexibly. We would cut down on duplication of tasks, which would mean staff would have more time to spend with patients. A single larger community rehab unit is much better able to cope with fluctuations in demand. Patients would have better access to specialist therapy and nursing support. The links with CTT and IRS would be better than if they were dealing with a number of units.

### What would happen to the buildings if the decision is made to centralise services?

We do not own the sites, so we cannot make decisions about what would happen to them. We would work with the owners and other local stakeholders to help them decide how best to use the sites.

Work would also need to be done to the available space at King George Hospital. This would mean looking at the way the space is laid out so government requirements to put men and women in different areas are met. Other work, such as painting and decorating and getting IT systems set up would also be needed.

### What about the St George's Hospital site in Hornchurch?

Havering CCG is still working with the site's owners and NHS England to develop a new health centre on the site. That is still in the planning stage and so any new centre would be some way off.

### Wasn't it the plan to put the rehabilitation beds that moved off the St George's Hospital site in 2012 back into the new health centre?

The public consultation on the redevelopment of St George's supported the preferred option not to include any beds, but to ensure flexibility the CCG has made sure there is enough space in the plans for some short-term care beds (not intermediate care beds). As this is still at the planning stage, it would be some time before any new centre was up and running and we want to make these improvements more quickly.

### What about involving social care and social workers?

The CTT includes social care staff as well as NHS staff, so the team thinks about the patient's needs as a whole, rather than separating them out into health or social care. The IRS also has very good links with social care.

### Do local authorities and care providers support these proposals?

These proposals have been agreed by the Integrated Care Coalition (ICC), a group of health and social care partners including local councils and care providers, which was established to review and propose how health and social care services can be made better for local people.

Following an in-depth review of local services, the ICC published a 'case for change' which identified a need to improve and modernise the way intermediate care services are delivered. A strategy was developed which took into account examples of alternative models and approaches here and overseas, and involved extensive local clinical, professional and public engagement.

"I would like to be able to score higher than 10."

# We want your views

We want you to tell us what you think of these proposals. Please complete the questionnaire at the end of this booklet and send it back to us, or write to:

**FREEPOST I Y 426**
**ILFORD**
**IG1 2BR**

If you'd prefer to send an email, send it to **haveyoursay@onel.nhs.uk**

You can also call: **020 3688 1089**

**All comments must be received by 5pm, Wednesday 1 October 2014.**

## How your views will be considered

Once the consultation closes, we will review and analyse all the responses we receive.

We will use this information to write a report for each of the three CCGs' governing bodies to consider, alongside any other evidence and/or information available (for instance the equalities impact assessments) and make a decision on the most appropriate way forward. They will also be able to see all the consultation responses in full.

If you are responding on behalf of an organisation or you represent the public (like an MP or a councillor) your response may be made available for the public to look at. If you are responding in a personal capacity, we will not publish your response but we may use unnamed quotes to show particular points of view.

We will put the dates of the governing bodies' decision-making meetings on our website. These are meetings held in public, so you are welcome to attend and all the reports they will look at will be published on our websites.

If you let us know your contact details (by filling this in on the questionnaire), we can keep you up to date with our work.

"Brilliant service, helpful, good treatment, and good communication."

# Questionnaire

**Please tell us to what extent you agree or disagree with the following statements:**

**1** The NHS should permanently run the new home-based services that have been trialled (the community treatment teams and the intensive rehabilitation service) because they help people to get better more quickly and to stay independent.

☐ Strongly agree ☐ Strongly disagree ☐ Agree ☐ Don't know ☐ Disagree

Comments

**2** The NHS should reduce the numbers of community rehabilitation beds if it can be shown that they are not used and are not needed.

☐ Strongly agree ☐ Strongly disagree ☐ Agree ☐ Don't know ☐ Disagree

Comments

**3** The NHS should reduce the number of community rehabilitation units because this is the best way to provide high quality, safe care.

☐ Strongly agree ☐ Strongly disagree ☐ Agree ☐ Don't know ☐ Disagree

Comments

# Questionnaire continued

**4** We believe that option five – home-based services where possible and one community rehabilitation unit on the King George Hospital site, with 40-61 beds - is the best way to organise intermediate care services in the future.

- [ ] Strongly agree
- [ ] Strongly disagree
- [ ] Agree
- [ ] Don't know
- [ ] Disagree

Comments

**5** If you disagree with our preferred option (option 5) please tell us what you think we should do instead.

- [ ] Option 1
- [ ] Option 2
- [ ] Option 3
- [ ] Option 4
- [ ] None of them

Comments

Use this space if you want to tell us anything else

# Monitoring questions

We would find it useful if you could tell us a bit about yourself so we can see what sorts of people are responding and whether they think differently from other groups. That helps us to understand if what we want to do might have more of an impact on some groups of people than others.

You don't have to give us your name if you don't want to and we will still take your views into account.

**Name**

**Are you providing this response as a representative of a group:**

- Yes
- No

If yes, what is the name of the group

**Would you like to be kept up to date with information about the NHS (including this consultation)**

- Yes
- No

If yes, please give us your email or postal address

**Which borough do you live in**

- Barking and Dagenham
- Havering
- Redbridge
- Other

**Are you?**

- Male
- Female
- Prefer not to say

**Are you responding as a…**

- Service user
- NHS staff member
- Carer
- Local resident
- Other
- Prefer not to say

**Are you employed by the NHS?**

- Yes
- No
- Prefer not to say

**What is your ethnic background**

White

- White British
- White Irish
- Any other white background

Mixed

- White and Black African
- White and Black Caribbean
- White and Asian
- Any other Mixed background

Asian

- Asian British
- Indian
- Bangladeshi
- Pakistani
- Chinese
- Any other Asian background

Black

- Black British
- Black African
- Black Caribbean
- Any other Black background

- Any other ethnic group
- Prefer not to say

**Which belief or religion, if any, do you most identify with?**

- Agnosticism
- Atheism
- Buddhism
- Christianity
- Hinduism
- Islam
- Judaism
- Sikhism
- Other
- Prefer not to say

**Do you consider you have a disability?**

- Yes
- No
- Prefer not to say

**How old are you?**

- Under 16
- 16-25
- 26-40
- 41-65
- Over 65
- Prefer not to say

This document is about our plans to improve some of the health services in Barking and Dagenham, Havering and Redbridge. If you cannot read the document and would like to know more, please contact us and tell us what help you need. Let us know if you need this in large print or a different format. If you do not speak English, please tell us what language you speak.

**English**

This document is about our plans to improve some of the health services in Barking and Dagenham, Havering and Redbridge. If you cannot read the document and would like to know more, please contact us and tell us what help you need. Let us know if you need this in large print or a different format. If you do not speak English, please tell us what language you speak.

**Bengali**

এই নথিটি বার্কিং ও ড্যাগেনহ্যাম (Barking and Dagenham), হ্যাভারিং (Havering) ও রেডব্রিজ (Redbridge)-এ কিছু স্বাস্থ্য পরিষেবার উন্নয়ন সংক্রান্ত আমাদের পরিকল্পনার বিষয়ে তৈরী করা হয়েছে। আপনি যদি নথিটি পড়তে না পরেন এবং এ বিষয়ে আরো জানতে চান, অনুগ্রহ করে, আমাদের সাথে যোগাযোগ করুন এবং আমাদের বলুন যে, আপনার কি সহায়তা প্রয়োজন। আপনার যদি এটি বড় হরফের মুদ্রন বা অন্য একটি ফরম্যাটে প্রয়োজন হয়, আমাদের তা জানান। আপনি যদি ইংরেজীভাষী না হন, অনুগ্রহ করে, আমাদের জানান যে, আপনি কোন ভাষায় কথা বলেন।

**Lithuanian**

Šiame dokumente atsispindi mūsų planai patobulinti kai kurias sveikatos priežiūros paslaugas Barkinge ir Dagenheme (Barking and Dagenham), Haveringe (Havering) ir Redbridže (Redbridge). Jei negalite perskaityti šio dokumento ir pageidaujate išsamesnės informacijos, susisiekite su mumis ir pasakykite, kokios pagalbos Jums reikia. Informuokite mus, jei pageidaujate dokumento stambiais rašmenimis ar kitokio formato. Jei nekalbate angliškai, informuokite, kokia kalba kalbate.

**Portuguese**

Este documento é acerca dos nossos planos para melhorar alguns dos serviços de saúde em Barking e Dagenham, Havering e Redbridge. Se não puder ler o documento e desejar saber mais, contacte-nos e informe-nos que tipo de ajuda necessita. Informe-nos se necessita em tamanho maior ou num formato diferente. Se não fala Inglês, informe-nos qual o seu idioma preferido.

**Punjabi**

ਇਹ ਦਸਤਾਵੇਜ਼, ਬਾਰਕਿੰਗ ਅਤੇ, ਡਾਗਨਹੈਮ (Barking and Dagenham), ਹੈਵਰਿੰਗ (Havering), ਅਤੇ ਰੈੱਡਬ੍ਰਿਜ਼ (Redbridge) ਵਿਚ ਕੁਝ ਸਿਹਤ ਸੇਵਾਵਾਂ ਵਿਚ ਸੁਧਾਰ ਸਬੰਧੀ ਸਾਡੀਆਂ ਯੋਜਨਾਵਾਂ ਦੇ ਬਾਰੇ ਹੈ। ਜੇ ਤੁਸੀਂ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਨਹੀਂ ਸਕਦੇ ਅਤੇ ਇਸ ਬਾਰੇ ਹੋਰ ਜਾਣਕਾਰੀ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਡੇ ਨਾਲ ਸੰਪਰਕ ਕਰੋ ਅਤੇ ਸਾਨੂੰ ਦੱਸੋ ਤੁਹਾਨੂੰ ਕੀ ਚਾਹੀਦਾ ਹੈ। ਜੇ ਤੁਸੀਂ ਇਸ ਸਫ਼ੇ ਨੂੰ ਮੋਟੀ ਛਪਾਈ ਜਾਂ ਕਿਸੇ ਹੋਰ ਫਾਰਮੈਟ ਵਿਚ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਸਾਨੂੰ ਦੱਸੋ। ਜੇ ਤੁਸੀਂ ਅੰਗਰੇਜ਼ੀ ਭਾਸ਼ਾ ਨਹੀਂ ਬੋਲਦੇ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ ਕਿ ਤੁਸੀਂ ਕਿਹੜੀ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ।

**Romanian**

Acest document este despre planurile noastre de a îmbunătăți o parte din serviciile de sănătate din Barking și Dagenham, Havering și Redbridge. În cazul în care nu puteți citi acest document și ați dori să aflați mai multe, vă rugăm să ne contactați și să ne spuneți de ce ajutor aveți nevoie. Spuneți-ne dacă documentul trebuie să fie într-un format mare sau într-un format diferit. Dacă nu vorbiți limba engleză, vă rugăm să ne informați ce limbă vorbiți.

**Tamil**

இந்த ஆவணம் பார்க்கிங் அண்டு டாகென்ஹம் (Barking and Dagenham), ஹாவெரிங் (Havering) அண்டு ரெட்ப்ரிட்ஜ் (Redbridge) ஆகியவற்றில் உடல்நல சேவைகள் சிலவற்றை மேம்படுத்துவதற்கான எங்களின் திட்டங்கள் பற்றியது. உங்களால் இந்த ஆவணத்தைப் படிக்க இயலவில்லை என்றால் மற்றும் மேலும் தகவல்களைப் பெற விரும்பினால், எங்களைத் தொடர்புக் கொண்டு, உங்களுக்கு என்ன உதவி வேண்டுமென்று கேளுங்கள். உங்களுக்கு இது பெரிய எழுத்துக்களிலோ அல்லது வேறு வடிவத்திலோ வேண்டுமென்றால் எங்களிடம் தெரிவியுங்கள். உங்களுக்கு ஆங்கிலத்தில் பேச தெரியாது என்றால், நீங்கள் என்ன மொழியில் பேசுவீர்கள் என்று எங்களிடம் கூறுங்கள்.

**Urdu**

یہ دستاویز بارکنگ اور ڈی جینہم (Barking and Dagenham) ہیورنگ (Havering) اور ریڈ برج (Redbridge) میں صحت کی چند خدمات کو بہتر بنانے سے متعلق ہمارے منصوبوں کے بارے میں ہے۔ اگر آپ یہ دستاویز نہیں پڑھ سکتے اور اس کے بارے میں مزید جاننے کے خواہاں ہیں، تو براہِ کرم ہم سے رابطہ قائم کریں اور ہمیں بتائیں کہ آپ کو کیا مدد درکار ہے۔ اگر آپ کو یہ دستاویز بڑے پرنٹ یا کسی دیگر فارمیٹ میں درکار ہے تو ہمیں بتائیں۔ اگر آپ انگریزی میں گفتگو نہیں کرتے، تو براہِ کرم ہمیں بتائیں کہ آپ کون سی زبان بولتے ہیں۔

This document was developed with the help of patient representatives from across our area.