MINUTES OF A MEETING OF THE HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE Havering Town Hall 26 October 2016 (7.00 - 9.15 pm)

Present:

Councillors Michael White (Chairman) Dilip Patel (Vice-Chair) June Alexander, Alex Donald (Part of meeting) and Carol Smith.

Also present:
Mairead McCormick, Deputy Chief Operating Officer (Barking, Havering and Redbridge University Hospitals' NHS Trust (BHRUT).
Barbara Nicholls, Head of Adult Services
Deborah Redknapp, Health Improvement Contract Specialist, Public Health
Alan Steward, Chief Operating Officer, Havering Clinical Commissioning Group (CCG)
Carol White, North East London NHS Foundation Trust (NELFT)

Anthony Clements, Principal Committee officer

15 ANNOUNCEMENTS

The Chairman gave details of the arrangements in case of fire or other event that might require the evacuation of the meeting room or building.

16 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

Apologies were received from Ian Buckmaster, Healthwatch Havering.
Apologies were also received from Sarah Tedford, BHRUT.

17 DISCLOSURE OF INTERESTS

There were no disclosures of interest.

18 MINUTES

The minutes of the meeting of the Sub-Committee held on 27 July 2016 were agreed as a correct record and signed by the Chairman.

19 BHRUT IMPROVEMENT PLAN AND PLAN FOR WINTER PRESSURES

An officer from BHRUT explained that the recent CQC visit to the Trust had now been completed but no feedback had been received as yet. A report was expected from the CQC by the end of November 2016. The Trust's improvement programme had developed into an improvement portfolio which fed into an Improvement Portfolio Board chaired by the Trust chief executive. The Board provided strategic direction and ensured the alignment of programmes as well as recommending sufficient resources were released for improvement work.

The improvement work had four components covering quality improvement, organisational development & workforce, service improvement and constitutional standards. The Portfolio Board reviewed progress monthly and reported via the Trust Executive Committee to the main Trust Board.

The Chief Operating Officer for Havering Clinical Commissioning Group (CCG) agreed that lessons needed to be learnt and that learning from incidents and mistakes needed to be clearer. Timescales varied for completion of the total of 35 improvement workstreams with some areas such as the governance and constitutional work being continuous targets. Workforce development was also ongoing.

As regards winter pressures, the Trust aimed for an 85% capacity to as this allowed extra bed capacity during bank holidays etc. Pressures were usually at their greatest towards the end of the Christmas/New Year holiday period. The Trust sought to maintain standards of care and patient dignity regardless of pressures.

The winter season usually meant a higher volume of hospital attendances as well as a longer length of stay for those patients admitted. There was a Trust-wide capacity plan which covered issues such as extreme weather and getting people to appointments in cases of transport difficulties. Staff availability during these periods was also an issue. BHRUT sought to prioritise in these instances communication with vulnerable groups and to prepare for increased levels of attendance and demand. A 24:7 urgent care centre had now been established at both Queen's and King George Hospital. There was also a wish to try to ensure more treatment was delivered at home rather than in a hospital setting.

Internal delays to treatment were scrutinised daily and the Trust worked with partners on this. There was also a Trust workforce plan in place although it was accepted that BHRUT also still had significant numbers of vacancies. Demand was monitored daily and an agreed process was in place to deal with any service disruption. This included responses from partners such as the Council and CCG. It was accepted that on the worst days of winter pressures, the Trust may need to look at what services could still be provided.

The officer emphasised that delays in the completion of discharge prescriptions lay more with junior doctors than with the hospital pharmacy itself. Work was in progress to encourage doctors to complete prescriptions on the evening before a patient's discharge.
BHRUT dealt with care home providers principally in conjunction with the Council via the Joint Assessment and Discharge Team. There were approximately 1,600 care homes beds for older people in Havering. In previous years there had been around 200 vacancies during the winter (although the Council's levels of fees were not accepted by all care homes) and it was possible that some homes could close for the winter, thereby reducing the number of beds available.

Expected demand was calculated by using a percentage increase on the previous year's demand levels and winter plans were agreed by the A & E Delivery Board comprising all relevant parties. Expected winter demand levels were required to be submitted by BHRUT to NHS England in the next two weeks and the Trust capacity plan included a tolerance of around 5%. Another option to deal with high demand could be to use additional rehabilitation beds provided by NELFT.

The Council's Director of Adult Services added that it was not the Council's preference to have people discharged from hospital to residential nursing homes and it would be preferable to discharge people back to their own homes. The former care beds at Royal Jubilee Court had been closed off as part of the Council's medium term financial strategy. The operation of the reablement service was currently being reviewed as the service had difficulty recruiting and retaining staff and was not delivering sufficient hours of service.

The Sub-Committee NOTED the position.

20 INTERMEDIATE CARE UPDATE

It was agreed that NELFT officers should also attend the next meeting of the Sub-Committee in order to give their response to the report of the recent CQC inspection of the Trust.

It was explained that investment in Child and Adolescent Mental Health Services (CAMHS) had led to the development of a welllbeing hub that would include an out of hours response for issues that did not require use of an acute setting. This would cover for example Looked After Children or young people struggling to cope. Investment had also been made in speech and language therapy and the Youth Offending Team.

The Brookside adolescent mental health unit had been closed temporarily following the CQC visit. The unit had reopened two weeks ago and initial

positive feedback had been received from the CQC. The unit would no longer be focussed on emergent personality disorders such as self-harming which it was sought to treat at home. The Brookside beds would now be available for service users with issues such as schizophrenia.

NELFT also focussed on intermediate care which sought to prevent people entering or staying in hospital. There had previously been 104 rehabilitation beds in Havering but it was felt that only 52-61 such beds were needed and this had led to the opening of the rehabilitation unit at King George Hospital in 2014. The rehabilitation facilities at the Heronwood & Galleon Unit in Redbridge had been closed as part of this change. The Intensive Rehabilitation Service delivered rehabilitation services up to 4 times per day in people's homes and ensured that 42 patients per week avoided hospital stays. Patient satisfaction for this service was very high. The Trust aimed to have a level of consistency among therapists but would state in a patient's care plan that different therapists could be involved in a patient's care.

Officers agreed that there was more self-harm and suicide among younger people and felt this was due to a variety of factors including peer group pressure and social media. The contact phone numbers for the NELFT crisis teams could be shared with the Sub-Committee.

NELFT were currently fully staffed for speech and language therapists and wished to extend this service to dementia-related issues such as swallowing and dysphasia.

21 CARE BED CHARGES

The Director of Adult Services confirmed that the Council's rates were reviewed each year and the Council would currently pay for example £471.51 per person per week for frail elderly beds. A service user's family could be asked to top up this charge, depending on financial circumstances. If a resident had savings in excess of £23,000, they would be expected to pay for their care themselves. A placement in a care home would cost £26-30k annually and there were 500-600 Havering residents currently in long-term care. Care homes for people under 65 had still higher charges. The Director would forward details of which care homes currently accepted the Council's rates.

It was noted that Havering care charges were cheaper than the average for both London and Essex and that some care homes in Essex charged £1,000 or more per week. If people were placed in a Havering care home from outside Havering then charges were paid by the home borough.

If a care home resident was in hospital for up to 4 weeks then the care home was still paid the full rate. If a client died during their care home placement, the provider was required to advise the Council within one working day. The Council then allowed a further five days on the placement to allow the person's family to make arrangements etc. It was possible that

this could be reduced to three days on cost grounds. Equivalent arrangements in other Councils varied between 1 and 5 days for this period.

If a client remained in hospital etc after 4 weeks then the Council would only pay 60% of care fees for the remainder of the absence or until notice was given. Adult Services would normally be aware of any top up arrangement but this was a separate arrangement between the care home and the provider. Members felt that 4 weeks was a considerable period to pay the full rate if a client was not resident at the home and that this should be reviewed. Officers felt that there was no reason to rule anything out around reducing these costs. A NELFT officer added that many contracts with residential homes were outcomes-based with penalties for e.g. patient falls or failure by the home to follow an end of life care plan.

The Director of Adult Services felt it was important to balance lowering of fees paid with the risk of providers leaving the market. The outcomes based model and use of incentives for high quality care seemed a good way forward. A lot of work was under way in preparation for the funding reforms in the Care Act. Officers were seeking to break down the various components of care home charges in order to help the Council to deliver savings.

Members felt that other issues that could be considered included releasing home equity to pay care bills and paying family members to care for relatives. This was being considered at national level but officers felt that it would be unaffordable in Havering due to the large number of carers already in the borough. Additionally, direct payments could not usually be given to family members.

It was AGREED that updates on this area should be given at subsequent meetings of the Sub-Committee.

22 ACCOUNTABLE CARE ORGANISATION

The Director of Adult Services explained that the Accountable Care Organisation (ACO) encompassed the boroughs of Havering, Barking Dagenham and Redbridge, the three local CCGs, BHRUT and NELFT. The ACO had been set up in response to the large challenges in the local health economy such as reduced Government funding for both the Council and Havering CCG.

It was possible that the ACO could serve as a pilot for the rest of London. The ultimate decision on the ACO was for the Treasury although NHS England also had an involvement. The Sustainability and Transformation Plan (STP) was also being worked on and the CCG Chief Operating Officer

felt this would lead to more work taking place at the North East London level. The latest STP submission had been completed in the last week and NHS England had recently announced that there would not be any more consultation on STPs at present as Ministers wished to reflect on the programme.

The STP work had impacted on work on the ACO and it was noted that NHS Transformation money was available via the STP. Better Care Fund monies remained separate and were administered by the Health and Wellbeing Board.

The former Council Chief Executive – Cheryl Coppell had been part of the ACO team but was expected to leave this position shortly. The future format of officer work on the ACO was in the process of being agreed.

The ACO had been established in response to rising demand for health services locally due to an increasing population and a rise in the number of long-term conditions. It was expected that population of three BHR boroughs could rise by 19-28% by 2030. Officers agreed that this meant that the population figures in the previous Health for North East London review were not accurate but there would be any additional funding to accommodate this. It was agreed that Havering was not funded to the correct levels for this work.

The first bid document for the ACO had been submitted in December 2015 and a Strategic Outline Case had to be submitted in the next 3-4 weeks. The Director would confirm the precise schedule for this. Governance of the ACO was the responsibility of the Democratic and Clinical Oversight Group which covered all 8 organisations involved.

It had also been agreed to deliver an Integrated Care Partnership with joint commissioning functions although the exact arrangements for delivering this were still to be confirmed. It was hoped that this work plus the development of a Locality Delivery Model would produce substantial savings for both health and social care. Details of this proposal were expected to be ready in March or April 2017.

The ACO would avoid disputes over funding etc and the CCG had started engagement on this with local GPs. It was hoped that the development of an Accountable Care System and locality working would allow better sharing of resources between the organisations involved in the ACO. It was accepted that GPs were currently confused by the new system but there was a wish to bring GPs into networks to work together. There were also plans to combine back office services for some GP practices. It was anticipated that there would be 8-15 GPs in a network. GP networks could also organise the sharing of certain medical services such as stitch removal. The Chair of Havering CCG and colleagues would be meeting with local GPs in November to discuss the networks concept.

Under the Locality Delivery Model, the locality, rather than the hospital, would be at the centre. It was felt important that health conditions within communities were understood and that GPs should start working together. There were currently 6 GP clusters in Havering but it was anticipated that this would reduce to 3 localities. It was emphasised that the local population would be at the centre of the model.

It was also wished to have more hospital services delivered in the community. Each locality would have a community hub that could be shared in order to facilitate this. It was accepted that it was vital to ensure that separate IT systems used plug-ins etc in order to communicate with each other. The CCG also wished to educate people to look after themselves better. Being able to see a patient's records and care plan would be a great help with this.

Havering would test a new model for working with children. This would take place in the north of the borough where there were higher incidences of deprivation, children with child protection plans etc. The Director added that the recent OFSTED inspection had found that the Council needed to do more work on children leaving care and the Council could house these young people up to the age of 25.

The CCG was looking at how people could be treated more in the community as this would help reduce delays to treatment at the hospital. This could be piloted in central Havering with conditions such as diabetes where enhanced support in the community could avoid the need for hospital admissions. It was confirmed that the DAFNE course for people with diabetes was still available. It was felt that Councillors could be involved in the community treatment model and a Member suggested that health advice could be put in the Council's Living magazine.

The Director emphasised that the locality work was not just about social care but also included areas such as housing, benefits advice, helping people back into work, parks and open spaces. It was therefore necessary to work in a more cohesive way. Interviews re the locality model and what people would like included within it had been carried out with 1,000 residents in each of the local boroughs.

The CCG Chief Operating Officer was confident that GPs would support the plans. It was hoped that a road map to the new model would be available by Aril 2017. It was AGREED that a further update on the ACO and locality work should be given at the next meeting of the Sub-Committee.

23 QUARTER 2 - CORPORATE PERFORMANCE REPORT 2016/17

The Sub-Committee was advised that the Council was currently seeing 48.6% of completion of drug treatments for opiates and non-opiates. This compared to a target of 50% although there was a tolerance of plus/minus 3% attached to this. It was wished to improve performance beyond this and stretch targets were therefore incorporated within the monitoring of this contract. Successful completion was a national measure and counted service users who completed treatment and did not present within a certain timescale. The service also sought to keep contact with clients after their treatment.

It was AGREED that confirmation should be sought over whether the performance indicators were also reported to the Health and Wellbeing Board.

24 URGENT BUSINESS

It was AGREED that the date of the next meeting of the Sub-Committee in January 2017 should be moved back by approximately one week in order to avoid a clash of dates with the ONEL Joint Committee. The Clerk to the Committee would circulate confirmation of the date of the next meeting (since confirmed as Thursday 26 January at 7 pm).

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Chairman