MINUTES OF A MEETING OF THE
INDIVIDUALS OVERVIEW & SCRUTINY SUB-COMMITTEE
Town Hall, Main Road, Romford
25 April 2017 (7.00 - 8.45 pm)

Present:

Councillors Linda Trew (Chairman), June Alexander, Linda Hawthorn, Keith Roberts, Patricia Rumble and Roger Westwood

Apologies for absence were received from Councillor Ray Best.

Also present:
Hemant Patel, Healthwatch Havering
Barbara Nicholls, Director of Adult Services
Alan Steward, Chief Operating Officer, Havering Clinical Commissioning Group (CCG)
Dr Russell Razzaque, Associate Medical Director, North East London NHS Foundation Trust (NELFT)
Carol White, NELFT

21 **MINUTES**

The minutes of the meeting held on 24 January 2017 were agreed as a correct record and signed by the Chairman.

22 **OPEN DIALOGUE**

The NELFT Associate Medical Director explained that Open Dialogue was a new model of mental health treatment for adults that looked at the local resources of a person's family and community. This had been found to significantly improve outcomes and produce a considerable economic saving. Family therapy techniques of this kind had been recommended by the National Institute of Clinical Excellence for conditions such as bipolar disorder, depression and schizophrenia.

A recent CQC survey had shown that nearly half of patients had felt their family was not involved enough in their case or treatment. For Open Dialogue, all staff would be trained in family therapy related skills – a collaborative approach involving family members, not just the person concerned.

Following Open Dialogue treatment, 82% of patients had no recurrence of symptoms after 2 years and 74% had returned to work or study. There were

also lower incidences of medication and hospitalisation amongst patients who had undergone the treatment.

The core principles of Open Dialogue focussed on the provision of immediate help and who could assist from the recipient's social or family network. It was also aimed to have psychological continuity with the same clinician being seen throughout the pathway. There was also a tolerance of uncertainty that ensured Open Dialogue was a joint process, avoiding premature conclusions or decisions.

Open Dialogue was a more flexible system, allowing the discussion of different conditions etc. For those people without sufficient family members willing to participate, peer support workers could be introduced to support the Open Dialogue process. Open Dialogue would be provided by NELFT home treatment teams in Havering and Waltham Forest and around 200 people in the UK had now been trained in the technique. The NELFT training course had also now been accredited by the Association of Family Therapists. If funding was received, there would be a total of 8 Open dialogue trial teams across the UK. Outcomes from the service had been very positive so far and there had also been an increase in staff morale amongst those teams providing the service.

Challenges for Open Dialogue included the establishment of an operational policy for the model by which it was hoped to be able to measure key outcomes. Further information on the technique was available on Youtube and officers would provide details.

Once the full trial of Open Dialogue commenced, connections would be made with GPs, pharmacists and other stakeholders. It was emphasised that it was necessary to understand a person's whole family or network in order to successfully resolve their problems. It was planned to offer the service initially for people who had fallen into crisis although there would not be any change to initial access to other mental health services.

The Committee noted the position and thanked Dr Razzaque for attending the meeting. It was agreed that the Committee would be kept updated with developments re Open Dialogue.

23 OLDER PEOPLE'S HOUSING STRATEGY

It was AGREED that this item should be deferred to the next meeting.

24 INTEGRATED CARE PARTNERSHIP

Officers explained that the Integrated Care Partnership (ICP) sought to bring forward further integration between the Council and the NHS. This was in response to the rising population and changing demographics within

Havering. It was accepted that the £55 million deficit facing the three local Clinical Commissioning Groups was a significant challenge.

The ICP sought to bring together a number of different services that were involved in e.g. discharging a person from hospital. Work was in progress to develop a locality model with three localities covering the north, central area and south of Havering, each with a population of around 80,000. This took into account the demographic growth expected over the coming years.

In order to better understand the needs and demands of communities, the Council's Joint Strategic Needs Assessment could be split by locality. There would be different needs and growth in each locality with for example, a lot of population growth in Rainham. The Council's social care services had already begun to integrate its services around localities with those offered by the North East London NHS Foundation Trust.

The Partnership aimed to look beyond just health and social care at other factors such as employment and housing that impacted on health and wellbeing. Children's Services also supported the model, with feedback from GPs that access to mental health services was difficult, being addressed by the establishment of a virtual team covering a variety of children's mental health services at an earlier stage.

Child and Adolescent Mental Health Services (CAMHS) was designed for only the most seriously ill children and funding had been received to seek to offer services at an earlier stage. Localities could be used to support a young person's family and network.

The transition from child to adult services had been criticised by OFSTED and the Partnership work aimed to give young people the support to be as independent as possible. It was aimed to support children's behaviour in the place where it was happening by skilling up families and teachers to manage challenging behaviour.

Support was offered to children with a variety of conditions such as ADHD, autism, Asperger's Syndrome, self-harming and anxiety. It was hoped that schools could talk to the locality team about any initial concerns over children although a child's family would also be worked with. Systemic therapy would be used to focus on what a child's family thought was important.

Officers felt that the School Nurse should be the first point of contact if a school had concerns over a child, rather than the school going direct to a child's family. The School Nursing Service was a universal provision and referral to this would not necessarily indicate a problem with the child's family. A representative of Healthwatch added that healthcare professionals often confused social problems for medical problems and the integration of health and social care should address this.

It was clarified that schools could prompt children to take their medication but could not administer this directly. Any parents with concerns in this area should speak to the School Nurse or Head Teacher.

It was planned move away from just receiving a list of problems from the person towards looking at a person's strengths, goals and support networks. Officers accepted that this was a different approach that would require an element of workforce transformation in order to achieve.

The north locality would focus on children's issues whilst the other localities would focus on areas such as urgent and emergency care. Adult Services' work would focus on intermediate care, covering areas such as reablement, rehabilitation services and the Community Treatment Team. These services aimed to keep people away from being admitted to hospital. As part of this work, the Council's reablement service had been brought together with the NELFT community rehabilitation service. The new service had started within the last week and would focus initially on people coming out of hospital although this would be extended in the future.

A lot of different people and services visited people in their houses and it was felt it would be useful if these services could be used to assist with monitoring people who were vulnerable. Housing officers for example could potentially refer clients for psychological therapies. Community networks were also needed that could support people at a lower level. It was also hoped to equip GPs to start to deal with these issues and allow intervention at an earlier stage.

The Chairman added that these aims of keeping out of hospital were shared by the Barking, Havering and Redbridge University Hospitals' NHS Trust and it was hoped to arrange a briefing for Members with a senior officer from the Trust.

Members felt that the Clinical Commissioning Group should consider the issue of repeat prescriptions as there were significant variations between practices in how these and medication reviews were administered. It was confirmed that a pharmacy representative was a member of the Integrated Care Partnership design group.

The Sub-Committee noted the report and it was agreed that an update on the work of the ICP should be taken at a future meeting.

25 **FUTURE AGENDAS**

In addition to an update on Open Dialogue, the Chairman suggested that a topic group or similar review could take place in order to survey clients that had benefitted from integrated services.

Other suggestions for the work programme included reviewing or visiting local care homes perhaps in conjunction with Healthwatch although the Sub-Committee was reminded that they could only visit a premises with the consent of the owner/manager. It was also suggested that the Sub-Committee could scrutinise how the Council engaged with providers of home care and residential homes. This work could address issues with recruitment and retention around what motivated staff and what were their reasons for leaving etc. An update on the position with Dial a Ride was also suggested.

26 **URGENT BUSINESS**

There was no urgent business raised.

Chairman