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Havering
LONDON BOROUGH

HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

7.30 pm	Tuesday 24 June 2014	Havering Town Hall

Members 6: Quorum 3

COUNCILLORS:

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

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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 DECLARATIONS OF INTEREST

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

4 MINUTES (Pages 1 - 10)

To agree as a correct record the minutes of the meeting held on 20 March 2014 (attached) and to authorise the Chairman to sign them.

5 INTRODUCTION TO SCRUTINY

To receive a presentation from the Clerk to the Committee on the role of Health Scrutiny.

6 LOCAL HEALTH ECONOMY AND INTERMEDIATE CARE

To receive a presentation from the Chief Operating Officer of Havering Clinical Commissioning Group on the local health economy and plans for intermediate care.

7 COUNCIL CONTINUOUS IMPROVEMENT MODEL - UPDATE ON PUBLIC HEALTH TRANSITION

As agreed at the previous meeting, to receive an update from the Acting Director of Public Health on the transition of Public Health into the Council.

8 HEALTHWATCH HAVERING - DEMENTIA AND LEARNING DISABILITIES REPORT (Pages 11 - 34)

To receive a report (attached) from a representative of Healthwatch Havering on recent Healthwatch events concerning dementia and learning disabilities.

9 COMMITTEE'S WORK PROGRAMME (Pages 35 - 38)

Report attached.

10 NOMINATIONS TO JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEES (Pages 39 - 42)

Report attached.

11 COUNCIL CONTINUOUS IMPROVEMENT MODEL

To note that the following Cabinet decision is due for a review of progress under the Council Continuous Improvement Model and to decide whether to take an update at the Committee's next meeting:

Healthwatch Implementation

12 URGENT BUSINESS

To consider any item of which the Chairman is 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.

Andrew Beesley
Committee Administration Manager

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MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY COMMITTEE
Havering Town Hall
20 March 2014 (7.00 - 9.45 pm)

Present:

Councillors Pam Light (Chairman), Ray Morgon, Wendy Brice-Thompson and Peter Gardner

Apologies for absence were received from Councillor Nic Dodin and Councillor Ted Eden

Also present:
Ian Buckmaster, Healthwatch Havering
Stephen Burgess, Barking, Havering and Redbridge University Hospitals NHS Trust
Ilse Mogensen, North East London Commissioning Support Unit
Caroline O'Donnell. North East London NHS Foundation Trust
Alan Steward, Havering Clinical Commissioning Group

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

44 **DISCLOSURE OF PECUNIARY INTERESTS**

There were no disclosures of interest.

45 **MINUTES**

The minutes of the meetings held on 23 January 2014 (joint meeting re Council budget) and 6 February 2014 were agreed as a correct record and signed by the Chairman.

46 **BARKING HAVERING AND REDBRIDGE UNIVERSITY HOSPITAL NHS TRUST (BHRUT)**

The BHRUT medical director explained that a wide ranging Care Quality Commission (CQC) inspection of both Queens and King George Hospitals had taken place in October 2013. The CQC report, received in December 2013, had recognised some improvements in e.g. nursing care. Issues concerning the emergency pathway and reconfiguration etc had however led to the Trust being put in special measures. The Medical Director accepted that more needed to be done concerning A&E, outpatients and Trust governance etc.

A capability review of the Trust had been undertaken, the report from which would be submitted to the National Trust Development Authority (NTDA). An Improvement Director had been appointed who had worked in a special measures Trust in South London, as had the new Director of Finance. A Buddy Trust – a well performing Trust of similar size to BHRUT, was also due to be announced.

The Medical Director emphasised that work was underway with staff and partners to move the Trust forward. A reinspection by the CQC was expected in the next 18 months. The NTDA would also expect to see progress over this period.

The Trust improvement plan was due to be submitted to the NTDA within the next week and an overview document could also be produced. As regards workforce issues, it was accepted that there were major staffing problems in A&E as well as in acute medicine and gastroenterology. This applied to both consultants and middle grade staff. Some recruitment problems were due to perceptions of the Trust and local area being poor.

The Medical Director felt that the entire emergency system was a problem including the wards and discharge procedures. He felt however that the major issues related to patient flows and finance. The maternity department had however improved significantly.

There remained a number of issues regarding transferring patients and notes and the Trust was seeking to institute a better system of governance. It was accepted that there had also been a lot of complaints about outpatient appointments and waiting times although these were issues in many hospitals. The Trust executive team wished to be more visible but there was often not enough time for this.

The Trust improvement plan was expected to be finalised by the end of March and would be published on the BHRUT and NHS Choices websites.

There were now some text reminders of outpatient appointments but the Trust needed to do more of this. There had been some problems with the installation at the Trust of the new Medway computer system. There was also a working group looking at outpatient issues.

It was not expected that the Trust would receive any further resources for this work other than perhaps a small amount of transition money. The Trust overspend was predicted to be £38 million for the next year. Five per cent efficiency savings were also required which would be in the region of £20 million.

It was confirmed that the Trust improvement plan would contain a section on health records. This would also cover issues around keeping records up to date. The Trust saw 648,000 outpatients per year with over a million patient contacts and the Medical Director felt there would always be occasional problems sue to human error etc.

The Medical Director agreed that the layout of outpatients needed to be improved and this would also be covered in the improvement plan. Queen's Hospital generally was also not easy to navigate. Some signage had been improved but the new Trust Chairman remained unhappy with this. Hospital volunteers would in future be more pro-active and wear tabards in order that they were identified more easily. Feeding buddies on wards were also being introduced.

The alteration work in Queen's A&E was currently being reconsidered but this would still need to be carried out in the summer. Changes to areas such as critical care and the moving of the renal dialysis unit were still being negotiated. The Medical Director accepted that A&E had been poorly designed originally.

As regards reconfiguration of the Trust, the outline business case was still being reworked. It was still planned to close the A&E at King George Hospital to blue light ambulances by December 2015. All Queens and King George activity was however being remodelled as the information used in the Health for North East London exercise was now too old. The new data was expected to be available in the next 4-5 weeks.

The current A&E target was to deal with attendances within 4 hours on 90.5% of occasions by the end of March. The current figure was 89% across both sites. There was poorer A&E performance seen in the evenings and at night due to a lot of locum staff having to be used. The Queen's Urgent Care Centre was now open 24:7 on some days and it was a priority to implement 24:7 working at the Urgent Care Centre throughout the week.

Assessment units were being extended and altered to create more short stay beds. This would allow suitable patients to bypass A&E and go straight to an assessment area. An observation area was also being opened at Queen's.

A new paediatric A&E consultant had recently started work with a second consultant starting in April 2014. A total of 17 doctors and 8 anaesthetists had also recently been recruited from India. It was accepted that retaining staff was also a problem. A package including retention premiums was in place for the staff recruited from India and the Trust was trying to be inventive with this issue. It was hoped to move to having a more regular recruitment cycle.

The recent NHS staff survey had shown improved overall results for BHRUT. Motivation and communication with managers had improved and staff also felt they could raise concerns. The CQC placed emphasis on the importance of the staff survey results.

A new Chairman had recently been appointed to the Trust – Dr Maureen Dalziel. Dr Dalziel was a public health doctor and had also previously been a Trust Chief Executive. With effect from 1 April, the new BHRUT Chief

Executive would be Matthew Hopkins – a nurse by background who had previously worked at Barts and Guys and St Thomas' Hospital Trusts. The Medical Director also confirmed that there would definitely not be any victimisation of whistle blowers at the Trust.

Smoking, drinking and hard drug use were harmful and costly to the NHS. The Medical Director felt that there was less evidence of harm from use of recreational drugs. The Trust saw more A&E attendances through misuse of alcohol than drugs.

It was emphasised that the original Health for North East London plans were still being used and it was not therefore necessary to consult on the current proposals. A&E activity had not gone down as predicted in the Health for North East London plans. Additionally, population growth had increased and activity levels had not gone down as anticipated in the original proposals. As such, a refresh of the relevant activity data was currently being undertaken.

The Medical Director emphasised that services would not be fully pulled out of King George Hospital until Queen's was fit for purpose. The special care baby unit would be moved from King George once money was made available to expand the equivalent unit at Queen's.

The Committee **recommended** that the BHRUT improvement plan be an agenda item at the Committee's first meeting after the Council election.

It was explained that the improvement plan was designed to get BHRUT out of special measures and reconfiguration of the hospital would be the second phase of improvement. If improvement were not delivered then the Trust was likely to enter Special Administration.

The Committee **noted** the update.

47 **CHAIRMAN'S UPDATE**

The Chairman confirmed that a letter had been sent on behalf of the Outer North East London Joint Health Overview and Scrutiny Committee giving the Committee's support for the planned move by Moorfields Eye Hospital to a new location.

Members had recently undertaken a useful site visit to Harold Wood walk-in centre. The Chief Operating Officer for Havering Clinical Commissioning Group (CCG) explained that the current contract for the centre, running until April 2016, was held by NHS England. The CCG would however be looking to manage the services it had responsibility for from April 2015.

Members were pleased that a number of issues previously raised by the Committee had been rectified by the walk-in centre provider – Hurley Group. The car park at the centre was due to be repaired following damage caused by the breast cancer screening wagon. The Chairman was also pleased that more of the building was now being used for clinical purposes. It was however disappointing that the scanning machine in the building was not being used. The CCG Chief Operating Officer agreed to investigate this.

The patient discharge topic group had recently met and considerable improvements had been made to discharge processes. There was however still some confusion over medication and gaps seen in some communications. Duplication of medicine for care homes remained a problem as well as delays in receiving medication from the hospital. The Chairman felt that patients could be sent home with prescriptions, given that many pharmacies were now open longer hours. It was confirmed that discharge issues were covered in the BHRUT improvement plan. The Committee **recommended** that scrutiny of discharge issues should continue in the new Council term.

The Joint Committee had also recently written to the Commissioning Support Unit giving its views on the cancer and cardiac proposals. The Committee broadly supported the proposals although felt it was essential that scrutiny should continue as the plans were implemented.

The Chairman expressed a wish that the CCG would continue to keep the Committee updated on developments.

Work on scrutinising children's health issues had been in progress and the Committee **recommended** that this should continue in the new Council term.

48 **NORTH EAST LONDON NHS FOUNDATION TRUST**

The Integrated Care Director at North East London NHS Foundation Trust explained that, following the closure of the child development centre at St George's Hospital, services for children with complex needs were currently being provided from 13 different locations. The London Road site was originally planned to be used for corporate services but, following the closure of St George's, had to be used as clinical space.

Other child development centres had been visited in order to inform the design of the London Road site. Stakeholder engagement sessions were planned for March and April and meetings had been held with the Council Lead Member and local groups such as ADD Up. Work would start on the building in May and it was planned to open for clients in December 2014.

Children's services were also being redesigned. Complex disability and mental health services would be integrated and co-located in London Road. It was emphasised however that there were no plans to close the mental health services currently provided at Raphael House in Romford. Neuro-

developmental pathways and services for conditions such as ADHD would also be brought together at the London Road site.

The London Road building would have 950 square metres of space but services would continue to be provided from Harold Wood Health Centre and NELFT would also look for a third location within Havering. The changes proposed would provide a more effective and efficient pathway for children. NELFT officers were happy to bring further updates to the Committee and for Members to visit the London Road site.

While the NELFT Director could not say that all the needs of the ADD Up support group had been met, it was felt that London Road was the best location at the time. NELFT were keen to involve stakeholders in the design aspects of the building.

It was confirmed that NELFT were seeing an increasing number of children with mental health needs. The current overall service caseload was approximately 5,300 children and this had gone up by 4-5% over the last two years.

The Committee **noted** the update and that the children's health topic group had recently visited Raphael House.

49 **HAVERING CLINICAL COMMISSIONING GROUP (CCG) FUTURE STRATEGIC PLANS**

The CCG Chief Operating Officer explained that the plans of the CCG over the next 2-5 years were driven by the Joint Strategic Needs Assessment which formed the basis for commissioning decisions. Havering had an older population, many of whom had multiple long-term conditions. Ninety per cent of patients with the most complex health problems accounted for 40% of emergency admissions.

There was poor satisfaction with services including access to primary care. There were also lifestyle problems in Havering such as alcohol, smoking and lack of physical activity. Dealing with the most complex problems would make the whole healthcare system function better.

The CCG felt that improving urgent care was not just about BHRUT but that the rest of the health economy should contribute to this. Improving the urgent care pathway was therefore a priority of the CCG over the next year. The CCG was looking to undertake a reprocurement of some of the key services within the urgent care pathway including NHS 111, GP Out of Hours and Urgent Care Centres. The aim was to encourage providers to innovate and work in a more integrated way. The aim was for services to start in 2015/16.

Use of the weekend GP opening service had increased but had still only reached 50-60% of capacity thus far. Open access to weekend GPs could

be operated on a trial basis rather than having referrals solely via the NHS 111 service.

As regards integrated care, the CCG wished to expand the number of conditions covered by the integrated case management system to include dementia and end of life care. More integrated health teams would allow integrated care at a local level. A collect and settle scheme was also being developed for people discharged home from hospital.

The CCG wished to see more care delivered closer to home and to have more outpatient appointments take place locally rather than in a hospital setting. More muscular-skeletal, urology and diabetes outpatient appointments would be delivered in the community from July 2014.

In primary care, the CCG was supporting GPs coming together to share services such as stitch removal within a GP cluster. Havering and Barking & Dagenham GP practices had submitted a bid to the Prime Minister's Challenge Fund for further investment in local primary care services. A Primary Care Improvement Director had also been appointed to the CCG.

The Committee **recommended** that further details of the integrated care work should be brought to a future meeting of the Committee.

The Better Care Fund submission and the CCG operating plan could be shared with the Committee. The operating plan would also be available on the CCG website. The CCG was also working with other CCGs, Councils and providers to submit a five-year strategic plan by the start of June 2014.

Members requested more details on the issues considered by the Urgent Care Board and the Chief Operating Officer responded that a summary of the Board's decisions may be produced. It was noted that the CCG governing body held its meetings in public and that papers were available on the CCG website. The governing body met approximately 5 times a year.

A map of health services in Havering could be provided and the Chairman wished to clarify the location of services that had moved from Queen's Hospital into community locations.

The Chief Operating Officer felt that the directory of services used by the NHS 111 telephone service was the key issue impacting on the effectiveness of the service. He felt there should be more stages of advice offered according to how serious the condition was. He wished to include NHS 111 as part of the urgent care pathway.

The CCG was working with the Red Cross on the out of hospital scheme to consider what was and wasn't working in the existing scheme. The Chief Operating Officer would forward details of which GP practices were in each Havering cluster. Two new clinical directors had been elected by all practices from 1 April – Dr Adur and Dr Anne Baldwin.

The CCG was currently holding discussions with pharmacists, particularly on how the medicines management service could be improved. The CCG was also discussing with BHRUT how information about options for stitches removal could be given out at Queen's Hospital.

The Chief Operating Officer confirmed that there were no new developments concerning the St George's Hospital plans, the bid for which remained with NHS England at present.

The Committee **noted** the update.

50 COUNCIL CONTINUOUS IMPROVEMENT MODEL

The Committee agreed that an update on the transition of public health into the Council should be taken at the next meeting of the Committee, since this issue was now due for review under the Council Continuous Improvement Model.

51 HEALTH AND WELLBEING BOARD MINUTES

There were no comments on the minutes of the meeting of the Health and Wellbeing Board held on 8 January 2014.

52 URGENT BUSINESS

The Committee considered the response by the North East London Public Pharmacy Partnership to the NHS England Community Pharmacy Call to Action. While the were no specific comments on the document at this stage, it was felt that people should make more use of pharmacies which could prescribe as well as offer medication reviews and health prevention advice. The proposed sale of pharmacies run by the Co-Operative organisation was a potential cause for concern.

As this was the Committee's final meeting of the Council term, the Chairman thanked her fellow Members and also the representative from Healthwatch Havering with which the Committee had built a good relationship. The Chairman also thanked the health officers present and the clerk to the Committee for their assistance.

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Chairman

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Have your say with healthwatch Havering

Services for people who have dementia or a learning disability

A review of services in Havering

A report of a series of workshops held by Healthwatch Havering
February and March 2014

What is Healthwatch Havering?

Healthwatch Havering is the 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

Introduction

In late February and early March, Healthwatch Havering held a series of workshops at five locations in Havering. The purpose was to find out what services were available in Havering for people who have dementia or a learning disability and what needed to be done to secure improvements.

The participants included people who use services and carers, volunteers from local third-sector organisations working with people who have dementia or a learning disability and social and health care professionals from Havering Council and local NHS organisations.

We chose Learning Disability and Dementia because these two groups are among the most vulnerable within our community.

Acknowledgements

Healthwatch Havering would like to thank all the participants for the open and frank contributions to the discussions at the workshops. The range of participants' experiences, knowledge and hopes, and their collective desire to secure the best possible outcomes for people who use services and carers made the exercise particularly valuable. Everyone who attended will be provided with a copy of the report

As a direct result of people coming together at the sessions, who would not ordinarily have come into contact, several initiatives have developed that might not otherwise have done so. We would like to thank the professional staff who took up these initiatives so quickly.

The conclusions and recommendations reached are entirely those of Healthwatch Havering.

How the sessions were organised

Five sessions were held between 25 February and 4 March at venues across the borough: in Central Romford, Collier Row, Cranham, Harold Hill and Hornchurch.

Attendees included service users and carers, a number of representatives from the voluntary sector, NHS organisations and local authority departments, everyone made significant contributions to the discussions.

The framework for each meeting and both topics was:

"What is missing?"

"What would make a difference?" and

"What have you experienced that is good?"

Attendees worked in individual groups sharing their knowledge and experience on both dementia and learning disabilities. Each group was chaired by a member of Healthwatch Havering. At the end of each session there was an open forum and each group fed back and shared the experience of their group.

Conclusions and recommendations

Our conclusions are:

- Overall services for people who have a learning disability or dementia appear adequate and there have been some good, innovative developments.
- Service planning over the years has taken account of the needs of people who have dementia; but much remains to be done, especially in early diagnosis
- Services for people who have a learning disability appear to be less advanced. The challenges are across all the age groups, but many parents felt very strongly about the support and access to basics such as aids and equipment.
- A more contemporary and intuitive care model for learning disability and dementia, which addresses the inequity of service and access across the Borough, is needed.
- The feedback indicates that people who use services and carers need better means of communicating their views and a better understanding of how to seek the support and help that they need.
- That is not necessarily a criticism of the services – there was no suggestion that staff do not listen, or seek views, or try to tailor services to individual need. However, the statutory provisions under which services are provided tend to be aimed at common needs rather than individual circumstances.
- Personalised budgets will undoubtedly help people choose what they want rather than what is on offer. However, it may take time both to give people the confidence to make their own choices and for "the market" to develop service packages that are tailored to

individual choice. **A clear message from the five events is that people will need help and support in taking on this responsibility.**

- Service users and carers appeared to be confused regarding the services on offer, the role of various voluntary sector organisations and who to contact and when.
- Service delivery problems are not confined to one sector: and there is evidence of joint planning and working across the agencies. However, from the comments given by users and carers, there is no doubting professional staff commitment and passion to achieve the best possible care standards for the residents in the Borough.

Our recommendations are:

Health checks

- To review the arrangements for providing and monitoring annual health checks
- To consider developing a dedicated, centralised service for health checks, creating a cadre of clinical staff with special expertise in learning disability and dementia
- To publicise the access and entitlement of health checks

General Practice awareness

- To ensure that all General Practitioners have the right level of training and expertise in dementia and learning disability
- To use those providers which are recognised as exemplars in good practice to mentor and support other general practice
- To determine where under-diagnosis of dementia is occurring within the Borough and establish a programme to address this
- To ensure that patients who need primary care services such as optometry and dentistry are promptly referred as appropriate
- To eradicate the delays between diagnosis and treatment
- To ensure that everyone has the opportunity, either by themselves or with the help of others, to discuss their health and social needs with practitioners

Communication and Awareness

- To develop a Borough information pack for learning disability and dementia which all organisations contribute to – simplicity is the key, and information overload must be avoided
- To consider something similar to the Butterfly scheme for learning disability
- To support the work of the Dementia Alliance
- To encourage closer collaboration between the statutory and voluntary organisations
- To establish befriending schemes

Staffing

North East London Foundation Health Trust to clarify the position in respect of Admiral nurses and their future role in the borough

One stop shop

- For residents to have their community services delivered in one location, consideration should be given to providing a 'one stop shop'. This would benefit service users and carers, improving the opportunity for information sharing, faster referrals and access to services.
- To design IT systems that work between all the different organisations, ensuring that information is up to date and relevant

Joint Strategic Needs Assessment

- To improve the level of local detail about learning disabilities and dementia, thus facilitating a better opportunity to plan and design care for the longer term.

Reachability

- To introduce 'Reachability' as the new criteria for measuring access to services, because unless services are 'reachable' they will not be used to their best advantage for the most vulnerable in our community

Specific points made during the five sessions

On the following pages is a summary of the contributions, discussions and comments made at the five events. The comments are set out using the question format of the sessions and under each question some key themes that emerged for both learning disability and dementia.

Learning disability

There are approximately 700 people recorded with a learning disability in the borough. Population statistics suggested that there should be a higher number something of the order of 2,500. Problems seem to arise with the recording and categorisation of learning disability. Autism was not labelled as learning disability as it is a condition in its own right.

Our understanding is that there are:

- 27 homes for adults with Learning Disabilities, the largest has 34 beds and the smallest 3 beds (average 7 places).
- 15 supported living units
- 7 day providers

A more comprehensive data base, perhaps within the JSNA, and a more detailed study of the residents of Havering with learning disabilities would help to provide more comprehensive and accurate information which could support the design of the wider range of provision and care that is needed.

What is missing?

Annual Health Checks

- Concern was expressed that Annual Health checks of people who have a learning disability are simply not being carried out. Annual health checks are the responsibility of the person's GP but the GP cannot be forced to do them. Health checks can take 30 minutes, and GPs are paid to do them, some GPs seem reluctant to spend that time.
- Competing priorities, such as ordinary consultations take much less time and several consultations could be done in the time taken to do a health check

- There appeared to be a need to raise awareness of the issue, it was not clear whether this was a matter which the CCG or Healthwatch England had responsibility.
- An idea suggested was to have one designated GP to do all health checks for learning disabilities in the borough. This would not only provide a recognised focal point for this care, but would develop a clinical team with a much more detailed knowledge of working with learning disabilities.
- This was felt to be particularly relevant when looking at diagnosing dementia within this group. People who have a learning disability, particularly those with Down's syndrome, often develop dementia far sooner than the general population; it can be hard to spot and, when it develops, does so more aggressively.
- It can be difficult to get a diagnosis of learning disability or dementia, with the result that support is in turn delayed.
- There was a suggestion that many people of the Asian community are unaware of dementia and learning disability issues for cultural reasons and a dedicated Health check service would help to support this group

Communication with professionals

- Any communications from health care providers, including hospital appointments – should be written in easy-to-read styles, so that people with a learning disability that included difficulty with reading could nevertheless read them for themselves.
- GPs, dentists and optometrists and other healthcare professionals are rarely trained to deal with learning disability.
- Although, understandably busy and therefore having little time to spare, staff at all levels in A&E need to be aware of how to deal with people who have such a disability – with particular awareness of the difficulty that some face in explaining their symptoms and feelings.
- Good practice is developing on learning disability within the Barking, Havering & Redbridge University Hospitals Trust (BHRUT) but the sharing of information between hospital staff and social care staff can be delayed and the social care team can sometimes not be made aware of an admission until a late stage.

- When admitted to hospital, people with learning disabilities still need support from carers particularly in communicating their needs and understanding what is happening to them. More input is needed from staff with a working knowledge of learning disabilities.
- Carers may need to stay in the hospital but this is not always possible. A short term budget increase may be needed to cover any extra costs and people need to know who to go to for advice
- Help is also needed for young people with learning disability in presenting their needs to the GP or other health care professionals.
- There was a feeling that there was a lack of support for people on the autistic spectrum. Quite often, a GP had to be convinced to refer them on to a specialist.

Helping people to be more independent

- The development of facilities to enable people with a learning disability to access as much as they could for themselves without others' interventions was an urgent need.
- Living in a supported environment rather than with relatives enables a person to be more independent; carers can be over protective. But it is important to avoid isolation – a buddy system can be invaluable.
- There is no befriending scheme, and people do not understand the needs of those who have a learning disability, and especially those developing dementia.
- It is important that individuals be encouraged to help themselves more. For example, with public transport, carers can help a person gain the confidence to use it appropriately.
- There is need to know how to access funding and what is available – for example if a person wants to attend college, currently there is a lack of assistance in understanding what is in the care package.

Finding out what is available

- People with a learning disability, especially those whose carers are themselves elderly, find it hard to access mainstream services. They often do not know how to, and thus cannot, communicate their needs to others.

- There was a call for more information generally, for example why not advertise more, or have slogans and adverts on buses. Letting people know where to go for advice: for example, how is the right to an annual health check communicated to the public?
- People who have a learning disability, and have never been in the system do not always get an inheritance from deceased parents or other relatives and so they become the responsibility of Adult Social Care.
- Carers of people who have a learning disability need to be aware of how to cope with dementia; the period following diagnosis can be a particularly traumatic time.
- If a carer has a problem, where do they go first? There is a lack of information, carers often not knowing where to start seeking support.

About how the services work

- Services for children with a learning disability are generally good and, if a user is known to Adult Social Care, for example, on transferring from Children's Services at 18, then they are more likely to continue to receive appropriate care
- Parents of children with a learning disability need to know the key person who is there to support them.
- Those who do not receive intensive support – perhaps because all care is arranged within the family - seem to slip through the gaps.
- As parents get older, natural family support can be lost and those who live at home with family as carers generally do not become known to Adult Care Services until an elderly carer dies, at which stage continuity of care becomes a crisis rather than a managed transition.
- The various strands of learning disability need to be looked at to ensure that people are getting the correct support.
- Although awareness is improving, there is a tendency to categorise rather than address the very many different types of need.

What would make a difference?

Help with managing health care issues

- To raise awareness, there was a need for better training of health and social care professionals, voluntary sector helpers and carers.
- A welcome improvement is the forthcoming reinstatement of the providers' forum.
- Better sharing of information across service providers and quicker notification to social services when a person was admitted to hospital was essential.
- BHRUT should improve their communication with other organisations as this was vital to assisting the patient and the dedicated community support
- Information should be kept up to date, between BHRUT, the GPs and the social care teams.
- A central office/conduit could be set up to encourage the co-operation between such services.

Families

- Families needed to be aware that people with Downs Syndrome were more likely to develop dementia earlier, and that the effects of the syndrome can mask the onset of dementia, making it harder to detect.

Residential homes

- The signs of dementia in learning disability needed also to be understood by staff of residential homes accommodating people with learning disabilities.
- This should form part of the 'routine' training because of the high turnover of staff in those homes.
- Once dementia has been detected, it was necessary to forget the learning disability and deal with the dementia, and staff and carers needed to be aware of this.
- When a service user goes from a care home to hospital, they should be accompanied by a carer from the home, who knows all there is to know about the person.

GP care

- GP services needed to be more aware of, and ready to respond to, the problems of people who have a learning disability.
- It was suggested that a scheme similar to the Butterfly scheme used by BHRT for dementia patients could be developed for the GP notes of people with learning disability this would alert reception and clinical staff to be alert and prepared.
- There would be an improvement in GPs monitoring of patients with learning disabilities if they could follow a learning disability health action plan.

Queen's Hospital (BHRT)

- Improved education and training for staff to enable them to identify the needs of a learning disability service use when being admitted to hospital
- Could a scheme similar to the Butterfly scheme be developed for learning disability patients
- Clinicians need to be aware about the additional needs of their patients who have learning disabilities, particularly communication needs
- There is a new learning disability nurse in place at BHRUT, which should improve matters and was seen as a very positive approach
- This new post should be communicated/ published more widely, so learning disability service users know who to contact.
- There is a communication book from BHRUT and this should be made more available public

Carers

- Families who are without other relatives support should be offered more respite care hours. They tend to use the hours up quickly when compared to families who have family support.
- There was a lack of understanding that carers and families had other responsibilities: their jobs, their homes, raising their children. They should not be made to feel guilty because they could not provide a home and full-time care for their relative
- There was concern that the Government was now expecting carers who were in receipt of welfare benefits to seek employment and report to the Job Centre, even though they were caring full-time.
- Carers also need to be aware of their entitlements to benefits.

- Service users and carers will need help and support in making sense of personal budgets
- Improved access to advice on financial matters from organisations that do not have a business interest in providing the information

Community learning disability passport

- The learning disability passport gives information but is missing practical advice.
- Community passports need to be updated to show what date they are admitted into hospital
- Person-specific information such as by what name a person likes to be called, what they like and dislike and what upsets them. This applies to dementia as well as learning disability.

Practical support

- It would be useful if there were more clubs and cafés for people with learning disabilities
- If clubs, cafés and other facilities for the general public were more welcoming of people with learning disabilities, perhaps develop a learning disabilities friendly logo
- A befriending scheme would help.
- Recognition of people with learning disabilities needs in using public facilities such as public toilets.

It was recognised work has started on many of the issues raised above and that good progress was being made. This is identified in the section below.

What have you experienced that is good?

Support

- Havering Adult Care Services were praised and appreciation was expressed of support from St Francis Hospice. The work of the new learning disability nurse at Queen's and residential homes staff were also praised.

Awareness

- The overall view was that it was good.

- The professionals from the different teams were working together.
- Meetings such as this series of events were seen as a real opportunity for non-confrontational, open and frank discussion between the professionals, service users and carers.

Care services

- There is good multi-disciplinary working, which should ensure that communication is used in the right way
- Mystery shopping takes place, and has worked well in identifying good practice and practice that needs change or developing
- There is a good partnership board that addresses employment issues.
- Supported living schemes help individuals to make better lives for themselves.
- In residential care settings, annual health checks are done.

Health services

- There is a lot more awareness in hospitals, with recent training in BHRUT and consultants are attending these training sessions. Nursing staff receive learning disability training in their inductions
- There has been good feedback about A&E and end of life care from learning disability service users and carers.
- The handling of cases with complex discharge issues from BHRUT has been vastly improved.
- There is demonstrable good practice in dealing with learning disability
- The learning disability team at the Hermitage centre has created a learning disability pathway.

Dementia

Havering has the highest proportion of older people in London and has experienced a 44% increase in the very elderly age groups 84 – 89 years; almost double that of London and England overall.

It is estimated that around 3,275 people in Havering (aged 65+) have dementia. This is predicted to rise to 3,794 by 2020.

There are 42 registered care homes for dementia but, of course, that figure will rise as residents living at home develop dementia.

What is missing?

Carers

- The view was expressed that there is little or no support for carers and the person with dementia, leaving people feeling isolated and unable to find help in the community but reluctant to involve Social Services initially.
- Once registered with Adult Social Care it is easier for people to gain access to the "front door".
- Carers have a right for their own needs to be assessed but need encouragement to come forward.
- Carers need greater awareness of the clinical issues affecting people with dementia
- There is no use giving people money in personal budgets if they do not know how or where to use it.
- An inability to find help in the community and leaving carers unable to get respite. There is very little respite, which is stressful for families.
- There is confusion over who is offering services. Age Concern no longer offers an advocacy service and there is no support for carers.
- Some patients refuse to visit the memory service – carers of people with dementia are told that the carer must compel the patient to attend the memory clinic, if not this would be a violation of the patients human right - but what about the carer's human rights?
- A crisis line to call for carers when a person becomes violent would be a significant help.

Access to information

- Information points are needed; there is a lack of information in hospitals, libraries and other public areas.
- More is needed for the growing BME population – a multi-cultural approach, making services acceptable.
- People with dementia may not know much English or even revert to speaking their native language, which not only exacerbates the already difficult nature of communication with dementia patients but leads to isolation
- Because of language barriers, people may not be aware of the services available to support them.
- A unit that can offer translation services within the community would help address this.
- The voluntary sector lacks communication with health professionals.
- There was a suggestion that people are unaware of the resources, voluntary organisations and professional health and social care resources available in the borough.
- A more co-ordinated approach between professional to ensure that accurate information is shared about service users prior to visiting peoples home.
- There is a lack of communication between Adult Social Care and voluntary organisations, and referrals are not always treated appropriately.

GP Care

- There is a lower than average diagnosis rate in Havering, possibly because of coding in GP practices if the incorrect code is used it sometimes is not picked up
- Demographics suggest there should be around 3,000 people with a formal diagnosis of dementia but only about 1,000 have been so diagnosed; the "missing" 2,000 should be identified quickly.
- Individuals and families did not know who to turn to when a diagnosis of dementia was made
- It seems that NELFHT and the CCG/GPs do not use the same coding systems.
- GPs need encouragement to diagnose under 50's.

- People can become lost between diagnosis and follow up and there are some very unacceptable delays
- It can be difficult to get GPs to make home visits
- When service users are discharged from clinics there is no continuity or follow-up service and carers and users seem to be left to fend for themselves.

General comments

There is a hidden population – people in care homes who not are not necessarily known to Adult Social Care or voluntary organisations, never go to memory clinic sessions and receive care from their GP only if their behaviour worsens.

Health passports are not being used enough, nor up-dated.

It would appear that they are only mentioned when someone is admitted into hospital.

It would help if facilities could be shared: with say NELFT, Physiotherapy and voluntary organisations together on one site, in a "one stop shop".

What would make a difference?

GP Care

- GPs are the first port of call.
- When people go to see their GP about dementia the GP often holds back; how can this be overcome?
- GPs need better awareness and understanding of, and training about, dementia.
- When a diagnosis is made it would be really useful to have someone on hand for a chat about relevant information and telephone numbers.
- An information pack is being prepared, but care is needed to avoid information overload, could organisations work together to provide one concise pack.
- The waiting time from Memory Clinic to receiving a prescription is too long; it can take weeks. GPs blame the system but medication should be available immediately.

- Better liaison is needed between GPs and NELFHT; it is improving but more need to be done. Consultants now give out mobile numbers.
- Isolation exacerbates dementia – not just age – people with mental illness need more help from GPs.
- GPs lack empathy – some GPs say what you would expect from a person who is aged 80.
- Clinicians and receptionists need to listen more – even though they are busy, they should take time for the small things that matter, like getting names right.
- There used to be regular talks given by the PCT in particular at St George's Hospital; this should be reintroduced as the talk was usually given by clinicians and it was very useful.
- Patients often have other health needs, for example, diabetes and it is often very difficult to get medication changes and follow up care organised as the GP does not always fulfil the role of the link clinician

General comments

- There is also concern about the lack of Admiral Nurses – and when one retires later this year, is understood that NELFHT will not be replacing her. That decision needs to be reversed.
- Age Concern raised their concern that they were no longer invited to attend multidisciplinary meetings and felt their input could make a positive difference.
- Wider membership of multi-disciplinary team would be helpful to share information before crisis point is reached
- The public need educating about dementia in order to overcome the possibility of stigmatising people.
- There are new national schemes working with children which have proven to have very positive outcomes
- Better information needs to be available on websites, or when calling centres.
- Advice on legal and financial help should be readily available.
- Carers need better training and overall support, it is a heavy burden 24 x 7
- A "buddy" scheme and a link so that carers and service users do not feel abandoned would help

- Carers need to know how to follow up problems before service users reach crisis point.
- Relatives should be given more information about their kin in care homes. What activities are being employed and how their time is structured.
- More awareness and information should be available. For example, people have commented that their friend is showing signs of dementia, who do they go to for advice about their friend?

What have you experienced that is good?

Health services

- There is good support from some GPs and the Admiral Nurses.
- The Council is investing in more liaison with carers. Carers forums are held and there is a single point of access at the Council
- Co-operation between the CCG and BHRUT is improving; information is being shared between them which they plan to send to The Memory Clinic and it is envisaged that a pattern will emerge. This should help identify the "missing" 2000 who have yet to be diagnosed with dementia
- Good community care can avoid the need for admission to hospital.
- The CTT and the CCG are proposing to provide facilities at night.

Social Care

- Good support from Adult Care Services
- Occupational Therapists are supportive and give advice as to what is needed in the home, such as alarms.
- Havering is passionate about dementia services in the borough and there is now a Dementia Programme Manager.

The voluntary sector

- There is good support from Age Concern, St Francis Hospice
- There are support groups for carers, lunch clubs and Alzheimer's cafés: these are well run, but people who are not in the "loop" find it difficult to access them.
- The Alzheimer's Society has issued a leaflet called "This is me" about the need of a dementia patient when they are receiving

treatment – it was originally for those going into hospital, but has been updated for all dementia patients undergoing treatment either in hospital, GP or in the home.

- The Alzheimer's Society has dementia champions, with training not only for their own staff and volunteers but for others.

Other

Joint Strategic Needs Assessment

- The JSNA is the document which helps to form the basis of informed decision making for commissioning services.
- It is robust in having well-documented national statistics, but it appears to be weaker in local data.
- Aspects of the JSNA such as statistics on learning disability and dementia should be provided in a simpler and shortened format for organisations working within this sector. The current format is a bit indigestible for people outside of the professional public health arena.

Library Services

- This service is well respected by all the agencies.
- Libraries are really committed to helping support groups, and support anyone wishing to hold an event.
- A Dementia Action Alliance is being formed in Havering. It would be helpful if local shopkeepers could put a sign up saying that they are a "dementia-friendly" shop. This would make those with dementia and the carers feel more comfortable as they can feel alienated when visiting shops.

Making a difference – actions already taken

In the course of the discussions, several issues were mentioned and it was agreed people felt should be taken forward as quickly as possible

. The following is a brief summary of some of the action taken:

- Following a suggestion that GPs lacked training in dealing with dementia, BHRUT agreed to investigate the position
- In respect of training for carers' groups, Adult Social Care is working with the CCG to find suitable premises as a matter of urgency
- NELFT and Age Concern are to discuss what happens when a person who has dementia refuses to see a GP or the memory service –
- Enquiries are being made about overcoming the obstacles to Age Concern and potentially any other relevant voluntary organisation resuming attendance as part of multi-disciplinary meetings
- The CCG is to discuss with NELFT the concern about the lack of Admiral Nurses – in particular, the suggestion that when one retires Note CCG have picked up on this and written to NELFT.
- A lead GP agreed to take forward the concerns on providing Health Checks to people with learning disability

Individual cases that came to light in the course of the events have been taken up with the relevant providers.

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
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HEALTH OVERVIEW AND SCRUTINY COMMITTEE

24 JUNE 2014

Subject Heading:	Committee's Work Programme 2014/15
CMT Lead:	Andrew Blake-Herbert, Joint Managing Director, OneSource
Report Author and contact details:	Anthony Clements Tel: 01708 433605 Anthony.clements@havering.gov.uk
Policy context:	To agree the Committee's work programme for the 2014/15 municipal year.

SUMMARY

At this stage of the municipal year, the Committee needs, so far as is practicable, to agree its work programme for the forthcoming year. This applies to both the work plan of the Committee as a whole and to the subject of any topic group run under the Committee's auspices.

RECOMMENDATION

That the Committee agree its work programme for the 2014/15 municipal year.

REPORT DETAIL

Shown in the schedule at the end of the report is a draft work programme for the Committee's five meetings during the municipal year (this does not include the Joint Overview and Scrutiny Committee meeting held in January to consider the Council's budget). This has been drawn up by officers following initial discussions with the Chairman and Vice-Chairman.

It is suggested that the Committee allocate time during the year for senior representatives of each of the local Health Trusts and Clinical Commissioning Group or other relevant bodies to brief the Committee on current issues and progress. The programme in the schedule therefore includes these briefing sessions as well as specific issues that are known at this stage. Given particular concerns Members have raised around aspects of the work undertaken by Barking, Havering and Redbridge University Hospitals' NHS Trust (BHRUT) and the Havering Clinical Commissioning Group (CCG) it is suggested that representatives of these two organisations be given an agenda item at alternate meetings of the Committee throughout the year. It is also suggested that Healthwatch Havering be asked on a six-monthly basis to present to the Committee on their current work and any issues of concern.

Members will note that a significant proportion of the work plan has been left blank at this stage. This is to reflect the fact that Members may wish to select further issues for scrutiny in light of the briefings they are given by health sector officers during the year. In addition, previous experience has shown that is beneficial to leave some excess capacity in order to allow the Committee to respond fully to any consultations or other urgent issues that may arise during the year.

Additionally, the Committee may wish to select an issue for more in depth scrutiny as part of a topic group review. Council has recommended that, in view of limited resources, only one such topic group is run at any one time. The Committee is therefore requested to consider what should be the subject of its next topic group review, if any.

It should be noted that the Committee has in the past made considerable use of its powers to request written information from the Health Trusts on any subjects within its remit. These powers can be used by the Committee at any time and are not therefore considered within this report.

IMPLICATIONS AND RISKS

Financial implications and risks:

None – it is anticipated that the work of the Committee can be supported by existing staff resources and minor budgets within democratic services.

Legal implications and risks:

The Committee's scrutiny powers are as given in the Health and Social Care Act 2011 (as amended).

Human Resources implications and risks:

None.

Equalities implications and risks:

None although one outcome of effective health scrutiny will be to reduce health inequalities for Havering residents.

BACKGROUND PAPERS

None.

SCHEDULE: PROPOSED HEALTH OSC WORK PROGRAMME 2014/15

24 JUNE 2014	**9 SEPTEMBER 2014**	**6 NOVEMBER 2014**	**20 JANUARY 2015**	**19 MARCH 2015**	**28 APRIL 2015**
Local Health Economy and Intermediate Care plans (CCG)	BHRUT	CCG	BHRUT	CCG	Committee's Annual report
Public Health Transition Update	Healthwatch annual report	NELFT	Healthwatch Havering		Healthwatch Havering
Healthwatch Dementia and Leaning Disabilities Report	St George's Hospital Update	NHS England			BHRUT
Workplan report					
JOSC nominations					
Introductory scrutiny presentation					
CCIM decision – Update on Healthwatch implementation					

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Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY COMMITTEE
24 JUNE 2014

Subject Heading:	Nominations to Joint Health Overview and Scrutiny Committees
CMT Lead:	Andrew Blake-Herbert, Joint Managing Director, OneSource
Report Author and contact details:	Anthony Clements Tel: 01708 433605 Anthony.clements@havering.gov.uk
Policy context:	To agree the Committee's nominations to serve on the Outer North East London Joint Health Overview and Scrutiny Committee and any pan-London Joint Health Overview and Scrutiny Committee.

SUMMARY

Havering has previously played a major role in the Outer North East London Joint Health Overview and Scrutiny Committee (ONEL JOSC) as well as in the pan-London equivalent. The Committee is therefore asked to confirm its nominations to both Committees for the current municipal year.

RECOMMENDATIONS

1. That, in line with political proportionality rules, the Committee nominate three Group Members as its representatives on the Outer North East London Joint Health Overview and Scrutiny Committee for the 2014/15 municipal year.

2. That the Committee nominate the Chairman as its representative at any meetings of the pan-London Joint Health Overview and Scrutiny Committee during the 2014/15 municipal year.

REPORT DETAIL

There are a large number of proposed changes and other health service issues that affect a considerably wider area than Havering alone. Issues related to Queen's Hospital for example impact not just on Havering residents but also those from Barking & Dagenham and Redbridge as well as parts of Essex. Mental health issues, under the remit of the North East London NHS Foundation Trust, impact on all these areas as well as Waltham Forest.

As regards formal consultations, Members should note that it is a requirement (under the NHS Act 2006 and the Health and Social Care Act 2011) that all Councils that are likely to be effected by proposed changes to health services must form a Joint Health Overview and Scrutiny Committee in order to exercise their right to scrutinise these proposals.

In light of these requirements, the boroughs of Barking & Dagenham, Havering, Redbridge and Waltham Forest as well as Essex County Council have formed a standing ONEL JOSC to deal with cross-border issues. Further details of the Committee's work and copies of the reports etc. it has produced can be obtained from officers and are available on the Council's website. It is suggested that the Committee agree, as in previous years, three representatives to sit on the ONEL JOSC, in line with proportionality rules.

Some issues, such as changes to stroke and trauma services, impact across the whole of Greater London and all boroughs therefore need to be involved in the scrutiny of these areas. As such, arrangements have previously been in place for a pan-London JOSC to meet when such proposals are brought forward. Previous practice has been that the Chairman represents Havering at any pan-London JOSC meetings and the Committee is requested to agree this for the 2014/15 municipal year.

IMPLICATIONS AND RISKS

Financial implications and risks:

There are none arising directly from the report. The work of the Committees mentioned is supported by existing staff resources and minor budgets within Democratic Services. With regard to the Joint OSC, the other four participating Councils make a financial contribution towards the support provided by Havering staff.

Legal implications and risks:

None.

Human Resources implications and risks:

None.

Equalities implications and risks:

None although one outcome of effective health scrutiny will be to reduce health inequalities for Havering residents.

BACKGROUND PAPERS

None.

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