MINUTES OF A MEETING OF THE
INDIVIDUALS OVERVIEW & SCRUTINY SUB-COMMITTEE
Town Hall, Main Road, Romford
24 March 2015 (7.00 - 9.20 pm)

Present:

Councillors June Alexander (Chairman), Philip Hyde (Vice-Chair), Ray Best, Viddy Persaud, Keith Roberts and Roger Westwood

Apologies for absence were received from Councillor Darren Wise

37 **MINUTES**

The minutes of the meeting of the sub-committee held on 27 January 2015 were agreed and signed by the Chairman.

38 **HEALTHWATCH HAVERING: BACKGROUND ON ENTER AND VIEW**

A representative from Healthwatch Havering provided the sub-committee with an overview of their "Enter and View" powers.

Healthwatch Havering provided a lay man view of establishments including GP surgeries, care homes and hospitals. Contact posters are put up in the establishment so that residents and their families can have their say, or raise concerns. All enter and view visits are carried out by volunteers. Notes are made of their visit which would then form a report. This report was sent to the establishment giving them 10 days to agree it. Once agreed the report is sent onto the CQC, the Local Authority and then publish on their website.

Enter and View was the opportunity for authorised respresentatives to:

- Go into health and social care premises to hear and see how the consumer experiences the service.
- Collect the views of service users (patients and residents) at the point of service delivery.
- Collect the views of carers and relatives of service users.
- Observe the nature and quality of service – observation involving all the senses
- Collate evidence-base feedback.
- Report to providers, CQC, Local Authority and NHS Commissioners and quality assurers, Healthwatch England and any other relevant partners.
- Develop insights and recommendations across multiple visits to inform strategic decision making at local and national levels.

Healthwatch Havering now only carry out announced visits, it was felt this was more conducive, they were there to help and get the best for the establishment and its residents/ patients.

All representatives of Healthwatch Havering had undergone training in Enter and View, Safeguarding, Deprivation of Liberties and Mental Capacity Act. Their role was to be well informed lay people to look at the service provided.

Members noted the presentation.

39 ADMISSION AND DISCHARGE FROM HOSPITAL TO CARE HOMES

Following a request from members about the admissions and discharges from Care Homes, officers provided a presentation on the processes in place.

The Sub-Committee were informed that there were 17 Nursing Care Homes with 964 beds, 22 Residential Care Homes with 643 beds and 20 Learning Disability Homes with 130 beds. There were two types of admission to hospital, the first was planned admission which was for an operation or tests under sedation, these would either be accompanied by a family member, carer or the home would provide sufficient information to the hospital about the individual's needs. The second would be unplanned admission these could be in the form of an urgent (via 999) sudden collapse, a serious fall, injury or at the request of the GP.

All care homes are now aligned with a GP surgery. The GP visited at least once a week. This enables the GP to get to know the residents, to understand the medications of the patient, can spot early issue and provide early intervention, offer out of hours support and can prescribe and refer to other specialists if necessary.

There are 20 Learning Disability homes in Havering who have 130 residents. Each resident is issued with a hospital passport which gives all their details together with their needs. In the event of an emergency an escort would accompany the resident. The hospital was aware of the passport however it does not always come back to the home with the resident.

Members felt that given recent technology the data could be uploaded onto a bracelet that could be worn by resident, which could be scanned at the hospital and prevent the need for paper copies which could get lost. It was through this would be useful for older people in care homes. Officers felt that this was a good suggestion.

End of Life Care was for the final 48 hours of an individual's life. This was very limited and ensured that the individual was comfortable, hydrated and their care wishes were in place. Whilst this was for the last 48 hours of their life, it was important that this was put in place at an earlier stage so that their preferences and choices can be made.

When an individual is discharged back to the care home from hospital this is planned. The relatives are the first to be informed as they would generally be the next of kin. The care home is contacted if there is a change to medication or mobility. If there is a change the care home would arrange for an assessment to be carried out on the hospital ward before the resident is sent back to the care home. Transport can also be arranged by the care home as this is often quicker than waiting for an ambulance.

Discharges of a new resident from hospital are often for "step-down" beds. This could be in the form of respite care due to hydration, nourishment or because they have a broken limb and have a co-dependent who they cannot care for. A social worker would carry out an assessment and a detailed support plan would be written for the needs of the resident. These plan are often shared with the individuals family.

Members raised concerns about hospitals discharging residents too early without mediation in place. Officers stated that there were improvement and this was now rare, however if it did happened there care homes could refer the inappropriate discharge form back to the hospital. The Quality and Suspension Team meet every three weeks to discuss these issues and investigate if necessary.

The Sub-Committee thanked the officers for an informative presentation.

40 OVERVIEW OF SAFEGUARDING

The Sub-Committee were given a presentation on Safeguarding Adults in Havering. It was noted that the Care Act and Making Safeguarding Personal put the user at the centre of safeguarding planning with a multi-agency approach. A Safeguarding Adults Board (SAB) was on a firm footing, it had been strengthened and had become more strategic over the past year. Members noted that the Board was attended by Chief Officers from all partners.

The Sub-Committee noted that a Local Safeguarding Adults protocol had been launched in line with Pan-London. A practitioner group had been set up and practitioners were actively encouraged to participate and identify cases/ issues for discussion. It was also noted that public awareness of safeguarding had increased.

There were a number of areas where the Adults Safeguarding Team wished to move forward. These included

- A review of the Business Plan to ensure consistency with Local Safeguarding Children Board Plan
- The creation of a supporting Operational Group and rationalisation of sub-groups

- Consultation with community groups, Voluntary Sector and Healthwatch to ensure that residents and stakeholders have their say about safeguarding and their priorities
- Permanent recruitment into the Safeguarding Adults Service Manager, as this was currently a temporary post
- Development of a Family Group Conferencing in Adult Services, as this had proved very successful in Childrens Services.

Officers explained that Adults can make a choice about their lives, if they have the capacity Adult Social Care will support the individual in their preference and choice. If an individual does not have the capacity, then the Deprivation of Liberties and Mental Capacity Act comes into play. Support is then given to the family and friends of the individual.

The Sub-Committee noted the results of two audits that had been undertaken. Concerns were raised as to the lack of communication and recording that have been undertaken. Officers stated that the next audit would be taking place in May 2015. The Sub-Committee would like the results of that audit.

Performance information was explained. Members noted that there had been 458 Safeguarding alerts by the end of December 2014. Of these 54% had progressed to investigation. There were also 1840 welfare alerts, with an average of 25 investigations and 8 case conferences per month. Members were concerned at this number, however it was explained that numerous alerts could be received for the same individual.

It was explained that neglect was the most common type of abuse, however this could be happening unwittingly, whereby an elderly couple live together, the husband has dementia and the wife is the carer. The wife may neglect herself in trying to care for her husband.

Deprivation of Liberty Safeguards (DoLS) was explained to the sub-committee. A recent court decision had provided a definition of what is meant by the term. A deprivation of liberty occurs when:

"the person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements."

The Care Quality Commission had been looking at DoLS and where they had been applied for. Due to this there have been a large number of best interest assessments having to be carried out. In 2013/14 there were 33 this has increased in 2014/15 to 370. As well as new best interest assessments, all outstanding assessments need to be reviewed. This has increase the workload. The best interest assessment must be carried out by someone who is not involved in that person's care or in making any other decision about it and must be a qualified social worker, nurse, occupational therapist or chartered psycohologist with the appropriate training and experience.

Members asked how long a best interest assessment takes. Officer stated that in order to conduct all interviews of family and carers and to get all the relevant information collated would take approximate one day. It was felt that the figure was now fairly stable, however reviews would still need to be carried out. There were approximately 60 referrals a day, not all would need an assessment.

A discussion was had about care homes in the borough and if the level of wages was a factor in neglect, as staff were not as caring as in the past. Officers stated that there were 40 care homes and 40 Learning Disability home in the borough, all of whom paid the national minimum wage and provided training. There were no homes in Havering with a poor CQC rating and regular meetings were held on all care homes with Havering HealthWatch and other partners. Havering had robust measures in dealing with safeguarding in care homes. In the past a care home that was not up to was suspended, the provider was informed and the residents were moved to an alternative home.

The Sub-Committee thanked the officer for a very informative presentation.

41 **DEMAND MANAGEMENT**

The Sub-Committee received a very in-depth presentation on Demand Management. Demand Management was about reducing and/or slowing down the rise in demand for services to levels that are manageable within the resource envelope that Havering have. The majority of savings attributed to demand arrangement will arise from cost-avoidance, i.e. preventing an increased spend that would otherwise result from more people entering “the system” and using our services.

The officer explained that this was a very big issue for Adult Social Care as the demand would continue to rise given the ageing population and the changing demographic profile in Havering. The Care Act would also have a disproportionate impact on Havering given both the demographic profile and the amount of care home located in the Borough. GP registrations were continuing to rise each quarter with 3,064 additional registrations in the last quarter (Q2 of 2014/15) alone. Members raised concerns about this issue.

It was noted that Havering was seeing more families with large sibling groups and very complex needs from ethnic minorities and demands for services had increased as a result of the Government’s recent welfare reforms.

The Sub-Committee noted the challenges faced by Adult Social Care, given that the directorate alone accounted for 60% of the whole Council budget. The need to dramatically transform the operating models by prioritising early help, intervention and prevention is hoped to be the resolution. Work had already started that focussed on delivering this.

Early Help, Intervention and Prevention (EHI&P) was explained. It was noted that 90% of the systems at present were in the statutory category with very little intervention, early help or prevention. Early demand management is about prevention management and was felt to be the right way to go.

The Sub-Committee were informed that there was lots of focus on demand management within senior staff meeting, working groups, the Care Act as well as many of the strategic documents, priorities and policies. The Demand Management Working Group was established in 2014 and had representation from across the Directorate including Public Health and Corporate colleagues. An Early Help, Intervention and Prevention Strategy had been produced to help tackle demand and prioritise EHI&P services. This had been aligned to the Health and Wellbeing Strategy, the Care Act Programme and the draft Directorate Plan. There were five pilots about the start which would feed into the Implementation Plan. Whilst this was a Directorate Strategy, it was likely to evolve into a Council-wide and partner-wide strategy.

The Sub-Committee noted that Havering performed poorly against national Self-Directed Support targets. Havering was still quite traditional in the service provision, but by moving to a more personalised service would improve those indicators. A case study was shared with the sub-committee which showed where a review had been carried out on the needs of a resident. It was found that some people could do more for themselves, and with a better use of equipment independence could be enabled therefore reducing the dependency on services. It was thought that this would have been a reduction in the personal budget from £11,767 to £8,537, meaning a saving of £3,230.

It was noted that Assistive Technology reduced the admissions to hospital and care homes. This increased independent and again the reduction of demand on services. The types of demand that are put on Adult Social Care were highlighted all of which could be addressed with early demand management.

Members raised concerns about how this would be delivered, given that the population was increasing. Further concerns were raised as to the reduced time that carers would spend with residents given often the carer may be the only person a vulnerable person may see. It was agreed that this item should come back for the Sub-Committee to scrutinise again.

42 DIAL A RIDE - UPDATE

The Chairman read out the following statement:

Following the discussions we have had in the past regarding the Dial a Ride service, Councillor Hyde and myself have met with representatives from Transport for London and Senior Officers for the Council to discuss this matter. A very productive meeting has been held, however due to the

confidential nature of the meeting I am unable to provide anything more at this stage.

As things progress I will ensure that this Sub-Committee is updated accordingly.

43 **FUTURE AGENDAS**

The Sub-Committee agreed that they would wish to receive a report on the provision of care both in residents own homes and in care home establishments at its next meeting.

Chairman