Public Document Pack

Havering
LONDON BOROUGH

INDIVIDUALS OVERVIEW & SCRUTINY SUB-COMMITTEE
AGENDA

7.00 pm	Tuesday 28 April 2015	Town Hall, Main Road, Romford

Members 7: Quorum 3

COUNCILLORS:

June Alexander (Chairman)
Philip Hyde (Vice-Chair)
Darren Wise
Ray Best
Viddy Persaud
Keith Roberts
Roger Westwood

For information about the meeting please contact:
Wendy Gough 01708 432441
wendy.gough@onesource.co.uk

Protocol for members of the public wishing to report on meetings of the London Borough of Havering

Members of the public are entitled to report on meetings of Council, Committees and Cabinet, except in circumstances where the public have been excluded as permitted by law.

Reporting means:-

- filming, photographing or making an audio recording of the proceedings of the meeting;
- using any other means for enabling persons not present to see or hear proceedings at a meeting as it takes place or later; or
- reporting or providing commentary on proceedings at a meeting, orally or in writing, so that the report or commentary is available as the meeting takes place or later if the person is not present.

Anyone present at a meeting as it takes place is not permitted to carry out an oral commentary or report. This is to prevent the business of the meeting being disrupted.

Anyone attending a meeting is asked to advise Democratic Services staff on 01708 433076 that they wish to report on the meeting and how they wish to do so. This is to enable employees to guide anyone choosing to report on proceedings to an appropriate place from which to be able to report effectively.

Members of the public are asked to remain seated throughout the meeting as standing up and walking around could distract from the business in hand.

What is Overview & Scrutiny?

Each local authority is required by law to establish an overview and scrutiny function to support and scrutinise the Council's executive arrangements. Each overview and scrutiny sub-committee has its own remit as set out in the terms of reference but they each meet to consider issues of local importance.

The sub-committees have a number of key roles:

1. Providing a critical friend challenge to policy and decision makers.

2. Driving improvement in public services.

3. Holding key local partners to account.

4. Enabling the voice and concerns to the public.

The sub-committees consider issues by receiving information from, and questioning, Cabinet Members, officers and external partners to develop an understanding of proposals, policy and practices. They can then develop recommendations that they believe will improve performance, or as a response to public consultations. These are considered by the Overview

and Scrutiny Board and if approved, submitted for a response to Council, Cabinet and other relevant bodies.

Sub-Committees will often establish Topic Groups to examine specific areas in much greater detail. These groups consist of a number of Members and the review period can last for anything from a few weeks to a year or more to allow the Members to comprehensively examine an issue through interviewing expert witnesses, conducting research or undertaking site visits. Once the topic group has finished its work it will send a report to the Sub-Committee that created it and will often suggest recommendations for the Overview and Scrutiny Board to pass to the Council's Executive.

Terms of Reference

The areas scrutinised by the Committee are:

- Personalised services agenda
- Adult Social Care
- Diversity
- Social inclusion
- Councillor Call for Action

AGENDA ITEMS

1 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

(if any) – received.

2 CHAIRMAN'S ANNOUNCEMENTS

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

3 DISCLOSURE OF PECUNIARY INTERESTS

Members are invited to disclose any pecuniary interest in any items on the agenda at this point in the meeting.

Members may still disclose any pecuniary interest in an item at any time prior to the consideration of the matter.

4 MINUTES (Pages 1 - 8)

To approve as a correct record the Minutes of the meeting of the Committee held on 24 March 2015 and authorise the Chairman to sign them.

5 BETTER CARE FUND

The Sub-Committee will receive a presentation updating it on the Better Care Fund.

6 FUNDING REFORM UPDATE

A verbal update on the Funding Reform will be given.

7 PROCESS OF DISCHARGE FROM HOSPITAL (Pages 9 - 12)

Following a request from member at the previous meeting, a report is attached which outlines the process when individuals are discharged from hospital.

8 PROVISION OF CARE AVAILABLE (Pages 13 - 18)

The Sub-Committee will receive a report setting out the provision of care available in the London Borough of Havering, both in residential/ nursing homes or in an individual's own home. (Report attached)

9 INDIVIDUALS OVERVIEW AND SCRUTINY SUB-COMMITTEE ANNUAL REPORT 2014/15 (Pages 19 - 30)

The Sub-Committee's Annual Report 2014/15 is attached for noting.

10 FUTURE AGENDAS

Committee Members are invited to indicate to the Chairman, items within this Committee's terms of reference they would like to see discussed at a future meeting. Note: it is not considered appropriate for issues relating to individuals to be discussed under this provision.

11 URGENT BUSINESS

To consider any other items in respect of which the Chairman is of the opinion, by reason of special circumstances which shall be specified in the minutes, that the item should be considered at the meeting as a matter of urgency.

Andrew Beesley
Committee Administration Manager

This page is intentionally left blank

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

This page is intentionally left blank

Havering
LONDON BOROUGH

INDIVIDUALS OVERVIEW AND SCRUTINY SUB-COMMITTEE

Subject Heading:	Process of Discharge from Hospital
CMT Lead:	Joy Hollister
Report Author and contact details:	Barbara Nicholls
Policy context:	The Community Care (Delayed Discharges) Act 2003

SUMMARY

This report outlines the process used by the Joint Assessment and Discharge (JAD) Team at Queen's and King Georges (part of Barking Havering and Redbridge University Trust) Hospitals to facilitate appropriate and timely discharge from hospital. The report also covers services provided in the community and in Accident and Emergency (A&E) designed to avoid unnecessary admissions.

RECOMMENDATIONS

This report is for information only.

REPORT DETAIL

The successful discharge of individuals following an emergency admission to hospital relies on effective joint working between Health, Social Care partners and the independent sector. Achieving timely and safe discharges from hospital is a key concern for both health and social care as a delay represents a delayed opportunity for an individual to return home.

Background

The Trust was placed in special measures by the CQC in December 2013. The current JAD Service was created on 2 June 2014, and in order ensure a whole-system approach between partners and to maximise weekend discharges, the JAD was designed to operated a 7-day service working a minimum core hours of 0900 – 1700. This ensures the availability of social workers, as well as NHS community services and hospital therapists (particularly where they work across the hospital/community interface) matches any increased focus within an acute trust on weekend discharges.

There was a follow up re-inspection undertaken by CQC in 4 March 2015, looking at the work which has taken place to improve care and services for patients. The JAD has played a key role in the BHRUT Improvement Plan - focusing on improving discharges.

Joint Assessment and Discharge Team

The JAD is formed of staff from Havering and Barking and Dagenham Social Care teams, as well as BHRUT and NELFT health staff, working (and managed) together as one team responsible for all LBH and LBBD hospital discharges that require Social Care services. In addition to this the team are also responsible for facilitating discharges in BHRUT for those patients whose case is funded by the NHS and for all self-funding patients requiring placements into residential or nursing homes following discharge. The team are also required to co-ordinate any concerns that may result in delays in hospital such as equipment delays or those awaiting care support from other Boroughs.

The JAD is a multi-disciplinary team of Social Workers, Nurses and administrative staff. The team is spilt into 5 clusters working alongside other teams such as Mental Health Services, Alcohol Liaison Services, and Housing departments etc. Each Cluster works with a group of wards to ensure consistency in professional relationships. This is further supported as a JAD worker is aligned to each ward and is the main contact for that ward.

Discharge Process

The Community Care (Delayed Discharges) Act 2003 places duties upon the NHS and councils in England to communicate about the discharge of inpatients. This applies, by statute, to acute care only, but the approach represents good practice for community hospital inpatients as well.

The NHS is required to notify councils of any patient's, "…likely need for community care services", and of their proposed discharge date. This is done through "Section 2" (pre-discharge notifications) and "Section 5" (discharge notifications) notifications respectively (named after the sections in the Act). A Section 2 requires an NHS body to notify social services of a patient's likely need for community care services after discharge. The information contained in an assessment notification is intended to be minimal, both to reflect patient confidentiality requirements and to minimize bureaucracy, It is a trigger for assessment and care planning. The Act sets out the requirement for social services care management to assess within 3 days. A Section 5 notifies social services of the proposed date of the patient's discharge. Patients and carers should be informed of the discharge date at the same time as, or before, social services. In addition, as good practice, hospital staff may give social services an early indication of when discharge is likely; to help with planning, but a formal discharge notification must be issued to give confirmation of the intended date. Ensure that the legal requirement of Section 2 and Section 5 notifications from acute trusts to social services to share patient information (and the required response standards) are understood and initiated by ward staff. Seek feedback from social care that Section 2 referrals are appropriate to optimise social workers' time. Embedding care managers with wards encourages a proactive and co-operative approach.

In practice, the JAD workers attend a multi-disciplinary Board each day at 0900 hours to go through all patients on the wards and to plan for discharges where Social Care support is required. It is as this point that JAD involvement commences.

The BHRUT ward staff will send an assessment notification to formally notify Social Care that a patient is in hospital and will possibly require social care intervention to enable a safe discharge. The assessment notification will also provide a predicted discharge date.

On receipt of this assessment notification, the patient's case will be allocated to a JAD worker. It is at this stage that the formal assessment process begins.

The JAD worker will work alongside other members of the multi-disciplinary team as a part of the assessment process engaging with the patient and families and representatives as required. When a patient no longer requires treatment or monitoring in an acute hospital setting a discharge notification will then be sent detailing the actual discharge date for a patient.

This assessment process can be completed within 24 hours or can take days, depending on the varied patient circumstances. For more complex cases a discharge planning meeting is held with the patient and their family members or other representatives, and all professionals involved in their care. On completion of the assessment the appropriate services are set up for the patient and start times for services are agreed. The discharge is confirmed once all services have been arranged and all parties are confident that the discharge will be safe.

JAD also has two Social Workers who work exclusively in the Emergency Department at Queen's hospital to support the Community Treatment Team with admission avoidance. These social workers will set up Social Care services for patients/patients who present to A&E, not requiring hospital admission, but needing Social Care support.

This team also provides support in the shape of information and guidance and signposting to other teams and Local Authorities.

JAD Performance

In hospitals such as Queen's, when compared to national comparators, more people are admitted to hospital than is the case elsewhere which creates an additional pressure on achieving improved discharge rates. It is also recognised that there is a particular challenge for Havering in demographic terms – having a high number of frail older people.

The JAD team's overall aim is to ensure the safe discharge of patients back to their homes in the community. Approximately 90% patients who require Social Care support are discharged back home with appropriate support services, the remaining users are discharged from hospital into 24 hour care setting (residential or nursing care services).

There are a number of ways that a delay to discharge can occur: (a) Health may be responsible for the delay (Health only); (b) Health and Social Care may jointly be responsible for a delay (Shared responsibility); or (c) Social Care may be solely responsible a delay.

The most recent analysis of delayed discharges of care has highlighted that of 1302 delay days (April 2014 – February 2015):

a) Health has been responsible for 823 (Health Only) – 63%
b) There has been an agreed Shared responsibility for 351 – 27%; and
c) Social Care responsible for 128 (Social Care Only) – less than 10%.

The primary reason for Social Care delays is patients awaiting a placement into 24 hour care setting (residential or nursing care) - 83 of the 128 days (64.8%); this is a significant decision at a difficult time for the patient and their families and representatives and will on occasion result in a delay in identifying a care home. Delays are also experienced when patients are waiting for equipment to be installed in their homes.

Performance continues to improve and in the last 3 months Social Care has only been responsible for 5 delayed days. Furthermore, in recent times the JAD has been discharging an increased number patients before the discharge notification date. This ensures a better outcome for the patients as they are not remaining in hospital for longer than is necessary.

Going Forward

The JAD team will continue to work closely with BHRUT and the CCG to ensure that delays to discharges are minimised wherever possible. Senior management will also be carrying out a review of the JAD team following its set up in 2014 to ensure that the correct level of staffing and management is maintained in the service. The review is planned to start in June 2015.

The JAD team has also commenced a comprehensive training programme for its staff following on from a detailed training needs analysis and will be ensuring that staff receive identified training to support them in their roles.

IMPLICATIONS AND RISKS

Financial implications and risks:

A joint Section 75 agreement has been set up for the funding of posts and for the delivery of the JAD service, between B&D, LBH and the health service. The funding arrangements and reporting functions have been agreed and the content of this report does not indicate a change in this position.

Legal implications and risks:

There are no apparent legal implications or risks in noting the content of this report**.**

Human Resources implications and risks:

Any HR implications or risks to the Council, or its workforce, or accommodation issues, are contained, and will be managed, using the normal business and HR frameworks for Havering employees working within the JAD Service. The recommendations in this report do not represent a change in this position.

Equalities implications and risks:

This report has no direct equality implications as it is an information report. However, delayed transfers of care can have significant implications on patients, particularly older and vulnerable people. It is therefore vital that the Council continue to facilitate timely and appropriate discharges from hospital. The Joint Assessment and Discharge Team and Management continue to work with BHRUT to support improved performance in this area. This area of work is important in reducing the health inequalities experienced by people with different protected characteristics, such as older people and people with disabilities.

BACKGROUND PAPERS

No background information papers used.

Havering
LONDON BOROUGH

INDIVIDUALS OVERVIEW AND SCRUTINY COMMITTEE

Subject Heading:	Provision of care available both in care homes and in the community
CMT Lead:	Joy Hollister
Report Author and contact details:	Barbara Nicholls
Policy context:	

SUMMARY

This report details the main types of care and support available to Adult Social Care (ASC) clients both in the community and within a residential setting. It also highlights the arrangements for monitoring care provisions in the borough.

RECOMMENDATIONS

This report is for information only.

REPORT DETAIL

In an environment of increasing demand for adult social care support with less available funds to spend, the Council has to develop innovative ways to support the care needs of its service users. A key aim of Havering ASC is to support vulnerable people in our community in doing as much as possible for themselves, utilising all their 'assets' to help them meet their outcomes, and for those that are reliant on care and extra support, to lead better more comfortable lives. The care and support they receive can be the difference between a life that is fulfilling and active and based on choices that are important to them, and one which is unnecessarily limiting. Adult Social Care tries to ensure, wherever possible, that service users are supported in their own homes in the community, and are encouraged to be as independent as possible, whilst preventing or delaying admissions into residential care settings and hospital.

Eligibility for Services

All individuals that approach ASC for support have an eligibility assessment carried out by a member of the social care service. This assessment will determine if the applicant is eligible for support. For those who do not meet the criteria for support ASC will provide appropriate information and advice. For those that do meet the eligibility criteria, a care and support plan will be completed to identify and agree the service user's needs and identified outcomes and discuss the help and support available to meet them. Care will not be provided or paid for by the Council in excess of this assessed need. The service ensures that all eligible social care clients have a review of their care and support package once a year. This is to ensure that clients' changing situations are captured and packages of care reflect the changing needs of service user.

Individuals Overview & Scrutiny Committee, 28 April 2015

Care available to individuals supported in the Community

There are a number of services that Havering provides within the community to provide support and minimise and prevent unnecessary admissions into a residential setting and/or hospital.

Reablement
Reablement is one of councils' main tools in managing the costs of an ageing population by reducing reliance on hospital and residential beds by intervening at an earlier stage. Providing personal care, help with daily living activities and other practical tasks, usually for up to six weeks, reablement encourages service users to develop the confidence and skills to carry out these activities themselves and continue to live at home. It tends to be provided to people who have just been discharged from hospital or are otherwise entering the care system following a crisis to help service users who have experienced deterioration in their health and/or have increased support needs to relearn the skills required to keep them safe and independent at home. Unlike traditional home care, where carers visit and complete tasks for the service user, domiciliary support assistants work with the service user to learn or re-learn the skills needed for everyday life. It can support things such as developing confidence to enable safe transfers including getting up from a chair, in and out of bed and on and off the toilet or support in finding new ways in dealing with everyday tasks including: food and drink preparation, shopping, organising and planning daily routines, using transport, laundry, household administration and community access. From April 2014 – February 2015, 1062 individuals have received reablement service in the Borough.

Home Care
For individuals with longer term needs, home care can help service users to live independently and safely in their own homes. As at the end of February 2015, 1113 service users were receiving some form of domiciliary care in the Borough. Service users may need support because of a disability, because they are frail and elderly, or had a fall. There are many types of support available, including help with personal care, such as washing, dressing, getting out of the shower or getting in and out of bed. Service users can also receive help with other daily tasks, including cooking meals, cleaning, shopping and taking medication. This support is provided by a home care worker provided by a private care agency.

Occupational Therapy
When service users have a disability that affects their daily life they may be offered equipment, or adaptations to their home to support and help maintain independence, or to assist a carer. Examples of simple equipment include bath seats to help with getting in and out of the bath and raised toilet seats to assist those with restricted mobility. Minor adaptions can include items such as grab rails, chair raisers or step alterations. Major adaptations examples are stair lift, ramp for a wheelchair, or a level access shower. Occupational Therapy staff will recommend major adaptations if it is necessary and appropriate to meet the needs of a person who has permanent disability and has a substantial or critical need. As at February 2015, 2734 individuals were in receipt of equipment or adaptations.

Assistive Technology and Telecare
Assistive Technology is any piece of equipment or system that is used to increase, maintain or improve the functional capabilities and independence of people with cognitive, physical and communication difficulties. AT helps service users do everyday activities that are difficult, or have become difficult. Examples of this type of equipment are speaking clocks and personal alarms.

Telecare is a part of Assistive Technologies - a range of sensor aids that offer remote support, reassurance and care that can let others know when a service user needs help in their home. Examples of functions that telecare can support are equipment to turn off a cooker automatically or prompt a service user that it has been left on or alert a service user if a sink or bath is overflowing. Telecare is available to people living in their own homes as well as people living in some residential homes and extra care housing schemes.

Supported Living Services
Some service users do not want to move to residential care or it may not be appropriate for them to do so, but find it difficult to cope at home. Services that support independent living are made up of suitable or adapted accommodation and some forms of personal care. Some supported living homes may be shared by two or three people with similar conditions, such as a substance misuse problem or a particular disability. Staff will usually visit the home to provide motivation, such as encouragement to go out to work, and carry out simple tasks such as shopping, housework and repairs, and provide help with administrative tasks or personal care, if required. As at the end of February 2015, 91 individuals were residing in a supported living environment.

Extra Care Housing
Extra Care Housing is an extension of traditional supported housing and allows older adults (aged 65 years and over) to live as independently as possible, with the reassurance of onsite care support when they need it. Such schemes will have housing available to buy, rent or part own which are purpose-built or adapted and personal care support available 24 hours a day to offer support. There will also be communal areas onsite for tenants to use with various activities determined by the people who live there. For example, it could be used for residents to develop their own support networks or to invite in visitors to undertake activities such as wellbeing clinics or chiropody. There will also be neighbourhood facilities close by such as post offices, shops, GP surgeries and public transport. In addition to the above, some extra care sites have dementia units which provide specialist care in a community setting.

Day Opportunities
Day services or day opportunities are services that help service users keep active, learn skills and maintain friendships and social contacts. As at the end of February 2015, 324 service users are attending a day service. Activities are many and varied and can include arts and crafts, gardening, using computers for learning, outings in the community and other group activities. ASC runs two in-house Day Centres: Yew Tree Centre, which offers service for people with sensory and physical disabilities, and Avelon Road Centre which offers services to adults with a range of learning disabilities. There are also a number of Day Services run by other organisations utilised by Havering Service users for people with mental health needs, and more complex learning disabilities and or physical disabilities and Dementia.

Care available within a residential care setting

For those service users that can no longer be maintained and supported in the community either in their own homes or in supported accommodation a care home may be the only option. As at the end of February 2015 there were 547 individuals in residential care homes and 227 in nursing care homes. Care homes provide personal care or nursing care. A care home registered to provide personal care will offer support; ensuring basic personal needs are taken care of. A care home providing personal care only will assist service users with meals, bathing, going to the toilet and taking medication.

Some service users may need nursing care, and some care homes are registered to provide this. Often these homes specialise in certain types of disability or conditions such as dementia and will also offer and end of life and palliative care.

There are also residential care homes that provide care and support for younger adults (18-65 years old) with, for example, severe physical disabilities, learning disabilities, brain injury resulting from an accident, or mental health problems. They can care for adults with more than one condition, and some homes will have expertise in providing care for adults with alcohol or drug dependency. These care homes may offer permanent residence or provide care for a temporary period.

Monitoring of Care Provision and Contract Management

The Quality and Assurance Team (QAT) within the ASC Service undertake quality assurance monitoring and evaluation of provider services within the Borough in accordance with regulations set out in the Care Act and the essential standards.

The Team has oversight of 124 providers across a number of service areas in the borough:

Care Homes Older Persons	39
Care Homes Learning Disabilities	25
Homecare	26
Reablement	1
Day Opportunities Older Persons	6
Day Opportunities Learning Disabilities	11
Extra Care	3
Supported Living	13

They work to ensure that quality standards are maintained across all the Provider services and to achieve a degree of consumer reassurance about the quality of services delivered in the Borough. The QAT carry out visits to Provider services (all unannounced) and to conduct routine checks and specific investigation work concerned with quality and contract compliance issues of the provider service. They work to implement the monitoring and inspection framework for all contracted, spot purchased, grant funded services and in-house Adult Social Care services, to ensure providers meet the Council's contractual standards; and ensure that relevant providers of Adult Social Care meet their performance targets and quality standards and outcomes as set out in contracts, SLA's and grants agreements. Formal meetings are held with key statutory stakeholders on a three weekly basis at the Quality and Safeguarding Board which discusses provider services and serious concerns. These concerns are risk assessed using the guidance for suspension protocol. The Board then make recommendations to the Head of Service about what remedial action should be taken.

In addition, they canvass the views of service users and carers about their experience of service delivery including how services can be improved and to ensure that these views are acted on appropriately.

The QAT also arrange and facilitate a quarterly provider forum. This forum brings together providers and creates an opportunity for emerging themes to be discussed and good practice to be shared.

The QAT also lead on the monitoring of contracts across care provision in the community and homes. Systems are in place to monitor and assess provider compliance against contracts, legislative requirements, care outcomes, value for money, quality and performance. The application of contract monitoring reiterates to providers the standards expected in delivering of services.

Going forward

In the coming year and thereafter, Havering ASC and Commissioning (working alongside Health colleagues and partners) will be working on a number of initiatives to further support service users independence in the community - examples of this type ongoing of work include:

Social inclusion project - reduced social contact, being alone, isolation and feelings of loneliness are associated with reduced quality of life. Social activity group interventions that target specific groups of people can alleviate social isolation and loneliness. Havering plans to achieve this by promoting and support access to social networks; resolving transport issues so that they do not prevent people from participating in the wider community; building links with community projects, community centres and schools to increase levels of social contact between people from different

generations; identify, respect and use people's skills, including the skills of older people gained in previous employment.

Shared lives scheme - shared Lives is an alternative to home care and care homes for disabled adults and older people. In Shared Lives, a Shared Lives carer and someone who needs support get to know each other and, if they both feel that they will be able to form a long-term bond, they share family and community life. This can mean that the individual becomes a regular daytime or overnight visitor to the Shared Lives carer's household, or (for 4,500 people in England) it means that the individual moves in with the Shared Lives carer.

Implementation of the Joint Dementia Strategy - Dementia is becoming more common and the cost of looking after people with dementia is going up. The aim is to improve the quality of life for people with dementia and their carers by developing services for people with dementia that meet the needs of everyone, regardless of their age, ethnic group or social status. The aim is to continue to ensure better knowledge about dementia and remove stigma around dementia and their family and carers; ensure early diagnosis support and treatment for people with dementia, and develop services to meet changing needs more appropriately.

IMPLICATIONS AND RISKS

Financial implications and risks:

There are no direct financial implications or risks arising as a result of this report, which is for information purposes.

Currently the Adults Social Care service does not have a Shared Lives Scheme. However, work is underway in exploring whether an existing provider or to commission an organisation to set one up in Havering.

It should be noted that in 15/16 the Adults Social Care Service has £5.2m MTFS savings allocated against a number of service provisions. Work has either completed or will be commencing in achieving these efficiencies.

The Care Act go live date of the 1st of April 2015 will also see legislative changes to the carer's rights and the thresholds of care packages. Work is underway to model the potential pressures on resources going forward and responsive action is being taken to deal with the changes in legislation.

Rav Nijjar – Strategic Finance Business Partner

Legal implications and risks:

There are no apparent legal implications in noting this Report

Stephen Doye - Legal Manager (Litigation) for and on behalf of Interim Head of Legal

Human Resources implications and risks:

There are no direct HR implications or risks to the Council, or its workforce, that can be identified at this time with regard to the recommendations made in this report.

Eve Anderson - Strategic HR Business Partner

Equalities implications and risks:

This report has no direct equality implications as it is an information report on the types of care and support available to Adult Social Care (ASC) clients both in the community and within a residential setting, and the arrangements put in place for monitoring care provisions in the borough.

The report also highlights some key projects that Havering ASC and Commissioning (working alongside Health colleagues and partners) will be working to further support service users' independence in the community such as:

- Social inclusion project;
- Shared lives scheme, and
- Implementation of the Joint Dementia Strategy.

These and all other relevant activities will be subject to individual Equality Impact Assessments so as to ensure that positive outcomes on clients with protected characteristics are optimised and any potential/likely negative implications identified are mitigated, if not eliminated.

Paul Green – Corporate Policy & Diversity Advisor

BACKGROUND PAPERS

No background information papers used.

Havering
LONDON BOROUGH

INDIVIDUALS OVERVIEW AND SCRUTINY SUB-COMMITTEE ANNUAL REPORT 2014/15

INTRODUCTION

This report is the annual report of the Sub-Committee, summarising the Sub-Committee's activities during its year of operation ended May 2015.

It is planned for this report to stand as a public record of achievement for the year and enable Members and others to have a record of the Committee's activities and performance.

SUB-COMMITTEE MEMBERSHIP

Councillor June Alexander (Chairman)
Councillor Philip Hyde (Vice-Chair)
Councillor Ray Best
Councillor Viddy Persaud
Councillor Keith Roberts
CouncillorRoger Westwood
Councillor Darren Wise

WORK UNDERTAKEN

During the year under review, the Sub-Committee met on five occasions and dealt with the following issues:

1. Introduction to Overview and Scrutiny

At its July 2014 meeting the Committee received a presentation giving an insight into how Overview and Scrutiny worked in Havering. The difference between executive decisions and those made by the Council was explained. Overview and Scrutiny was the function by which Council decisions, or indeed any actions taken in connection with Council functions, can be reviewed and/or scrutinised. The factors for successful scrutiny Topic Groups were outlined and it was noted that the more tightly and realistically framed that the recommendations are, the more likely they are to be adopted/ implemented.

2. Overview of Adult Social Care

At its meeting in July 2014, the Committee received a presentation setting out the services within Adult Social Care and Commissioning. A brief description of what each section was responsible for was explained. Members were given a detailed presentation on the Care Act and Better Care Fund, including details of

how the Care Act pulled together a number of legislation and law into one document.

3. Review of Services in Havering for People with Dementia or a Learning Disability

In July 2014 the Committee received a presentation from HealthWatch Havering setting out the findings of a review that had been carried out into the services available for people who have dementia or a learning disability. A number of workshops were carried out to find out from carers, volunteers and users what services were available in Havering. The framework for each workshop and for both topics was based around the following questions:

- What is missing?
- What would make a difference?
- What have you experienced that is good?

Over 100 people attended the workshops and a number of conclusions were reached. From these conclusions HealthWatch Havering agreed on a number of recommendations that had passed onto the relevant agencies.

4. Age Concern Reorganisation/ Relaunch (Tapestry)

At its meeting in September 2014, the Committee received a presentation from the CEO of Age Concern Havering on the proposed new branding and renaming to Tapestry. It was noted that Age Concern Havering remained independent when the national organisation became Age UK. New branding and logos were discussed together with the introduction and implementation of new values and new ways of working. A number of new services would be delivered to the clients of Tapestry. These included:

- Integrated service wide food program
- New community based activities involving “exercise for health”
- Increased community integration and involvement with all ages
- Integration of new technologies

The launch of the re-branding would take place in December 2014.

At its meeting in January 2015, the Sub-Committee were given a presentation on the new Tapestry organisation and its work. It was noted that the Tapestry Mission was “*To enable adults to lead a healthy, positive and fulfilling life”.* This would take account of the changes to service provision so that it would be available for all adults. Tapestry had three main priorities: Prevention, Care and Support. The values that underpinned the activities of Tapestry were Enterprising, Empathetic and Expert. It was noted that the service would be about identifying solutions for clients, to be understanding and professional and to be the best in terms of knowledge and learning.

The Sub-Committee was informed that whilst at present services available were by word-of-mouth, in the next few month there would be a bigger marketing drive

which would make use of more technology. The organisation would have to grow 25% in the next year, they had a very experienced board and the members were very confident that they could deal with the changing marketplace.

5. Dementia Strategy Review

In September 2014 the Committee received a presentation setting out the progress of the Dementia Strategy from the Locality Lead at the Clinical Commissioning Group Havering. The strategy was built around a number of statements from which indicators were collected. These included:

'I was diagnosed early' – The current rate of diagnosis was 57% which was an improvement on the previous year (47%) however there was always scope for improvement. There were approximately 3000 people in Havering who were thought to have dementia. The target figure for 2016/17 was 67%. It was noted that a lot of good work had been done however more work was needed in identifying patients, particularly in GP surgeries as this was the biggest area where diagnosis was poor.

'I understand so I make good decisions and provide for future decision making' – Members were informed that surveys of carers had been carried out in hospitals. The survey included questions about the care received, further information being offered and if the support was adequate to the relative's needs.

'I get the treatment and support which are best for my dementia and my life' – The Committee was informed that there were 40 care homes with Dementia Champions and 50 organisations in the Dementia Action Alliance. The Havering CCG was encouraging outstanding GP practices to sign up to the Dementia Action Alliance (DAA), however any organisation could be part of the DAA. A number of banks had signed up to the DAA in recognising if a number withdrawals are being made in a short period of time.

'I am treated with dignity and respect' – It was noted that the CCG would commission all future services with a requirement that it includes a dementia element as standard. There were consultations with then Phlebotomy service for those with dementia, since the waiting times were more difficult for someone with dementia.

The CCG would ensure that the Care Plans on the Health Analytics were shared between all local acute trusts so that there was a smooth transition between departments. This was particularly pertinent in A&E so that patients were known to have dementia before being approached by a clinician.

6. Funding Reform

At its meeting in September 2014, the Committee received a presentation from the Head of Adult Social Care and Commissioning setting out the Funding Reform under the new Care Act.

The main direct financial implications from the funding reform would be the rise in the upper capital threshold for means-tested support from £23,250 to £118,000. This would take effect from 2016/17. A cap would be set at £72,000 for the maximum contribution anyone would make to adult social care. This would include any residential and community services, and all previous contributions made towards community care services would be taken into account and be accrued towards the cap. All self-funders would be required to be provided with an independent personal budget, which would be reviewed and updated regularly. This budget will allow for the individual to progress towards the care cap.

The Committee was made aware of emerging concerns and priorities. These included affordability of services, and what they may cost, how many social work staff were required to meet the demands of residents and the review of all business process to make them more efficient and streamlined.

7. Healthwatch Havering Annual Report

At its meeting in September 2014, the Committee received an oral report from the Chairman of the Healthwatch Havering on its Annual Report 2013/14 which set out the work carried out by the organisation in the last year. It was outlined that Healthwatch Havering was a local independent consumer champion for health and social care. The umbrella body was Healthwatch England, which is part of the Care Quality Commission (CQC).

The launch of Healthwatch both nationally and locally conincided with emerging public concerns raised about Mid-Staffordshire Hospital and Winterbourne House care home, Locally, concerns were raised about a series of adverse CQC and other reports about care in Queen's Hospital and in several care homes in the borough. At the time the CQC carried out a new inspection regime of Queen's Hospital which placed the hospital in "special measures". Whilst Healthwatch Havering was not directly involved in the decision, it did submit evidence to the inspection team and was invited to a meeting where the CQC announced its findings.

Healthwatch Havering was a statutory members of the Havering Health and Wellbeing Board. It also had formal representatives on Health, Individuals and Children's Services Overview and Scrutiny Committees and a wide range of other relevant bodies, both local and regional to North and East London.

Healthwatch Havering had prioritised the eight established Health and Wellbeing priorities from their own perspective. The order being:

- The CQC inspection of Queens Hospital (Priority 7: Reducing avoidable hospital admission)
- Frail and Elderly Members of our community (Priority 5: Better integrated care for the 'frail elderly' population and Priority 1: Early help for vulnerable people)

- The Better Care Fund (Priority 8: Improvement the quality of services to ensure that patient experience and long-term health outcomes are the best they can be)
- The Care of Children in our Community (Priority 6: Better integrated care for vulnerable children)
- Joint Strategic Needs Assessment (Support the development of all 8 priorities)
- Dementia Strategy (Priority 2: Improved identification and support for people with dementia)
- Children and Families Bill (Priority 1: Early help for vulnerable people)
- Specialist and Cardiovascular Services (Priority 3: Earlier detection of cancer)
- Childhood Obesity (Priority 4: Tackling obesity)

Healthwatch Havering had also identified six key priorities for 2014/15. These were End of Life Care, Frail and Elderly care within the Emergency Department, Access to Primary Care, Access to Health Checks and Immunisation, Continue the programme of Care Home Visits, and to identify a project working with Young People. All these areas reflected concerns that have been brought to the attention of Healthwatch Havering and which supported the overall health and wellbeing of people.

8. Dementia and Diagnosis Topic Group

At its meeting in September 2014, the Sub-Committee established a topic group to look at Dementia and Diagnosis in Havering. The Sub-Committee wished to understand how awareness of dementia could be raised, pre-diagnosis procedures, understanding the process once diagnosis had taken place and what was in place for people and their families living with dementia.

The group met with representatives from the Havering Clinical Commissioning Group (CCG) and North East London NHS Foundation Trust, together with visiting two care homes in the borough who specialised in care for people living with dementia.

The group also attended a Focus Group run by the CCG and Dementia Action Alliance and were able to talk with people living with dementia and their carers about any areas that needed improving to make their lives better.

9. Learning Disabilities and Support Topic Group

At its meeting in September 2014, the Sub-Committee established a topic group to look at Learning Disabilities and Support available in Havering. The Sub-Committee wished to ensure that the council was helping those individuals with a learning disability with the transition from School to College/ University, and where capable, into work opportunities. It was agreed that members from the Children and Learning Overview and Scrutiny Sub-Committee should be co-opted onto the group as there would be an overlap of remit.

The group met with representatives from both Adult and Children's Social Care, the local College, the Job Centre and the Havering Chamber of Commerce, to understand what was currently in place. Representative from Special Educational Needs Support and Advocacy (SENSA) and Positive Parents were also invited to meetings to give their perspective of how parents and carers found the process.

The group agreed that there were improvements needed especially around the Education, Health and Care Plans. A number of recommendation would be included in the final report to Cabinet.

The group

10. Information and Advice Service

At the November 2014 meeting, the sub-committee received a brief on the information and advice provided by Adult Social Care. Officers explained when information may be needed and that by providing good information and advice would improve the wellbeing of people and may delay or prevent the need for further support.

Information was available from a number of areas, including Carepoint, Children's Centres, Neighbourhood Offices, Libraries, MyLife Havering (where you can find information online in one single place about the services and support available locally for children, young people and adults with special educational needs and disabilities), Voluntary sector organisations (Age Concern) and national organisations including NHS Choice, Net Doctor and the CQC website.

11. Telecare Presentation

At the meeting in November 2014, a presentation on assisted technologies was received. These were to promote independence and provide care at a distance. The Telecare centre ran 24 hours a day, 7 days a week with a response service. There were approximately 4,500 clients who received the service, the majority were elderly and lived in their own homes. The Sub-Committee viewed a number of the technologies including a pendant, a watch, flood detector, temperature extreme detectors as well as pill dispensers and on-track systems such as Skyguard and Vaga-watch. The latter were GPS systems which could track people who wandered outside of a particular area. The smallest area that could be set was 200 metres.

The Sub-Committee noted that there were 11 responders in total who worked across the 24 hour rota system. During the day there would be 5-6 responders and in the evening there would be 2-3 responders. The response time targets were 90% in 45 minutes and 100% in an hour. The average response time in Havering was 23 minutes with 99.2% in 45 minutes in the month of October.

The minimum cost was £4.68 a week, which included equipment, installation and all call-outs. The service was installing on average 100 units a month and

removing approximately 50 a month. All equipment was re-used and the service was not fixed to one supplier. The equipment was regularly tested and maintained every year.

12. Complaints Annual Report

At its meeting in November 2014, the Adult Social Care Complaints, Comments and Compliments Annual Report was received. The Sub-Committee noted that there had been a slight increase in complaints between 2012/13 and 2013/14. A breakdown of the complaints by services area was explained. The highest area of complaint was about external homecare however this service had the largest number of clients.

Recording of monitoring information had improved from previous years, with the method of contact for 2012/13 as mainly traditional e.g. letter, email and telephone, whereas the direction towards more online communication was recorded in 2013/14. It was noted that there had been 102 compliments made to the service which was almost the same as the complaints (108). The total number of member enquiries received during 2013/14 was 76, a 30% increase from 2012/13, and 75% were responded to within 10 days.

13. Dial a Ride

At its meeting in November 2014, the Sub-Committee received a presentation on the Dial a Ride service within Havering and the issues that were faced by its users. It was explained that this committee and its predecessors had been investigating this issue for a number of years.

The Sub-Committee noted that the service was provided free to its members, providing that they meet the relevant criteria. The cost per journey was £25.66 compared with just £12 per journey under the Taxicard scheme. Members noted the issues experienced by users of the Dial a Ride service, together with meetings and information that had been sought from different contacts at Transport for London over the previous years.

It was noted that consultants had been employed by TfL to carry out a Review of London's Social Needs Transport Market findings. A brief had been prepared and shared with the sub-committee. The sub-committee were keen to talk to TfL in order to progress and improve the service for residents in Havering.

In January 2015, the Sub-Committee met with a local Dial a Ride user to find out the concerns and issues faced on a daily basis by residents who used the Dial a Ride service. Members noted that since a new computerised scheduling system (Trapeze) had been implemented in 2008, the service had not been as efficient. Prior to the computerised system Dial a Ride could complete approximately 30 trip a day in Havering, however now they could only complete 16 trips a day. The system could not take account of group booking i.e. two members travelling together from the same location, or in the same street at the same time. Frequently Dial a Ride would send a separate vehicle for each individual. Other

issues included only one way travel with no return trips and difficulty in obtaining trips at weekends and evenings.

The Sub-Committee agreed that they would continue to progress the issues highlighted with TfL.

At its meeting in March 2015, the Chairman informed the Sub-Committee that the Vice-Chair and herself had met with representatives from Transport for London and Senior Officers from the Council to discuss the matter. A very productive meeting had been held, however due to the confidential nature of the meeting nothing further could be provided at this stage. As things progressed the Sub-Committee would be updated accordingly.

14. Council Continuous Improvement Model

In accordance with the Council's Continuous Improvement Model the Sub-Committee received an update on the following Cabinet reports:

Section 75 Agreement with North East London NHS Foundation Trust – A partnership arrangement between Havering and North East London NHS Foundation Trust (NELFT) had been established to provide mental health services for adults and older adults in Havering. The first Section 75 agreement for mental health was in 2009, and was renewed in 2013. Money was pooled between LBH and NELFT to deliver the service, and council staff were seconded to NELFT.

The budget for mental health services was outlined with the council contributing £11.88 million for the staffing and £1.25 million for commissioned services, with NELFT contributing £14.5 million.

The Sub-Committee was able to view a number of performance indicators for 2014/15 associated with mental health in Havering. It was noted that nationally for some years the key priority had been to support people with mental health issues to live as independently as possible, with less reliance on institutional settings (such as hospital beds and residential care settings), and Havering's activity information reflected this. It was also noted that the percentage of people with mental health being detained under the Mental Health Act rose in June, although it was not clear the full details of this spike.

Arranging for the provision of domiciliary care to adults – A framework had been agreed in November 2012 which commissioned a service where care agencies provided home care. At the time of the agreement there were twelve providers identified, this had then dropped to eleven. The total framework value was £37 million over a four year term; the service was half way through its term.

The Sub-Committee noted that the quality of care provided was satisfactory, however this linked with the corporate complaints. There was a national issue in recruiting staff for home care and this was true of the Havering providers. Concerns were raised about the impact this could have on the reablement team in the coming winter months if care packages were not delivered.

15. Havering Autism Plan

In January 2014, the Sub-Committee received a brief presentation on Adult Autism. Details were given of how the Autism Spectrum Condition could affect individuals. This included not knowing the world around them, not understanding body language, and having difficulty with social interactions. The officer explained the different support and reasonable adjustments that could be made for each individual.

The Sub-Committee noted that the National Adult Autism Strategy would be refreshed and it was the expectation that local authorities would take a lead on transforming health & social care, community and universal services as well as promoting support for Adults with Autism through organisational change and local leadership.

It was noted that the projected Adult Needs and Information Service had estimated the number of Adults with Autism in Havering was 1433. This was predicted to rise by 12% by 2030 to 1597. It was further noted that there was a growing number of young people with Autism Spectrum Condition, Learning Disabilities and Challenging Behaviours entering the system via the transition process.

16. 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 at its March 2015 meeting.

All representatives of Healthwatch Havering have 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.

All enter and view visits are announced and carried out by trained volunteers. Notes are made of visits which form a report. Once agreed this report is sent onto the CQC, the Local Authority and published on the Healthwatch Havering website.

17. Admission and discharge from Hospital to Care Home.

Following a request from members about the admissions and discharges from Care Homes, officers provided a presentation on the process in place at the meeting in March 2015.

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 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 for the individual to attend alone. The second would be an unplanned admission, these could be in the form or an

urgent (via 999) sudden collapse, a serious fall, injury or at the request of the GP.

Each resident within a Learning Disability home was 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. It was noted that whilst the hospital was aware of the hospital passport, these did not always come back to the home with the resident. Members felt that given recent technologies that the data could be uploaded onto a bracelet that could be worn by the resident and scanned at the hospital. This would prevent the need for paper copies which could get lost. It was agreed that this would also be useful for older people in care homes.

The process in discharging from hospital back to either a care home or an individual's own home was discussed. The Sub-Committee noted that the next of kin would be the first to be informed of the discharge. If an individual needed to be discharged into a care home before returning to their own home, this was often "step-down". This could be a form of respite care due to hydration, nourishment or because they had broken a limb or had a co-dependant who they could not care for. A social worker would carry out an assessment on the hospital ward and a detailed support plan would be written for the needs of the individual.

18. Overview of Safeguarding

At its meeting in March 2015, the Sub-Committee received a presentation on Safeguarding Adults in Havering. The Care Act and Making Safeguarding Personal had put the user at the centre of safeguarding planning with a multi-agency approach. The Safeguarding Adults Board (SAB) was on a firm footing, it had 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 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 too.

The Care Quality Commission had been looking into the Deprivation of Liberties and where these had been applied for. Due to this there had been a large increase in best interest assessments having to be carried out. The Sub-Committee noted that in 2013/14 there had been 33 assessments however in 2014/15 there had been 370 assessments carried out. Officers stated that as well as the new assessments, all outstanding assessments need to be reviewed; this had therefore increased the workload. All best interest assessments must be carried out by someone who is not involved in that person's care or in making any other decisions about it and must be a qualified social worker, nurse, occupational therapist or chartered psychologist with the appropriate training and experience.

19. Demand Management

An in-depth presentation on Demand Management was given to the Sub-Committee at its March 2015 meeting. It was explained that 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 arrangements will arise from cost-avoidance, i.e. preventing an increased spend that would otherwise result from more people entering " the system" and using Adult Social Care services.

It was explained that this was a big issue to Adult Social Care as the demand would continue to rise given that ageing population and the changing demographic profile in Havering. The Care Act would also have a disproportionate impact on Havering given the amount of care homes located in the borough. The Sub-Committee were concerned that GP registrations had continued to rise each quarter with 3,064 additional registration in the second quarter to 2014/15.

The challenges were noted that would face 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. Officers stated that work had already started on focussing to deliver this.

The Sub-Committee were informed that there was lots of focus on demand management within senior staff meetings, 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 (EHI&P) 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.

IMPLICATIONS AND RISKS

Financial implications and risks:

None – narrative report only.

Legal implications and risks:

None – narrative report only.

Human Resources implications and risks:

None – narrative report only.

Equalities implications and risks:

While the work of the Committee can impact on all members of the community, there are no implications arising from this specific report which is a narrative of the Committee's work over the past year.

BACKGROUND PAPERS

Minutes of meetings of Individuals Overview and Scrutiny Sub-Committee 2014/15.