MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
Havering Town Hall
6 November 2014 (7.00 - 10.00 pm)

Present:

Councillors Nic Dodin (Chairman), Philippa Crowder (substituting for Councillor Dilip Patel) Patricia Rumble, Gillian Ford and Jason Frost

Ian Buckmaster, Healthwatch Havering (part of meeting)

Also present:
Barbara Nicholls, Head of Adult Services, LBH
Fiona Barnard, Service Quality Manager, LBH
Dr Dan Weaver, Acting Chair, Havering GP Federation
Dr Jagan John, Prime Minister's Challenge Fund lead, BHR
Alan Steward, Chief Operating Officer, Havering Clinical Commissioning Group (CCG)
Caroline O'Donnell, North East London NHS Foundation Trust (NLEFT)
Anthony Clements, Principal Committee Officer, LBH (minutes)

21 **ANNOUNCEMENTS**

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

22 **APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS**

Apologies for absence were received from Councillor Dilip Patel (Councillor Philippa Crowder substituting).

23 **DISCLOSURE OF PECUNIARY INTERESTS**

There were no disclosures of interest. Ian Buckmaster of Healthwatch Havering left the meeting room during the item on implementation of Healthwatch in order to avoid a conflict of interest.

24 **MINUTES**

The minutes of the meetings held on 8 September 2014 (joint meeting of all overview and scrutiny committees) 9 September 2014 and 23 September 2014 (joint meeting with children and learning overview and scrutiny committee) were agreed as a correct record and signed by the Chairman.

25 DEMENTIA FRIENDLY COMMUNITY STATUS

The Committee noted with pleasure that Havering had become only the second London borough to be awarded dementia friendly status. Congratulations were recorded to the Council, Clinical Commissioning Group (CCG) Healthwatch and local businesses who had all been involved in gaining the accreditation.

26 INTENSIVE REHABILITATION SERIVE AND OCCUPATIONAL THERAPY

North East London NHS Foundation Trust (NELFT) officers explained that a partnership had been established between NELFT and Havering CCG to deliver care at home. The productivity of community beds had been reviewed and this had led to the introduction of the community treatment team and intensive rehabilitation service (IRS).

The IRS composed of a team of physiotherapists, nurses and occupational therapists. The service, which had commenced in November 2013, operated seven days a week across Havering, Redbridge and Barking & Dagenham. A total of 535 patients had been seen since the service started. The service had received very good satisfaction survey scores and a large number of compliments had been received about the service provided.

It was clarified that occupational therapy was no longer provided as a standalone service but was delivered within multi-disciplinary teams such as the IRS, community rehabilitation team and mental health service teams. The community treatment team was a seven day a week service treating people at home.

NELFT's community health and social care service had been remodelled over the last six months and now consisted of six cluster-based teams comprising community nurses, therapists and mental health link workers. These teams were designed to provide longer term support at home.

The community rehabilitation team was a multi-disciplinary service for sufferers of neurological conditions such as head injuries, Parkinson's disease, motor neurone disease and multiple sclerosis. Occupational therapists were also based in mental health services such as community recovery and early intervention teams from where casework support and specialised intervention could be offered. It was clarified that post-traumatic stress disorder would normally be treated under NELFT's community recovery teams. It was conformed that military veterans received priority access to medical services.

Services now commissioned from the Richmond Fellowship helped people with mental health conditions access education and training and it was confirmed NELFT were engaged with these services. No other mental health services were currently being recommissioned.

The waiting time to receive treatment varied depending on acuity. Home treatment could be provided with two hours of referral while a routine response could be provided within four weeks. The period from referral to diagnosis had been reduced to 10 weeks and the national target for diagnosis of dementia was believed to be 67%.

NELFT officers would confirm the number of Havering patients seen by the IRS to date though it was confirmed that Havering did have the highest throughput of the three boroughs. More patients were being seen by the service than under the former community beds model.

There were a total of 36 staff in the IRS. There were 1-2 vacancies that were filled with agency staff although it was agreed that recruitment to occupational therapy was a problem nationally. There were a total of 10 occupational therapists for the three boroughs covered which was a higher figure than under the community beds model.

There had been a good referral rate from GPs to both the IRS and the Community Treatment Team. Referrals could also be made by patients direct. A representative of the Havering GP Federation agreed that services were performing very well and that referrals had been easy to make.

There had only been one complaint received thus far concerning the IRS although officers would check on this. 92% of service users who responded to the Friends and Family test had indicated they were very happy with the IRS.

It was accepted by officers that NELFT needed to work with the Council and CCG on improving access to equipment. It would be necessary to strengthen social care input into the community health and social care team. NELFT officers also agreed that they would be able to assist with the requirements of the Care Act.

The Committee **NOTED** the presentation.

27 PRIMARY CARE TRANSFORMATION PROGRAMME

The lead for the Prime Minister's Challenge Fund across Havering, Barking & Dagenham and Redbridge explained that the three local CCGs had won £5.6 million from the fund in order to improve services.

There were a total of 48 GP practices in Havering. Havering's current population was 237,000 and this was expected to reach 250,000 by 2016. Havering also had the largest older population in London. It was felt that there was a need to improve primary care and the Primary Care Transformation Programme sought to use the monies from the Prime Minister's Challenge Fund to do this. The funding would be used for three areas – improving GP access, supporting people requiring complex care and the introduction of shared IT systems.

It was planned to improve patient experience in primary care and to introduce more GP appointments available in the evenings and at weekends.

The complex care workstream focussed on the 1,000 most vulnerable patients in Havering. A team had been set up including GPs, social care specialists, nurses and consultants with the aim of reducing the reliance on hospital care for this group of patients. A treatment centre was available at King George Hospital but it was explained that this would only be needed for diagnostics with most treatment taking place in a person's home.

Care would be tailored to each patient, taking into account their goals and what they wished to accomplish. It was planned that this programme would increase primary care capacity for other patients, in addition to reducing admissions to hospital. There would be quicker decision making for the 1,000 patients under the scheme with consultants undertaking home visits. The Complex Care 1,000 team would also have access to all notes for patients using improved IT systems. This would allow better decision making for patients. Patients could choose to leave their GP to transfer to the new programme but would be free to return to their old GP if they wished.

Havering GPs were committed to the complex care 1000 project for two years and patient experience would be analysed by Nuffield Health. It was agreed that the patient experience analysis by Nuffield Health should be brought to a future meeting of the Committee.

GPs wished to undertake more telehealth with for example remote blood pressures teats and consultations by Skype introduced. It was accepted that the sharing of notes was an issue and that not all patients were happy for their notes to be shared within doctors. It was hoped to move to I-Pads to allow the inputting of notes directly onto all relevant systems. Following the introduction of the new IT system from February 2015, care providers and Council staff would be trained on the new procedures.

Recruitment to the new scheme had been good although the number of GPs reaching retirement remained an issue for the health economy. GPs were aiming to encourage the training of new recruits. GPs recruited to the complex care 1,000 programme were very experienced and not currently employed. There was a high level of commitment to the project. It was confirmed that the project was supported by GPs who wished to refer patients to the service.

It was felt that the complex care scheme was innovative and would be positive for both primary and secondary care. Direct publicity of the service was being considered but it was hoped that GPs would in any case refer patients themselves. Referrals could be made by a GP in conjunction with a patient's family but it was not possible for patients to self-refer. A health

analytics system would indicate if patients suffered from five or more co-morbidities and hence were eligible for the complex care 1,000 programme.

There was currently one full-time consultant (seconded from Barts Health) as well as three GPs working on the complex care programme. Further recruitment would take place as demand increased. There were around 30 people in the team overall. It was noted that three GPs for the 1,000 patients compared favourably with the national average of one GP for 1,800 patients.

Work was under way with BHRUT to ensure adequate access to hospital tests etc for the 1,000 patients as this was likely to reduce the need for A & E services for this group.

The Committee **NOTED** the position.

28 GP FEDERATION

The Interim Chair of the local GP Federation – Havering Health explained that the Federation was a group of local GPs working together. The aim of the Federation was to ensure a well-resourced, high quality local health service. Thirty-nine of the fifty-eight GP practices in Havering had joined the Federation and this represented around 84% of patients at Havering GPs. Those practices that had not joined the Federation would also be engaged with.

The Federation was closely regulated by the Assurance Panel of the Care Quality Commission as well as by the existing GP regulations enforced by NHS England and other organisations. The Federation had also engaged with Healthwatch Havering.

GP Federations were being encouraged by the London Health Commission in the light of declining funding for GP services. There were also increasing demands on GPs due to the ageing population and higher disease prevalence and complexity of care. GP Federations were now operating in a number of areas including Barking & Dagenham, Hackney and Tower Hamlets. The Federation wished to work with the Sub-Committee to improve the quality of care for Havering patients.

While there was a fee of £1,000 to join the Federation, it was not felt that this was the main reason why some GP Practices had declined to join the Federation. One practice had declined to join as it disagreed with the general philosophy of Federations.

The GP Federation had provided access via a hub to appointments from 6.30 – 10 pm, Monday to Friday. The level of expertise in the Federation meant it could for example help GP practices improve their rates of smoking cessation. Work would be undertaken with the Barking & Dagenham and

Redbridge Federations to develop training for GPs. Recruitment would also be addressed by the Federation.

It was hoped to extend opening of the hub to include weekend GP appointments although the CCG had also commissioned a weekend service. This was however planned to cease operating at the end of March. The hub was a pilot scheme for two years at the end of which it was planned to procure a permanent provider.

The demand for the Federation's out of hours services had increased recently with 28 appointments offered each evening. Weekend appointments were not available as yet. The Federation was keen to increase referrals to the service from Queen's Hospital and via the polyclinic at Harold Wood. No referrals had however been received as yet from A & E and the possibility of having the out of hours service present on site at A & E was being investigated.

The emphasis would also be placed on reducing attendances at A & E and the 'Don't go to A & E' campaign was being updated with the launch of a phone app. Referrals to the out of hours hub from NHS 111 and via GPs had now commenced.

It was accepted that there was a lack of information about the out of hours service in GP surgeries but this was intentional at this stage. All Havering GP surgeries were aware of the hub and were able to make referrals to it. It was not possible for patients to self-refer as the pilot was looking at current need and the Federation did not wish to generate any additional demand at this stage. The CCG would however look at how GP surgeries were promoting the out of hours services. It was confirmed that NHS England had also asked that information about NHS 111 should be on Practice answering machines.

29 CARE ACT

The Head of Adult Services explained that the Care Act had received Royal Assent in May 2014 and that the legislation would be enacted from April 2015. The associated funding reforms would take effect from April 2016. The Act put carers on the same footing as those they cared for and placed upon the Council a new duty to support carers. Personal budgets, a form of direct payments were also now on a legislative footing.

The funding system for care and support was being reformed by the Act with a cap introduced on care costs and a much higher threshold for care payments. These changes would have a lot of implications for Havering. The universal deferred payment scheme was also being extended which allowed Councils to reclaim care costs from a person's property after they had died.

Also being introduced was a continuous duty of care if people moved between boroughs as well as new duties to ensure care was still provided if a provider failed. Transition arrangements between children's and adult care were also strengthened by the Care Act. Safeguarding adults would also now be placed on a statutory footing. The Council already had a Safeguarding Adults Board which met bi-monthly and the Council was required to ensure that the Board had a proper workplan. The Council and partners were also required to cooperate when conducting investigations and partners could not demand any payment for doing this. A process was being developed for the Board to conduct safeguarding reviews and advocacy for safeguarding was also required to be supported.

Regulations covering the duties and responsibilities of the Council had been published in October 2014. A lot of current adult social care legislation, some of which was contradictory, was being replaced by the Care Act.

The current position was that people with savings in excess of £23,250 would have to pa\y the full cost of their care but under the Care Act, this would be raised to £118,000. The maximum contribution paid towards care would also be capped at £72,000. This did not include up to £12,000 per year on 'hotel costs' such as food and accommodation, which still had to be paid, even if the maximum cap had been reached.

The average cost of a Havering care placement was £550-600 per week and people reaching the age of 18 with care and support needs would have a zero cap and hence would not be expected to make any payment. The situation for people who were already in the system or who entered care just before the funding reforms commenced was unclear and further guidance from central Government was awaited.

It was expected that more assessments of care needs would be required under the Care Act but it was not possible to be certain of numbers at this stage. Draft guidance on the funding reforms was expected in December (2014) but it was noted that there were 41 older people's care homes in Havering with a total of 1,550 beds. Currently 64% of residents were self-funding or from other boroughs and this could have serious implications for Havering. There was a likelihood that other Councils would seek to use Havering care homes and there had been a lot of lobbying on this issue by the Local Government Association and the Association of Directors of Adult Social Services.

A series of work streams had been set up in Havering to manage the introduction of the Care Act. A Programme Board chaired by the Group Director – Joy Hollister oversaw the process. Emerging concerns and priorities included affordability, modelling and estimating (for example how many people in Havering were self-funding) as well as capacity issues such as the amount of infrastructure needed for the Care Act. Signposting and front door issues were also a concern as were required changes to the practice of social workers.

It was emphasised that there were a number of good points regarding the Care Act such as the bringing of all adult social care legislation into one place for the first time. The new rights for carers were a positive as was the putting of safeguarding of adults onto a statutory footing. Officers felt however that the funding reform remained a problem.

There was no change to the Deprivation of Liberty and Safeguarding (DOLS) procedures which were already carried by the Council although there could be some financial implications as DOLS now also applied to community settings such as supported living. There had been a total of 120 DOLS referrals so far this year which had a significant cost implication.

Literature for residents on the Care Act was currently being developed. An article had been put in Living magazine and weekly bulletins were produced for staff which it was suggested Members may also benefit from receiving. A series of factsheets on the Care Act had been produced by the Department of Health and officers would distribute these to the Committee.

The Chairman pointed out that residents were likely to approach Councillors for advice concerning aspects of the Care Act and it was confirmed that further briefings for Members were planned. Engagement work was also under way with care providers. A representative from NELFT added that she would draw on Council teams for social work support if required. It was also noted that it would be necessary to improve IT systems in order to support implementation of the Care Act.

The Committee **NOTED** the position with the Care Act and thanked offices for the update.

30 URGENT BUSINESS

It was **AGREED** that an update on the work the CCG was undertaking in Children's Health should be brought to a future meeting of the Committee.

It was also **AGREED** that the CCG's workstream on common illnesses and improving patient knowledge should be scrutinised at the Committee's March meeting.

31 IMPLEMENTATION OF HEALTHWATCH

This item was an update on the implementation of a Cabinet Decision that had been due for review under the Council Continuous Improvement Model.

The Quality Manager explained that the Health and Social Care Act 2012 had required the Council to commission a Local Healthwatch organisation by April 2013. Healthwatch Havering had evolved from the former Havering LINk organisation and worked in conjunction with Healthwatch England – an independent national consumer champion for health and social care.

Local Healthwatch (Healthwatch Havering) had a number of functions including signposting, promoting choice and recommending areas of investigation to Healthwatch England and the Care Quality Commission. It was the statutory responsibility of the Council to ensure that Healthwatch Havering was delivering an effective service.

Funding for Healthwatch Havering totalled £117,000 derived from a formula grant from central Government and additional local funding. Final allocations of funding for the next financial year were expected to be known by January/February 2015.

The Council had been required to establish an independent and credible Local Healthwatch in Havering that also offered value for money. Healthwatch Havering had established good relationships with the Council, CCG and Care Quality Commission.

Healthwatch Havering sought to act on complaints and concerns regarding quality. Healthwatch representatives visited care homes and other facilities and spoke to service users, relatives and staff. Healthwatch had made a lot of reasonable and realistic requests for improvements to providers and many of these had been implemented by Trusts, care homes etc. Officers therefore felt that Healthwatch Havering was providing an effective service and offering value for money.

Members noted with pleasure that Healthwatch Havering had received considerable recognition outside of Havering itself. The representative from NELFT added that the Trust had received enter and view visits from Healthwatch and supported its work fully.

The Chairman added that he was full of praise for Healthwatch Havering and its work. A Healthwatch director played an important role at meetings of the Committee and the Chairman felt that Healthwatch gave important and welcome support to the work of the Committee.

The Committee **NOTED** the update.

_____

Chairman

This page is intentionally left blank