AGENDA

1. Apologies for Absence

2. Declaration of Members' Interests

   In accordance with the Council’s Constitution, Members are asked to declare any interest they may have in any matter which is to be considered at this meeting.

3. Minutes - To confirm as correct the minutes of the meeting held on 20 January 2015 (Pages 3 - 9)

Local Eye Care Services Scrutiny Review

4. Presentation on the 'local picture'

   A presentation will be delivered by the Director of Public Health and a local ophthalmologist.

5. Workshop

   A workshop with local stakeholders of the review will be held in committee rooms 1 and 2. At the conclusion of the workshop, the meeting will move back into the chamber.
6. Verbal feedback from the Workshop

The Lead Member will invite members to provide verbal feedback from the workshop.

Other items

7. Intermediate Care Proposals - Redbridge Health Scrutiny Committee's referral to the Secretary of State (Pages 13 - 31)

8. Implementation of the Care Act 2014 (Pages 33 - 62)

9. Barking & Dagenham HealthWatch's Enter and View of Fern Ward, King George Hospital (Pages 63 - 84)


11. Urgent care 'surge' appointments in primary care - verbal update

12. Any other public items which the Chair decides are urgent

13. To consider whether it would be appropriate to pass a resolution to exclude the public and press from the remainder of the meeting due to the nature of the business to be transacted.

Private Business

The public and press have a legal right to attend Council meetings such as the Health and Adult Services Select Committee, except where business is confidential or certain other sensitive information is to be discussed. The list below shows why items are in the private part of the agenda, with reference to the relevant legislation (the relevant paragraph of Part 1 of Schedule 12A of the Local Government Act 1972 as amended). There are no such items at the time of preparing this agenda.

14. Any other confidential or exempt items which the Chair decides are urgent
Our Vision for Barking and Dagenham

One borough; one community; London’s growth opportunity

Encouraging civic pride
- Build pride, respect and cohesion across our borough
- Promote a welcoming, safe, and resilient community
- Build civic responsibility and help residents shape their quality of life
- Promote and protect our green and public open spaces
- Narrow the gap in attainment and realise high aspirations for every child

Enabling social responsibility
- Support residents to take responsibility for themselves, their homes and their community
- Protect the most vulnerable, keeping adults and children healthy and safe
- Ensure everyone can access good quality healthcare when they need it
- Ensure children and young people are well-educated and realise their potential
- Fully integrate services for vulnerable children, young people and families

Growing the borough
- Build high quality homes and a sustainable community
- Develop a local, skilled workforce and improve employment opportunities
- Support investment in housing, leisure, the creative industries and public spaces to enhance our environment
- Work with London partners to deliver homes and jobs across our growth hubs
- Enhance the borough’s image to attract investment and business growth
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MINUTES OF
HEALTH AND ADULT SERVICES SELECT COMMITTEE

Tuesday, 20 January 2015
(6:15 - 8:10 pm)

Present: Cllr Eileen Keller (Chair), Cllr Sade Bright and Cllr Edna Fergus

Apologies: Cllr Danielle Lawrence, Cllr Syed Ahammad, Cllr Sanchia Alasia, Cllr Abdul Aziz, Cllr Peter Chand and Cllr Faruk Choudhury

13. Declaration of Members' Interests

There were no declarations of interest.

14. Minutes - To confirm as correct the minutes of the meetings held on 30 September and 19 November 2014

The minutes were agreed.

15. Scoping Report

The Group Manager for Intensive Support (GMIS) stated that on 30 September 2014 an options paper was presented to the Committee asking members to discuss and agree which topic they wished to undertake a scrutiny review on in 2014/15. Members agreed to undertake a scrutiny review on local eye care services.

The GMIS then presented the report which outlined the proposed methodology and terms of reference for the review, which were:

- Whether there are gaps or obstacles in current service and pathways
- How supply and take-up of Optometry (Opticians) and other eye service compares with other London boroughs and the national average
- Whether local low vision services for Blind and Partially Sighted people are fit for purpose and whether take-up is appropriate
- CCG plans regarding eye care services
- The role of GPs
- Emotional and other support for people newly diagnosed
- How well local services for blind and partially sighted people rate when benchmarked against the national “seeing it my way” charter

The terms of reference and the methodology proposed in the report were agreed.

16. Scene Setting

Peter Corbett, Chief Executive of the Thomas Pocklington Trust (the Trust) thanked the Committee for inviting him and his colleague Phil Ambler, Director of Policy, to discuss the national context of eye care health as part of the Committee’s scrutiny review.
Mr Corbett explained his background and the circumstances in which he started working for the Trust, a large endowed charity offering support to people who are blind or sight impaired. He had been Chief Executive of the Trust since 2011 when he made it his priority to understand what people with sight loss conditions really needed.

The Trust looked at the UK Vision Strategy and saw a lot of merit in it but they found that a lot of the content did not seem to have been translated into local action. They investigated whether all of London's 32 boroughs had a local vision strategy and found that Barking and Dagenham Council was the only one that did, which it was to be congratulated on. The Trust had spent about three years working on ensuring that all boroughs have a vision strategy, which was implemented locally.

Mr Ambler and Mr Corbett then delivered a presentation on the national context of living with sight loss. The following information was noted by the HASSC.

There was a big disparity between the number of people living with sight loss and the number of people registered as blind or partially sighted. There were a range of reasons for this including:

- People not presenting themselves to health services; for example, it was recognised that certain ethnic minority groups were less likely to present themselves to health services in relation to their eye health. Also, in people with learning disabilities the sight condition may not be picked up because certain symptoms were attributed to their disability.
- People may not realise that their sight was deteriorating as they were getting older.
- People may not notice that they have a refractive error which needs correction with spectacles or lenses, or that they were wearing the wrong prescription spectacles or lenses.

The Royal National Institute for the Blind estimated that around 3910 people were living with sight loss in Barking and Dagenham but only 870 people were registered.

There was a general lack of awareness about eye health; for example, many people held the belief that glasses would be unaffordable and therefore avoided visiting their local optometrist. Many people were also unaware that in addition to refractive error, optometrists could pick up serious diseases such as glaucoma and sometimes even stroke.

The emotional impact on individuals who had lost their sight could be very strong due to the effects on their employment, social life and independence. About 66% of those living with sight loss of working age were unemployed. The vast majority of people living with sight loss did want to work but faced barriers. They were flung into a new world and faced the struggle of having to learn new skills very quickly. Accessing information and services such as leisure, housing and transport could become a huge challenge. It is important that people suffering from eye loss receive rehabilitation to teach them key skills such as learning how to access information using a computer to increase mobility and employability, for example.

People living with sight loss had an increased risk of having a fall, and faced
communication barriers. For example, GPs sometimes asked people with sight loss whether they could ask a friend to read their own very private medical information to them, which was not always what the person was comfortable with.

Mr Corbett stated that the key difference he had seen in the quality of life of people living with sight loss, as a result of good support, was the confidence to use public transport. Some Transport for London services were excellent in making transport more accessible; however, to get to the services, people suffering from sight loss had to have the motivation to get up, get dressed and get out of their home. To get to that stage, they needed the right support and to build up their confidence.

Nowadays it was very common to hear about ‘person centred care’; however, people suffering with eye conditions were very often not put at the centre. It was very rare that people affected by sight loss received the right level of attention from key parts of the pathway and there was also fragmentation in geographical areas which could be better linked-up. Primary and secondary health services, the local authority and the voluntary sector all needed to join-up and put the person at the centre to provide excellent care all the way along. An example of projects working to make services more joined up was East London Vision (ELVis) a cluster for seven east London boroughs, which included Barking and Dagenham.

Professionals in public health, ophthalmologists, GPs and rehabilitation workers were doing a lot of work to support people with sight loss. However, in spite of this a lot of people were not meeting all the professionals they needed to, leading to poor overall care. Sight loss should not be looked at in isolation; rather, all the health pathways for the individual should be looked at and joined up where necessary to provide better care; for example, people should be incentivised to stop smoking not only because it was a risk factor for cancer but also because it was a risk factor for certain sight complications.

The Trust was highly in favour of every eye clinic having an Eye Clinic Liaison Officer to signpost people to relevant services. At the moment only half of eye clinics had this post.

Older people were most affected by sight problems. Rehabilitation often meant that a lower level of care could be provided. Some people suffering from sight loss were at an increased risk of injury from accidents because they were being cared for by unpaid carers who could not provide the right level of care.

Even where people did receive rehabilitation the time lag was often too long which meant that people deteriorated emotionally and their financial situation could worsen quickly too. There was a major opportunity in the sector to demonstrate that joined up work could provide very effective and cost effective models of giving people what they need. A key question was how could the voluntary sector join up with the local authority to provide low-cost rehabilitation support?

It was recognised that there was a limit to resources. Local committees whose remit included sight loss also had to deal with many other competing issues. The voluntary sector has to make sure it plays its part in enabling people to have less reliance on paid for support. Sight loss was an issue struggling for profile.

Proper investment in early intervention was crucial in providing good care and cost effectiveness as it would ensure more people with sight loss were in employment
and reduce the care needs of older people. 50% of sight loss conditions were avoidable. If a person has a family history of diseases that affect the eye, the sooner it is investigated, the sooner it can be addressed. Smoking, obesity and hypertension were considered risk factors for certain eye conditions.

The Divisional Director, Adult Social Care (DDASC) asked what could be done about lower level eye health issues, such as not enough people going to optometrists for an eye test. Mr Corbett stated in response that there was evidence that underprivileged communities in particular had fewer practices in their locality and that there was a variation amongst different ethnic groups when it came to visits to optometrists. People needed to be made aware that they could shop around for cheaper glasses and did not have to purchase the ones suggested by their local optometrist or optician. Whilst optometrists were business people interested in how they could run their businesses better, they could collectively think of ways to address these problems. Mr Corbett strongly recommended that the Council undertake a mapping exercise of optometrists in the Borough. The other possible area to explore was the offer of domiciliary tests in care homes, for example.

Mr Ambler stated that various studies have been done, for example, one had been undertaken in Leeds which found that the distance to an optometrist's is a major factor when it came to people deciding whether they were going to go for an eye test. A lot more could be done on raising public awareness on eye health. For example, there was a project in Sheffield whereby the voluntary sector, local optometrists and the police worked together to encourage people to have eye tests. The police would ask members of the public at a supermarket car park whether they could read the number plate of a car from a certain distance. If the person said no, the police would advise that the person visit an optometrist.

The Director of Public Health stated that the figures given during the presentation on how many people were suffering from sight loss were predictions only; the real prevalence was not known. He also raised the question of corrective surgery and measuring how many people were doing this privately. Finally, he highlighted that eye sight could be affected by passive smoking as well as direct smoking. Mr Corbett stated that whilst it was correct that the actual prevalence of sight loss was not known, a lot of data that people relied upon such as GDP and inflation were estimates, and it was important to work with the information available.

The GMIS stated that the epidemiology of eye care suggested that most estimates probably underestimated the actual number. The health of Barking and Dagenham's general population was lower than average, therefore it was likely that their eye health was poorer than average too.

In response to questions the Corporate Director of Adult and Community Services stated that the scrutiny review would be carried out by members of the Committee who would be engaging with local stakeholders and undertaking visits. The GMIS and the Scrutiny Officer would write up the Committee's findings and recommendations, and officers supporting this Committee would oversee the process of implementing the recommendations.

17. Interactive session

The GMIS handed out ‘simulation spectacles’ for members to try on to gain a
greater appreciation of what it was potentially like to live with the following eye conditions:

- Cataracts
- Macular degeneration
- Tunnel vision (from glaucoma, for example)
- Tunnel vision and low visual acuity (loss of peripheral and central vision from retinitis pigmentosa, for example)
- Hemianopia (caused by damage to the visual centres in the brain from a stroke or head injury, for example)
- Diabetic retinopathy

18. The Local Account

The Group Manager, Integrated Care (GMIC) provided an outline of the report on the Local Account, the Council’s statement to the local community and service users about the quality of social care services in Barking and Dagenham. He described the background to the Local Account, the structure of the 2013/14 version, its highlights and the consultation that had been undertaken locally with various groups before it was finalised.

The GMIC then covered some of the areas of work the Department would focus on this year including:

- Getting ready for the implementation of the Care Act 2014 for 1 April 2015, which will bring major change to how social care services are delivered. The Department will be rolling out a Care Act training programme as well as releasing publicity materials on changes brought about by the Act soon.
- The launch of the Joint Assessment and Discharge team, which brings hospital, community health and social care teams into one so that people coming out of hospital get a better service.
- Improving systems for responding to Deprivation of Liberty Safeguard applications (where people are prevented from doing something for their own protection) to meet rising demand.
- Continuing work to make sure that residents, service users and staff all know how to raise safeguarding alerts when they are concerned about someone’s safety or wellbeing in social care services.
- Launching the first Market Position Statement, that sets out how local services need to develop in order to meet the demands of people using services.
- Improving processes for ensuring the quality of local services, focusing attention on those that are a concern, and working closely with the Care Quality Commission.
- Developing a new Carers’ Strategy, with input from local carers and their support organisations, and work out new ways to deliver services for carers in the future.
- Working with HealthWatch to strengthen the voice of social care users, carers, patients and the public, and to make sure their voice gets heard at the Health & Wellbeing Board.

The GMIC stated that consideration was being given to changing the format of future local accounts to make it more engaging for service-users and the
community. One of the ideas put forward was presenting the local account in video format. The GMIC asked members for their thoughts on this.

Members expressed enthusiasm for the suggestion of a video format as it could be played in places like GPs surgeries, dentist surgeries and the reception areas of other local services, which would be a good way to make it accessible to a lot of people. Suggestions were made on engaging younger users and tailoring the format for different groups as well as presenting the account as a podcast.

19. Joint Health Overview & Scrutiny Committee (JHOSC)- update

The DDASC provided an update on the discussions around the agenda items of the last two Joint Health Overview and Scrutiny Committee meetings as follows:

- **14 Oct 2014:**
  - Urgent Care Procurement - the Chief Operating Officer of Havering Clinical Commissioning Group (CCG) explained that there were a large number of different providers of urgent care across the four boroughs and outlined the four local CCGs plans to improve this via a procurement exercise. The procurement exercise would cover services including NHS 111 and the GP out of hours service. All walk-in centres in NHS London would also be included with the exception of that at Barking Community Hospital where a new contract had recently been put in place. Members asked about what type of organisations could bid for contracts and whether this process would involve an element of privatisation of NHS services. The Chief Operating Officer stated that all sorts of organisations could bid for contracts including ones who were currently providing the services.
  - Intermediate Care Consultation - the four boroughs shared their positions on the proposals.
  - GP List Sizes and Contract Arrangements - a representative provided an update on the position.

- **13 Jan 2015:**
  - There was no Barking and Dagenham member representation at this meeting; however, he and the Scrutiny Officer were in attendance.
  - Pharmacy Arrangements - a Redbridge local pharmacist briefed the JHOSC on a communication template he had created to communicate with GPs regarding patients’ treatment, which he believed would lead to better care and cost effectiveness for the NHS in the long run if taken up by pharmacies to be used in a standardised way.
  - Great Ormond Street Hospital – the Hospital’s Director Of Planning & Information delivered a presentation on the services provided, provision for the four boroughs’ residents and challenges ahead.
  - Maternity Services - officers from Barts and BHRUT provided an update on maternity services at local hospitals. The DDASC asked the about the future commissioning of services at Barking Community Hospital but the representative was not able to provide details at that stage. Havering’s HealthWatch outlined findings of their April 2014 enter and view of Queen’s Maternity Services.
  - NHS 111 - a representative of the NHS 111 service provider
summarised the key features of the Service in Outer North East London.

- Urgent Care Procurement – the Chief Operating Officer provided an update on the Programme.

In relation to maternity services, members discussed the currently inequitable breast feeding support service for the Barking and Dagenham mothers as compared to the other boroughs. The Director of Public Health stated that he was aware of BHRUT’s plans to provide a generic service for women across all the boroughs going forward. Members stated that this was something the HASSC may potentially need to visit in the next municipal year.

20. Work Programme

It was noted that there would be workshops on 4 March 2015 before the Committee’s formal meeting to give members the opportunity to engage with local stakeholders as part of the eye care services scrutiny review.

It was agreed that the provisional item for the meeting on 4 March 2015 on the re-inspection by the Care Quality Commission of BHRUT be rescheduled for the meeting in June 2015 as it had been announced that the re-inspection would be taking place in early March 2015.
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### Local Eye Care Services Scrutiny Review

**Report of the Corporate Director of Adult and Community Services**

**Open Report**

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<tr>
<th>Report Author:</th>
<th>Masuma Ahmed, Scrutiny Officer</th>
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**Accountable Divisional Director:** Anne Bristow, Adult and Community Services

**Accountable Director:** Bruce Morris, Adult Social Care

**Summary:**

As part of the agreed programme for the Scrutiny Review on Local Eye Care Services 2014/15, the Director of Public Health and a local ophthalmologist will deliver a presentation for members, providing information on issues such as the prevalence of certain eye conditions in the Borough and an outline of the existing health and social care pathways for service users. This will be an opportunity for members to ask questions about how well services are joined up and the existing gaps in service provision.

Following the presentation and discussions, there will be a ‘workshop’ style event in committee rooms 1 and 2 where members will be able to engage with a variety of local stakeholders, including professionals and representatives of the voluntary sector to gain a wider perspective of the kinds of challenges faced by local people living with sight conditions and what more could be done to support them.

Following the workshop, members will be asked to return to the chamber where the Lead Member will ask members to provide verbal feedback on their workshop discussions.

**Recommendation(s)**

The Health and Adult Services Select Committee (HASSC) is recommended to note the presentation, engage with the local stakeholders during the workshop and provide feedback from the workshop on possible recommendations or further areas to explore, which will inform some of the content of its scrutiny report resulting from this review.

**Reason(s)**

The HASSC agreed to receive a presentation on local eye care services and engage with local stakeholders as part of the programme for this scrutiny review at its meeting on 20 January 2015.

**Background Papers Used in the Preparation of the Report:** None
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Intermediate Care Proposals - referral to the Secretary of State for Health by the London Borough of Redbridge’s Health Scrutiny Committee

Report of the Corporate Director of Adult & Community Services

Open Report | For Decision
---|---
**Report Author:** Masuma Ahmed, Scrutiny Officer, Legal & Democratic Services | **Contact Details:**
Tel: 020 8227 2756
E-mail: masuma.ahmed@lbbd.gov.uk

**Accountable Divisional Director:** Bruce Morris, Adult Social Care

**Accountable Director:** Anne Bristow, Adult & Community Services

**Summary:**
The Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (CCGs) consulted on their proposals to change the way NHS rehabilitation services are provided across the three boroughs by reducing the number of inpatient beds across the three boroughs and providing more treatment in people’s own homes. The three separate CCGs came together to agree these proposals across the local authorities concerned and the consultation went through the three boroughs’ scrutiny processes simultaneously. The consultation was undertaken from 9 July to 15 October 2014 and was referred to formally as the consultation on the ‘Intermediate Care Proposals’. At its meeting on 26 January 2015 the London Borough of Redbridge’s Health Scrutiny Committee resolved to refer its concerns regarding the proposals to the Secretary of State for Health.

This report asks the Health & Adult Services Select Committee (HASSC) to note Redbridge’s referral letter (at Appendix 3) and the update report from Barking and Dagenham CCG (at Appendix 4) on the potential implications of this move. The HASSC is asked to agree whether it wishes to indicate support for the referral by writing to the Secretary of State for Health.

**Recommendation(s)**
The HASSC is recommended to agree:

(i) whether or not it supports the referral made by the Redbridge Health Scrutiny Committee to the Secretary of State for Health, and

(ii) if it does support the referral, delegate the responsibility to write to the Secretary of State for Health on behalf of the HASSC, to express that support, to the Lead Member, Councillor Keller.

**Reason(s)**
The Intermediate Care Proposals and the consequent referral by Redbridge relate to the HASSC’s function to scrutinise any matter relating to the planning, provision and operation of the health service in the borough or accessed by Barking and Dagenham residents. This report also relates to the Council’s objective to ‘ensure everyone can access good quality healthcare when they need it’.
1. **Introduction and Background**

1.1 The Intermediate Care proposals involved reducing the number of inpatient beds provided across the three boroughs in the specialist community hospitals and provide more treatment in people’s own homes. The inpatient beds are currently provided at specialist NHS facilities at Grays Court in Barking & Dagenham, King George Hospital (following the closure of Havering inpatient beds at St George’s Hospital), and Heronwood and Galleon in Redbridge.

1.2 If implemented, the proposal would see a reduction in the total number of inpatient beds across the three boroughs. The beds would be provided at King George Hospital for the residents of all three boroughs, with dedicated cross-borough services, the Intensive Rehabilitation Service (IRS) and the Community Treatment Team (CTT), providing therapy and urgent response services in people’s own homes.

2. **Summary of key consultation with Barking & Dagenham members and the three boroughs’ responses**

2.1 In addition to other forms of consultation, representatives of the CCG attended:
- A (closed) meeting of the HASSC on 31 July 2014 to present the proposals to HASSC members and the Cabinet Member for Adult Social Care and Health
- a public meeting of the Health & Wellbeing Board on 9 September 2014 and
- a public meeting of the HASSC on 30 September 2014.

2.2 At these meetings the HASSC and the Cabinet Member for Health and Adult Social Care, expressed a number of concerns with regards to the potential local impact of the proposals, including issues around local need, clarity around the possible alternative use of Grays Court and the potential impact on other health services there, medical cover, location and travel times and stroke rehabilitation.

2.3 The HASSC’s formal response to the consultation, dated 15 October 2014, is provided at Appendix 1 and the CCG’s response to this, dated 18 November 2014 is attached at Appendix 2.

2.4 Whilst Havering’s Health Overview and Scrutiny Committee was in support of the proposals overall, Redbridge’s Health Scrutiny Committee expressed significant concerns around the proposals relating to the adequacy of the content of the consultation and whether the proposals would be in the best interest of the health service in their area.

3. **The CCGs’ decision following the consultation period**

3.1 Following the end of the consultation period on 15 October 2014, on 11 December 2014, the governing bodies of the three CCGs agreed to:
- permanently establish the home-based services, the CTT and IRS
- reduce the number of community rehabilitation beds to 40-61 for the three boroughs
- locate these beds on one site at King George Hospital in Redbridge.
4. **Referral by Redbridge’s Health Scrutiny Committee to Secretary of State for Health**

4.1 Following the announcement of the CCGs’ decision, at its meeting on 26 January 2015, the London Borough of Redbridge’s Health Scrutiny Committee resolved to refer its concerns regarding the proposals to the Secretary of State for Health under provisions of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. The referral letter is provided at Appendix 3.

4.2 Following the referral to the Secretary of State by the Redbridge Health Scrutiny Committee, the CCG have provided an update on the potential implications of this move. This is attached at Appendix 4.

5. **Financial Implications**

Implications completed by Roger Hampson, Group Manager, Finance (Adults and Community Services)

5.1 There are no financial implications directly arising from this report.

6. **Legal Implications**

Implications completed by Dawn Pelle, Adult Care Lawyer, Legal and Democratic Services

6.1 Whilst there are no direct legal implications of this report, as a result of the referral made by the London Borough of Redbridge, the way intermediate care health services are delivered in the Borough may potentially be affected, depending on the course of action taken by the Secretary of State in response to the referral.

6.2 The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 sets out the courses of action the Secretary of State may take upon receiving a referral from a local authority on proposals to substantially vary a health service in the authority’s area.

6.3 Where a local authority has reported to the Secretary of State because it is not satisfied that the consultation on a proposal has been adequate in relation to content or time allowed, and/or because the authority considers that the proposal would not be in the interests of the health service in its area (as Redbridge has done), the regulations state that the Secretary of State may make a decision in relation to the subject matter of the referral, make a final decision on the proposal, or give directions to the National Health Service Commissioning Board to require the CCG to:

   a) to consult (or consult further) with the authority in relation to the proposal;
   b) to determine the matter in a particular way;
   c) to take, or not to take, any other steps in relation to the matter.

6.4 Before coming to a decision on the referral made by Redbridge, the Secretary of State may request the Independent Reconfiguration Panel (a non-departmental public body and independent expert on NHS service change) to review the proposals, in an advisory capacity.
Background Papers Used in the Preparation of the Report:


List of appendices:

Appendix 1   HASSC’s response letter to the Intermediate Care Consultation
Appendix 2   CCG’s response to HASSC’s letter
Appendix 3   Redbridge Health Scrutiny Committee’s referral to the Secretary of State for Health
Appendix 4   Update on the Intermediate Care Consultation from the Barking and Dagenham Clinical Commissioning Group
Dear Dr Jagan John

Intermediate Care Consultation

Thank you for asking the Barking and Dagenham Health and Adult Services Select Committee (HASSC) to respond to the consultation on the Intermediate Care proposals relating to how NHS rehabilitation services are provided across Havering, Barking & Dagenham, and Redbridge. I write to you on behalf of the Committee in my capacity as Lead Member to outline members' concerns regarding the potential local impact of the proposals raised at a meeting with the HASSC on 31 July 2014, a meeting of the Health and Wellbeing Board on 9 September 2014 and a formal meeting of the HASSC on 30 September 2014.

Local Need

Members have previously expressed concerns about organising services to cover the disparate populations and needs of Havering, Redbridge and Barking and Dagenham with a “one size fits all” approach. The characteristics of the different local authority areas in terms of poverty and wealth, housing, demographics, and health needs is well understood. We were disappointed in that regard not to hear more from CCG representatives about the potential impacts of the proposals on Barking and Dagenham residents from the outset.

Grays Court

Grays Court is owned by the Council and on a long lease to the NHS. The proposals do not cover the alternative use of Grays Court. We have been advised by the CCG that there are 17 “stroke beds” at Grays Court and they are not subject to this consultation. There are also a range of specialist outpatient services and clinics on the ground floor at Grays Court and it is unclear whether these are included in the scope of the consultation.

We are concerned that with the proposals in their current form there is every possibility of a half empty, or empty building in the middle of the borough. Whilst we are aware that alternative uses for the building by Council services have been considered, we do not feel that these ideas will be feasible if there are still NHS inpatient beds in the building. Therefore before we are able to support the proposals in principle, we would like to see a
written agreement about the future use of Grays Court and also, financial and other legal matters would need to be resolved.

Grays Court is near to another NHS facility, Broad Street Walk-in Centre, which was recently closed despite considerable opposition from the Council, voluntary sector and local residents. It is generally considered that, in view of the health needs of the local population, Barking & Dagenham requires more local investment to cater for both those with long term health conditions, and a growing younger population. Taken together with the well documented problems in the acute hospital, BHRUT, we are concerned that there will be a risk that these proposals will put further stress on a health and social care system that is already stretched.

I attended the Health and Wellbeing Board on 9 September 2014 where the CCG delivered a presentation on the proposals. The Board stated that the closure of two services in Barking and Dagenham (Grays Court and Broad Street Walk in Centre) feels disproportionate to closures in the other two boroughs. It was reiterated at the HASSC meeting on 30 September that residents are likely to perceive these proposals as a further reduction in NHS services in the borough. Whilst the clinical rationale for Grays Court is understood, it has still raised concern that the centralisation of services is happening out of Borough. We ask for assurances that there will be no further closures of local services.

**Medical Cover**

At the Health and Wellbeing Board meeting, a clinician stated that at times he did not have full reassurance that patients were receiving the appropriate level of care and support overnight. We also seek assurance from the CCG about levels of medical cover and patient safety overnight in the current inpatient services.

With the ongoing recruitment problems of consultants at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), the consultation poses questions as to whether King George Hospital will be given appropriate levels of medical cover. We seek assurance that appropriate medical cover will be given to this unit, particularly overnight, and what plans are being put in place to ensure that this is achieved considering the recruitment problems at BHRUT.

**Location and Travel Times**

The CCG have argued that travel times to King George Hospital will be less of an issue as more people will be treated in their own homes. While this is true it is also the case that some residents will require inpatient treatment and their family and friends will be reliant on public transport to King George to visit them. Although the hospital is a 20 minute walk from Goodmayes station and is connected by local bus routes, residents could face significant travel times in getting to King George.

For example, Transport for London Journey Planner results to King George Hospital list approximate minimum journey times as:
In light of these concerns, we request an impact assessment covering alternative travel plans comparing Grays Court and King George Hospital, to better understand how local residents will be affected.

**Stroke Rehabilitation**

The scope of the proposals do not cover the full range of services that would usually be considered as NHS Intermediate Care services. Stroke rehabilitation is specifically excluded from the consultation remit as this is referred to as being part of a different care pathway.

Given the current proposals would effectively leave half of the beds at Grays Court empty, it is highly likely this will put the viability of this element of the service at Grays Court at risk and we see the future of the two elements of the service delivered from Grays Court as intrinsically linked. We would therefore like to see forthcoming proposals for changes in Stroke services delivered from Grays Court before coming to a conclusion about the Intermediate Care Consultation.

Furthermore there is growing evidence of small numbers of people ready to leave hospital having their discharge delayed because they are not considered suitable or ready for rehabilitation, and other people with very specialist needs who are delayed waiting for specialised long-term rehabilitation. We suggest the proposals need to either include services for this group of people, or at the very least deal with the impact of these proposals on those groups of patients, and the services that are provided to them.

In conclusion, whilst we understand the clinical rationale behind the proposals and support services that enable more people to be treated in their own homes, we are concerned about the impact the proposals will have locally, particularly what the alternative use of Grays Court will be, and the impact on residents travelling to King George Hospital to visit their family, relatives or friends using impatient services.

We ask that the CCG continue to work with our officers to address these particular impacts, and take into account our other concerns before implementing the proposals.

Yours sincerely

Councillor Eileen Keller
Chair, Health and Adult Services Select Committee
CC
Councillor Maureen Worby, Cabinet Member for Adult Social Care and Health
Anne Bristow, Corporate Director, Adult and Community Services
Bruce Morris, Divisional Director, Adult Social Care
Dear Councillor Keller

Thank you for your letter of 14 October 2014 regarding the Intermediate Care Consultation. I am pleased that you are supportive of the need to provide care in people’s home as far as possible and that you recognise the clinical rationale for the proposals. You have raised some concerns about the potential local impact of the proposals and the CCG welcomes the opportunity to work with officers to address the issues you raise in your letter.

I make an initial response to the main issues you raise in your letter below.

**Impact on Barking and Dagenham residents.**

You raise concerns about a “one size fits all” approach across Barking and Dagenham, Havering and Redbridge (BHR) as this does not take into account the specific and different needs of the residents in our borough, compared with our neighbouring boroughs. I understand these concerns however I believe that we have considered the individual needs of residents in developing the new model.

The model of care that we have developed is based on assessing an individual’s needs and providing care to meet those needs in the best place for them, which for many people is in their own home, where they prefer to be. This is a great improvement on the previous model of care which had a much more standardised approach to providing bed-based intermediate care without the option of providing rehabilitation at home. This individualised approach means that Barking and Dagenham residents will, like other boroughs’ residents, get support tailored to their needs rather than having to go through the same rehabilitation process for all patients discharged from hospital.
We know that although Barking and Dagenham’s older population is not projected to grow as rapidly as other boroughs, it will see changes in, for example, the needs of the oldest old. The particular needs of these people will be much better met by the new model than the previous system of intermediate care.

I understand that you are concerned about the impact on Dagenham in particular given that another service has recently closed there and the perception of local residents that NHS services are being reduced in the borough. We would maintain that the new model has increased access to intermediate care services for residents in Barking and Dagenham. Based on current utilisation we are forecasting that 3140 Barking and Dagenham residents will receive intermediate care support in 2014/15 compared to 2499 in 2013/14, an increase of 26%.

The HASSC also expressed concern that the proposal could put further stress on the health and social care system. Through the trial, it has been demonstrated that the new model has supported people being discharged home earlier with support and the home based services have prevented hospital admissions. Intermediate care is one of the schemes that will be jointly commissioned by the CCG and LBBD through the Better Care Fund, which has been approved by the Health and Wellbeing Board. This will ensure a continued focus on the effective use of both health and social care resources.

Grays Court and stroke services

The HASSC has expressed concerns about the potential impact of the proposals on Grays Court and on other services provided from the estate. There are no service changes planned for the specialist outpatient services and clinics provided from the ground floor at Grays Court and these are not included in the consultation.

The consultation is on a new model of intermediate care, as defined in the BHR integrated Care Strategy, which may have an impact on the 26 intermediate care beds in Grays Court. Specialist stroke rehabilitation services, including the 17 stroke beds at Grays Court for Barking and Dagenham and Havering residents, are not part of the consultation and are subject to a separate review that will be starting in December 2014. This review will need to take into account the impact of the CCG decision on the new intermediate care model which will be made in December. The HASSC will be consulted on any service changes arising from this review.

It is unfortunate that the timescales for the two business cases were not aligned and the CCG acknowledges the potential risks if intermediate care beds are relocated and stroke beds remain on-site. We will work with Council Officers to agree how the estate risks can be mitigated through the Finance and Estates Group which is led by the CCG Deputy Chief Officer.

Medical cover at Grays Court

Patients are admitted to a community intermediate care bed following hospital discharge when they have been assessed as being medically fit. The treatment goals during their stay are focused on rehabilitation with support provided primarily from therapists and nurses.

There is 24/7 medical support which is accessed by the senior nurse on call either via the consultant on call or a middle grade doctor depending on time and urgency of the call.
If a patient deteriorates beyond the medical plan in place staff will call an ambulance in an emergency situation if required. I am satisfied that the medical cover is adequate for rehabilitation patients who are admitted to the unit.

**Travel times to King George's Hospital**
The following factors need to be borne in mind when considering changes to travel times if inpatient beds are centralised at King George Hospital:

As you note, many more people will be cared for in their own homes so will have no travel to do whereas currently they, and their families and friends will need to travel to one of the intermediate care inpatient services in BHR e.g. Grays Court.

Patients who are admitted to an in-patient bed will have shorter lengths of stay than previously so the burden of travel will be reduced as the number of journeys family and friends will need to take will decrease for shorter stays.

Our analysis shows that whilst the travel times to King George Hospital from some locations is longer than to Grays Court the travel route is often more direct with fewer transport changes. We will undertake a fuller assessment of this in the development of the final business case.

**Delayed discharge from hospital**
The trial of the new model for intermediate care has demonstrated that delayed transfers of care have reduced for general rehabilitation patients. The CCG is working with NHS England to support the discharge of patients with very specialist needs who are not part if this review.

In conclusion, given that you are supportive of the clinical rationale of the proposals we have made regarding intermediate care, I am confident that we will be able to work together to address your concerns about the potential impact of implementation of these proposals. I therefore propose that we engage with your officers to develop a joint implementation plan that will resolve the concerns about Grays Court in particular.

Yours sincerely,

Dr Jagan John  
Clinical Director Barking and Dagenham CCG

cc: Anne Bristow,  
Corporate Director Adult & Community Services, LBBD

Bruce Morris,  
Divisional Director of Adult Social Care, LBBD

Zoe Anderson,  
Senior Public Affairs and Consultation Manager, NELCSU
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Dear Secretary of State,

INTERMEDIATE CARE PROPOSALS AFFECTING REDBRIDGE RESIDENTS
REFERRAL TO THE SECRETARY OF STATE

On 26th January 2015, the Health Scrutiny Committee for Redbridge resolved to refer a decision, made by Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups on 11th December 2014 regarding the future of local intermediate care services, to the Secretary of State. This referral is made pursuant to Regulation 23(9) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

The referral is made following the Committee’s initial response to the consultation, which outlined the following concerns:

1. Inadequate time for the consultation – the Committee recommended that the consultation be extended by a month but it was only extended by 2 weeks following the intervention of Jane Ellison, MP, and not as a direct result of the Committee’s request.

2. Dissatisfaction with the adequacy of the content of the consultation – in particular, that consultation questions were leading.

3. Concern that the proposals would not be in the best interests of the health service in the area or to Redbridge residents – the Committee highlighted that bed modelling was not robust and the ‘National Audit of Intermediate Care Report 2013’, albeit an audit, suggested the mean number of commissioned intermediate care beds per 100,000 of the population was 26.3 beds and this would suggest that the number of beds required by Redbridge, Barking & Dagenham and Havering would be 184, not 40-61 as proposed by the CCGs.

Roger Hampson – Chief Executive

Web: www.redbridge.gov.uk
Twitter: @Redbridgelive
Facebook: www.facebook.com/redbridgelive
At its meetings on 24th July 2014, 23rd September 2014 and 26th January 2015, the Committee heard from a number of local public speakers and representatives from third sector groups, such as Age UK Redbridge; Redbridge Carers Support Service; Wanstead and Snaresbrook Residents’ Alliance and Redbridge Healthwatch, and the Committee was also informed about a petition by Save the Wanstead Hospital, which has in excess of 3000 signatories.

Whilst some support was expressed at these meetings about the benefits of the proposed enhanced intermediate care services, there are continuing concerns, including whether nine months was a sufficient enough period for the CCGs to undertake the pilot on which the proposals are based; and also that the proposed new service should not be introduced at the cost of losing the existing service, i.e. the beds based at the Heronwood and Galleon Unit in Wanstead.

A summary of the key concerns outlined at the Committee’s recent meeting on 26th January, attended by representatives from Redbridge CCG and the provider organisation, North East London Foundation Trust, is set out below:

- Inadequate consultation process – that there was a lack of awareness about the consultation due to an initially insufficient consultation period and insufficient circulation of consultation documents and that the consultation questions were leading; in addition, it was noted by the Committee that a public speaker commented that GPs were not consulted during the formal consultation.

- Insufficient bed modelling regarding the proposed number of intermediate care beds for the Redbridge population – a public speaker suggested to the Committee that the Business Case that supported the decision by the CCGs made no reference to the bed base need.

- A lack of consideration for the views of the Redbridge public regarding the impact on carers, and in particular the views expressed via Redbridge Healthwatch.

The Committee’s referral is based on a majority cross-party decision.

I look forward to hearing from you.

Yours sincerely

John Powell
Director of Adult Social Services and Housing

Councillor Stuart Bellwood
Vice Chair, Health Scrutiny Committee
(in the chair on 26th January 2015)

Roger Hampson – Chief Executive

Web: www.redbridge.gov.uk
Twitter: @RedbridgeLive
Facebook: www.facebook.com/redbridgelive
Executive summary

This paper provides the committee with an update regarding potential implications of the Redbridge Health Scrutiny Committee’s decision to ask the Secretary of State to refer the consultation to the Independent Reconfiguration Panel for its consideration.

It will also update regarding progress of the stroke rehabilitation review and discussions regarding Grays Court estate in Dagenham.

Recommendations

The committee is asked note and consider the contents of this report.
1.0 Purpose of the Report

1.1 To provide the committee with an update regarding potential implications of the Redbridge Health Scrutiny Committee's decision to ask the Secretary of State for Health to refer the intermediate care consultation to the Independent Reconfiguration Panel for its consideration.

1.2 It will also update regarding Grays Court in Dagenham.

2.0 Background/Introduction

2.1 Barking and Dagenham CCG, Redbridge CCG and Havering CCG have been trialling a new model of intermediate care since November 2013. The outcomes of the trial have been reported the CCG Governing Body and the Health and Wellbeing Board. A pre-consultation business case proposing a new home-based model of intermediate care was approved the CCG Governing Body in June 2014. A 14 week public consultation ran from 7 July to 15 October 2014. This involved extensive engagement with community and voluntary groups.

2.2 The CCG attended a closed HASSC meeting on 31 July 2014 and a public meeting of the HASSC on 30 September 2014 to present the proposals. A written response to the HASSC’s formal response to the consultation was provided on 18 November 2015 (attached).

2.3 On 11 December 2014, Redbridge Barking and Dagenham CCG’s governing body agreed the future model of intermediate care as:

- Permanently establish the new home-based services-Community Treatment Team and Intensive Rehabilitation Service
- Reduce the community bed base in line with the community bed modelling i.e. flex between 40-61 beds (average 50)
- To locate these beds on one site at King George Hospital.

2.4 The governing bodies also agreed that implementation of the changes would require the following specific actions to be taken:

- 2015/16 activity trajectories for CTT and IRS to be revised in line with actual delivery 2014/15.
- Commissioning intentions for 2015/16 include a requirement for improved seven day access/admission to community beds.
- Ongoing monitoring and scrutiny via contract performance review processes.
- Barking and Dagenham CCG will work with the London Borough of Barking and Dagenham to agree an implementation plan that will take account of their concerns about the future use of Grays Court and the impact of this change in Dagenham, and taking account the review of the stroke services that is currently underway.

2.5 The evidence considered by the CCGs’ governing bodies is contained within the decision-making business case (157 pages) which is available online: http://www.barkingdagenhamccg.nhs.uk/Downloads/About-us/Intermediate%20care%20services/141205%20Intermediate%20Care%20Decision%20Making%20Business%20Case.pdf

This includes evidence as follows:

- updated service performance information and patient and clinical outcomes
- details the public consultation process undertaken following governing body agreement in June 2014 and the outcome of this process
- provides detail of the equalities impact assessment completed to support the consultation process
- outlines the intermediate care consultation steering group’s recommended proposal for governing body decision and detailed supporting information
• provides detail of implementation timescales subject to governing body agreement.

An analysis of the impact on travel as a result of the proposed changes was also included in the DMBC following a specific request from this committee.

2.6 The governing bodies also reviewed consultation responses and members of the public and other stakeholders were also able to make representations at the beginning of the governing body and their comments were also considered during decision making.

21% of respondents to the consultation were from Barking and Dagenham. The response to the consultation from Barking and Dagenham residents was as follows:

<table>
<thead>
<tr>
<th>21% of respondents to the questionnaire were from Barking and Dagenham, and they thought…</th>
<th>Support % Higher (↑) or lower (↓) than overall results</th>
<th>Opposition % Higher (↑) or lower (↓) than overall results</th>
</tr>
</thead>
<tbody>
<tr>
<td>The NHS should permanently run the new home-based services that have been trialled (the community treatment teams and the intensive rehabilitation service) because they help people to get better more quickly and to stay independent.</td>
<td>90% ↑ 9% ↓</td>
<td></td>
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<tr>
<td>The NHS should reduce the numbers of community rehabilitation beds if it can be shown that they are not used and are not needed.</td>
<td>73% ↑ 21% ↓</td>
<td></td>
</tr>
<tr>
<td>The NHS should reduce the number of community rehabilitation units if it can be shown that this is the best way to provide high quality, safe care.</td>
<td>64% ↑ 25% ↓</td>
<td></td>
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<tr>
<td>Option five – home-based services where possible and one community rehabilitation unit on the King George Hospital site, with 40-61 beds – is the best way to organise intermediate care services in the future.</td>
<td>72% ↑ 22% ↓</td>
<td></td>
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</table>

- Barking and Dagenham respondents were in favour of each of the proposals
- Barking and Dagenham respondents were more positive about all the proposals than respondents overall
- Barking and Dagenham respondents showed most support for permanently running the new home-based services, with 9 out of 10 people in favour
- Barking and Dagenham respondents showed least support for reducing the number of community rehabilitation beds, but almost 2/3 were in favour
- Almost 3/4 of Barking and Dagenham respondents were in favour of the preferred option.
3.0 Impact on Grays Court

3.1 The CCG has agreed to work with the London Borough of Barking and Dagenham to agree an implementation plan that will take account of their concerns about the future use of Grays Court.

3.2 A stroke rehabilitation pathway review is currently taking place and the committee will be updated on this as it progresses.

3.3 The timescale for the relocation of community rehabilitation beds to King George Hospital was agreed by governing bodies for autumn 2015.

The implementation plan will be overseen by the BHR Finance and Estates Group (which includes representation from BHRUT, NELFT and CCGs) with local authority representation.

3.3 There are no planned changes to services provided from the outpatient unit at Grays Court.

4.0 Risk

4.1 On 26 January 2015, Redbridge Health Scrutiny Committee decided to write to the Secretary of State asking him to refer the consultation to the independent reconfiguration panel. The majority of respondents within Redbridge (56%) supported the CCGs’ preferred option and the Redbridge Health Scrutiny Committee’s own response includes the following:

‘The Committee and all of the stakeholders welcome the opportunity to enhance and improve the Intermediate Care Services for Redbridge Residents and can see that the proposal is to locate services in King George Hospital which is welcomed...’.

4.2 The CCG has written to the Secretary of State for Health outlining why we do not agree with the grounds on which Redbridge Health Scrutiny Committee is requesting the proposals be referred. We are yet to receive a formal response from the Secretary of State regarding this, however will provide regular updates to the committee as this progresses.

4.3 This decision may result in a delay to implementation which could have consequences for patients’ care locally. Through the course of the trial, more than 10,000 patients have been cared for by the community treatment team and intensive rehabilitation service in the past year with improved outcomes and patient experience. Only 1300 would have been cared for in the old bed-based system alone—a difference of 8,700 patients in a year.

4.4 These successful services have also proved very popular with patients and carers who have constantly rated them at more than nine out of ten. Without these services in place, many more patients would have ended up in our already overstretched A&E departments and required more help from their family and/or carers.

Community rehab bed occupancy levels currently identify that 49% of community beds across the BHR economy are sitting unused as a result of more people receiving care at home. This is not sustainable or an acceptable use of valuable NHS resources.

4.5 The implementation of a new model for intermediate care is one of the key schemes in the Better Care Fund plan which was approved by the Health and Wellbeing Board in September 2014. Savings generated from the relocation of beds to King George Hospital would be used to manage
financial pressures in the Barking and Dagenham CCG/ London Borough of Barking and Dagenham pooled budget. The CCG has identified non-recurrent funding in 2015/16 to manage cost pressures arising from the Care Act implementation. Recurrent funding would need to be found from savings within this pooled budget.

Attachments:
1. Barking and Dagenham CCG response to HASSC letter of 15 October 2014

Author: Gemma Hughes/Sarah D’Souza
Deputy Chief Operating Officer, Barking and Dagenham CCG

Tara-Lee Baohm
Deputy Director of Strategic Delivery

Date: 18 February 2015
HEALTH AND ADULT SERVICES SELECT COMMITTEE

4 MARCH 2015

**Title:** Implementing the Care Act 2014

Report of the Cabinet Member for Adult Social Care and Health

<table>
<thead>
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<th>Open</th>
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<tr>
<td>Wards Affected: ALL</td>
<td>Key Decision: NO</td>
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</tbody>
</table>

**Report Authors:**
- Ian Winter CBE, Care Act Programme Lead
- Glen Oldfield, Care Act Project Officer

**Accountable Divisional Director:**
Bruce Morris, Adult Social Care

**Accountable Director:**
Anne Bristow, Adult and Community Services

**Summary**

The purpose of this report is to give elected Members assurance that the implementation programme remains on track to deliver the key requirements of the Care Act 2014.

The report describes the implementation programme and flags key risks to delivery. The report also explains the current position and the areas of focus and activity as we approach the critical milestone of 01 April 2015, the date by which the majority of the Care Act must be in operation. Changes due in April 2016 and issues arising are also outlined for Members.

A short presentation will be delivered at the meeting to highlight the key issues of this report.

**Recommendation(s)**

The Health and Adult Services Select Committee (HASSC) is asked to:

(i) Scrutinise the implementation programme to deliver the Care Act 2014 to assure itself that the Council will be compliant with key requirements from 01 April 2015.

(ii) Carefully consider the challenges that this extensive policy, practice and system change demands of adult social care services, particularly the risk of unquantified demands for services and subsequent pressure on workforce and resources.

**Reason(s)**

The Care Act 2014 imposes significant legislative change on the Council and requires major changes to both policy and service delivery.

Many of these changes will directly increase demand from residents who may require information, advice, preventive services, assessment and direct payments for services. Many who, hitherto, did not approach adult social care will make demands on Council resources.
1. **The implementation programme**

1.1. Given the significant scale and scope of the Care Act 2014 the Council has established a cross-directorate Care Act Programme Board chaired by the Corporate Director of Adult and Community Services to oversee implementation. The Programme Board has representation from across Council services (including Finance, Legal, Revenues & Benefits, Children’s Services and Housing) where Care Act 2014 duties will have an impact. The implementation programme is being supported by a small team of dedicated officers.

1.2. The programme is divided into six workstreams each of which is led by a senior manager who is responsible and accountable for delivering the key activities to implement the Act. To give the HASSC a sense of the breadth and scale of the programme the key implementation tasks are set out in summarised high-level programme plan included at Appendix 1.

2. **Accountability of the programme**

2.1. The implementation programme is accountable to the stakeholders below:

- The Cabinet Member for Adult Social Care and Health
- The Cabinet, where the Care Act impacts on other portfolios or executive decision-making is required
- The Health and Wellbeing Board (H&WBB) as the local leader of the health and social care system
- Corporate Management Team (CMT), where there are cross-cutting or corporate impacts
- HASSC, as the relevant body of the Council’s overview and scrutiny function

2.2. The Care Act Programme Board reports as appropriate to these groups where decisions must be taken or issues resolved beyond the remit of the Programme Board. Frequent reporting of progress and reporting when there are key issues ensures accountability at all levels. Examples of this reporting are listed in the background papers to this report (see section 9).

2.3. The implementation programme is also required to give external assurance at a regional level through the quarterly ADASS stocktake. The purpose of this exercise is for local authorities to outline their progress on key areas of delivery and identify areas where authorities might benefit from additional regional support. In February 2015 the Care Act Programme Team submitted its third stocktake response which was completed by Anne Bristow (Corporate Director of Adult and Community Services) and Cllr M Worby (Cabinet Member for Adult Social Care and Health).

2.4. The HASSC is an important part of the system of accountability and the purpose of this report is to give assurance that programme governance is robust and that implementation is moving forward and keeping to national milestones for delivery.

2.5. The HASSC may wish to review the forward plans of the Cabinet and H&WBB and consider whether pre-decision scrutiny or policy development input from Members on Care Act related matters would be appropriate. Officers will be happy to provide future reports and briefings about the Care Act and the implementation programme upon request of the HASSC.
3. **Risks and challenges**

3.1. The Act is of considerable scale and scope and there are major risks and challenges which must be managed and overcome in order to implement the programme.

- **Timescales**
  
The timetable for delivering the Care Act is highly pressured. The majority of the changes must be implemented by 01 April 2015. However, the statutory guidance and regulations which give local authorities implementation instructions were only finalised in October 2014. This has left a very short timescale for implementing the most complex package of reforms in over twenty years.

- **Finance**
  
The Care Act 2014 requires significant changes to adult social care functions and has implications for other Council services. Some grant funding from the Department of Health has been allocated to meet the costs, and the local Better Care Fund has an allocation which is to be used for Care Act implementation. However, the total funding will almost certainly not be sufficient to meet the costs we have identified through our financial mapping and modelling. There is no entirely satisfactory model for calculating new demand. While as much work as possible has been completed there are inherent risks regarding demand that it is impossible to fully quantify.

  This puts pressure on Adult and Community Services' base budgets as there are areas of unfunded spend moving into 2015/16. In 2016/17 and future years we expect pressure on budgets to be greater as responsibilities towards self-funders and increased demand for services as a result of 2015 changes begin to ramp up. Currently we estimate this pressure to be at least £4 million in 2016/17 and ongoing.

- **New and potentially unsustainable demand**
  
The Care Act introduces new duties and extends others, most importantly giving new rights and entitlements to unpaid carers. It is therefore likely that once the Care Act changes are embedded and knowledge and awareness grows among residents there will be additional demand for services.

  A live example of this comes from a small third sector organisation working with people with disabilities. In just one week, they have reported a nine-fold increase in demand as a direct result of the national advertising and leaflet campaign which is significantly raising expectations.

  At this point it in time it is very difficult to determine the nature and level of this extra demand but we expect the pressure points are:

  o Demand from current carers, given their new right to demand assessment and consequent services as required by the Act.

  o Increased demand for prevention and wellbeing services/interventions, and

  o From April 2016, demand for services from self-funders notably managing care accounts, detailed financial information and options and supporting systems to manage the cap on care costs.
• Legal challenge

The Care Act creates a single legal framework for adult social care. This is a landmark and welcome step but, in the process, sixty years of legislation is repealed or revoked. This means that from 01 April 2015 all existing established case law is open to re-interpretation under the Care Act. This exposes the Council to the possibility of legal challenge as individuals or groups and their representatives seek clarification or interpretation of the new requirements of the Act.

• IT development

We are working closely with our existing IT suppliers to implement changes and upgrades to meet Care Act requirements. In the main we are satisfied that our IT suppliers are working towards delivering the necessary upgrades by 01 April 2015 and work is progressing in most areas. However there will be limited time to test new systems before they can be rolled out for use by staff. Any further delays in developing IT solutions are likely to have a knock-on effect on our ability to train staff and introduce new systems into a live environment. Contingency plans have been developed in case systems are not fully operational by 01 April 2015.

• Readiness of partner organisations

There is concern that NHS organisations have not given sufficient steer or guidance from NHS England on the implications of the Care Act for them.

The Council’s implementation team has offered support to partner agencies and the H&WBB has sought assurance from partner bodies about system readiness by means of a report to its 10 February meeting. This activity aside, the HASSC may wish to receive direct assurance from NHS partners of their readiness for and compliance with the Care Act.

• Funding reforms and appeals (2016)

Further to the considerable work that is taking place to deliver the April 2015 changes, the implementation programme is looking ahead to April 2016 when the remainder of part one of the Care Act is to be implemented. These changes are significant and far-reaching and will require programme work throughout 2015. The 2016 changes can be summarised into three important areas (see also section 5 of this report):

  o **Cap on care costs** - The cap will place a £72,000 limit on the costs of care that people will face to meet their eligible care and support needs. When a person reaches the cap the local authority will pay a contribution towards the person’s care fees to cover the cost of care to meet their needs.

  o **Extended means test** - Under current rules, if a person has less than £23,250 in assets they will receive means tested help and they will contribute only what they can afford from their income if their assets are below £14,250. Under the new system, people in a care home with less than £118,000 in assets will qualify for means-tested local authority help with their care costs and they will contribute only what they can afford from their income if their assets are below £17,000.
o **Appeals** - Section 72 of the Care Act will introduce a system of appeals to challenge decisions taken by local authorities in respect of a person’s care and support across nine separate dimensions of each person’s situation.

3.2. Overall we are confident that with significant focus and effort we will deliver the parts of the implementation programme that will make us compliant with the law from 01 April 2015. Inevitably the process of fully embedding implementation and transformation will continue well beyond April 2015. This is the position of the majority of local authorities.

4. **Implementation priorities**

4.1. As we enter the final month before the 01 April 2015 milestone the implementation programme is concentrating on delivering key ‘must do’ requirements to ensure compliance and frontline operational readiness. The implementation activities are as follows:

- Implementing revised procedures for front line and support staff
- Engaging, developing and equipping the workforce

4.2. To maintain focus on what must be delivered the Care Act Programme Team has developed a log of products and outputs that are required by 01 April 2015. This tool is being reviewed and updated weekly by the Programme Team and is guiding workstream activity between now and April.

5. **The challenges of April 2016**

5.1. The consultation on the funding reforms and appeals system is underway and closes on 30 March 2015. Local authorities are invited to give their comments about the draft regulations and guidance. A response from the Council to this consultation is being prepared by the Cabinet Member for Adult Social Care and Health.

5.2. Arising from the April 2016 changes we will need to have in place:

- New charging arrangements to reflect the extended means test and the introduction of the cap on care costs
- Care accounts and independent personal budgets for all clients who contribute towards the costs for their care (which now includes self-funders)
- Local processes and procedures for responding to appeals. Given the wide scope of the appeals system this could be a big area

5.3. Now that we have detail in the form of draft statutory guidance and regulations we are beginning to make plans to implement the next set of very significant requirements demanded by the Act.

6. **Financial Implications**

Financial implications are set out in the report to Cabinet on 16 February 2015, attached as an appendix.

Prepared by Roger Hampson, Group Manager, Finance
7. Legal implications

Legal implications are set out in the report to Cabinet on 16 February 2015, attached as an appendix.

Prepared by Dawn Pelle, Adult Care Lawyer

8. Risk management

8.1. Risks to the implementation programme are well documented in the body of the report. Risks are managed through the Care Act Programme Board through the Programme Risk Log which is reviewed periodically. Care Act 2014 implementation also features on the Corporate Risk Register to ensure oversight of risk and escalation of issues if needed.

Background papers used in preparing this report

— Care Act Statutory Guidance
— Care Act Programme Board documentation
— Care Act 2014: Preparedness of NHS organisations (H&WBB, February 2015)
— Care Act 2014: National and local communications (H&WBB, February 2015)
— Care Act 2014: Implementation update (H&WBB, December 2014)
— The Care Act 2014 (H&WBB, July 2014)
— The Care Bill: Adult Social Care Funding (H&WBB, December 2013)
— The Care Bill (H&WBB, November 2013)

List of appendices

— Appendix 1: Summarised Care Act Implementation Programme
— Appendix 2: The Care Act 2014 (Cabinet report, 16 February 2015)
— Appendix 3: Care Act 2014 briefing (appendix to Cabinet report, 16 February 2015)
## SUMMARISED CARE ACT IMPLEMENTATION PROGRAMME

### Information & Advice

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Local communications responding to national publicity campaign</td>
<td>16/03/2015</td>
</tr>
<tr>
<td>Local material developed</td>
<td>06/02/2015</td>
</tr>
<tr>
<td>Letters to carers and domiciliary care users adapted for local use</td>
<td>28/02/2015</td>
</tr>
<tr>
<td>Briefings for staff, partners and Members</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Information and advice plan</td>
<td>17/03/2015</td>
</tr>
<tr>
<td>Improved functionality of the Care and Support Hub with effective links to AIS/FACE</td>
<td>01/04/2015</td>
</tr>
<tr>
<td>Accessible information on the care and support system locally, how to make a complaint, how to access care</td>
<td>01/04/2015</td>
</tr>
</tbody>
</table>

### Assessment & Eligibility

<table>
<thead>
<tr>
<th>Description</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop appropriate and proportional assessment including changes to IT systems and tools to deliver this</td>
<td>01/04/2015</td>
</tr>
<tr>
<td>Eligibility scorecard</td>
<td>01/04/2015</td>
</tr>
<tr>
<td>Risk analysis to underpin assessment and eligibility</td>
<td>01/04/2015</td>
</tr>
<tr>
<td>Eligibility determination letter [see also assessment determination letter]</td>
<td>01/04/2015</td>
</tr>
<tr>
<td>Information for self-funders (including easy read)</td>
<td>01/04/2015</td>
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<tr>
<td>Revised information for council funded individuals (including easy read)</td>
<td>01/04/2015</td>
</tr>
<tr>
<td>End-to-end revision of operational procedures for frontline and support staff, Including JAD.</td>
<td>01/04/2015</td>
</tr>
<tr>
<td>Bespoke IT generated fact sheet or generated information pack re service options</td>
<td>01/04/2015</td>
</tr>
<tr>
<td>Signposting to independent financial information &amp; advice</td>
<td>01/04/2015</td>
</tr>
<tr>
<td>Revised guidance for staff on safeguarding</td>
<td>01/04/2015</td>
</tr>
<tr>
<td>Guidance for staff on wellbeing</td>
<td>01/04/2015</td>
</tr>
<tr>
<td>Guidance for staff on Identification, appointment, and monitoring of independent advocacy</td>
<td>01/04/2015</td>
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### Charging & Financial Assessment
<table>
<thead>
<tr>
<th>KEY OUTPUTS BY WORKSTREAM</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Assessments ready reckoner tool and process</td>
<td>31/03/2015</td>
</tr>
<tr>
<td>Charging Policy</td>
<td>01/04/2015</td>
</tr>
<tr>
<td>Deferred Payments policy</td>
<td>01/04/2015</td>
</tr>
<tr>
<td>Letters on interest charges to existing DPA holders</td>
<td>28/02/2015</td>
</tr>
<tr>
<td>Deferred Payments module</td>
<td>13/03/2015</td>
</tr>
<tr>
<td>Wrap around information and advice for deferred payments</td>
<td>30/04/2015</td>
</tr>
<tr>
<td>Letter templates of financial assessments team</td>
<td>03/02/2015</td>
</tr>
<tr>
<td>Obtain property valuations on all existing DPAs</td>
<td>16/03/2015</td>
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</table>

**Commissioning**

| New interim advocacy provider specification                                               | 31/03/2015      |
| New interim advocacy gateway specification                                               | 31/03/2015      |
| New 2016 advocacy provider and gateway specifications                                    | 31/07/2015      |
| New 2016 advocacy tender documentation                                                  | 30/09/2015      |
| Screening assessment for advocacy                                                        | 31/03/2015      |
| Process map for advocacy                                                                  | 15/03/2015      |
| Interim new specification for Carers of Barking and Dagenham                            | 15/03/2015      |
| Long term new specification for carers’ support hub                                      | 30/06/2015      |
| Commissioning strategy                                                                  | 31/07/2015      |
| Prevention strategy as part of H&WB Strategy                                             | 16/05/2015      |
| Issue usual price for residential care for 2015/16                                        | 31/03/2015      |
| Provider Failure Regime - market analysis                                                | 30/04/2015      |
| Provider Failure Regime                                                                  | 30/06/2015      |

**Safeguarding**
### SUMMARY CARE ACT IMPLEMENTATION PROGRAMME

<table>
<thead>
<tr>
<th>KEY OUTPUTS BY WORKSTREAM</th>
<th>End date</th>
</tr>
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<tr>
<td>Performance &amp; Assessment Framework</td>
<td>April 2015</td>
</tr>
<tr>
<td>Safeguarding pages of website</td>
<td>April 2015</td>
</tr>
<tr>
<td>Annual Report</td>
<td>July 2015</td>
</tr>
<tr>
<td>Partnership Compact Agreements</td>
<td>April 2015</td>
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<tr>
<td>Information Sharing Agreement</td>
<td>April 2015</td>
</tr>
<tr>
<td>Strategic Plan</td>
<td>April 2015</td>
</tr>
<tr>
<td>Establishment of statutory Safeguarding Adults Board</td>
<td>April 2015</td>
</tr>
<tr>
<td>Establishment of sub-groups</td>
<td>April 2015</td>
</tr>
<tr>
<td>Agreement of budget contributions with partners</td>
<td>April 2015</td>
</tr>
<tr>
<td>Agreement of partner responsibilities</td>
<td>April 2015</td>
</tr>
</tbody>
</table>

**Workforce**

- Carry out training needs analysis: 30/09/2014
- Draft workforce development plan approved by CAPB: 15/12/2014
- Deliver training modules (Phase 1): 01/04/2015
- Deliver system specific training modules (Phase 2): 01/04/2015

**Integration (Housing)**

- Identify activity for Housing to be compliant with the Act (separate plan exists for these tasks)
CABINET
16 February 2015

Title: The Care Act 2014

Report of the Cabinet Member for Adult Social Care and Health

<table>
<thead>
<tr>
<th>Open Report</th>
<th>For Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wards Affected: All</td>
<td>Key Decision: No</td>
</tr>
<tr>
<td>Report Author: Glen Oldfield, Care Act Project Officer</td>
<td>Contact Details: Tel: 020 8227 5796 E-mail: <a href="mailto:glen.oldfield@lbbd.gov.uk">glen.oldfield@lbbd.gov.uk</a></td>
</tr>
</tbody>
</table>

Accountable Divisional Director: Ian Winter, Care Act Programme Lead

Accountable Director: Anne Bristow, Adult and Community Services

Summary

The Care Act 2014 is of considerable scale and impact and is the biggest package of reforms to adult social care in the last 60 years.

This report explains the rationale behind the reforms, gives an overview of the thrust of the Act and its main provisions, highlights the impact of the Care Act for the Council and our partners, and outlines our approach to implementation. The report also spells out implications for areas of corporate policy and the latest financial position.

Recommendation(s)

The Cabinet is recommended to note the impacts of the Care Act 2014 on the Council.

Reason(s)

The Care Act 2014 imposes significant legislative change on the Council and requires major changes to both policy and service delivery.

1. Background and context

1.1. The Care Act 2014 is the most comprehensive overhaul of social care since 1948, it consolidates and modernises all social care law into a single framework replacing a fragmented catalogue of legislation that was developed somewhat piecemeal. When the Care Act becomes operational from 01 April 2015 the following pieces of primary legislation will be repealed or disapplied:

- National Assistance Act 1948
- Health Services and Public Health Act 1968
- Local Authority Social Services Act 1970
- Chronically Sick and Disabled Persons Act 1970

Page 43
1.2. As well as consolidating the legislation, the Care Act 2014 seeks to bring social care law into the 21st Century. The Act enshrines in legislation and statutory guidance modern adult social care policy and practice. There is a new focus and direction for social care which centres on prevention, wellbeing, and personalisation. The main provisions of the Act are summarised in section 2 of this report.

1.3. The Care Act 2014 builds upon the Health and Social Care Act 2012 with the intention to strengthen integration between health and adult social care. It also responds to recent scandals such as Winterbourne View, the failures of Mid-Staffordshire NHS Trust, and the collapse of Southern Cross (a major provider of residential and nursing care) to which new duties regarding safeguarding vulnerable adults, raising care quality standards, and managing provider failure relate.

1.4. The Care Act 2014 also takes up the recommendations of the Dilnot Commission (2011) which proposed to help people with modest wealth and end unlimited care costs by putting in place a cap on the amount a person will pay for care in their lifetime. To achieve this, a package of funding reforms will come into effect from April 2016. Further information about these is set out in section 3 of this report.

1.5. Part one of the Care Act 2014, which covers care and support law, comprises 80 sections of primary legislation. In addition, 23 sets of regulations (secondary legislation) provide further definitions, explanatory notes, criteria, and legal duties which must be followed or applied in implementing the Care Act 2014. Further, the statutory guidance which accompanies part one of the Act consists of more than 400 pages of in-depth detail to implement the law and 9 technical annexes that describe specific processes, charges, or rules.

1.6. The statutory guidance was only finalised in late October 2014 leaving local authorities a very short period of time to implement a large package of reforms. With the majority of part one of the Act becoming operational from 01 April 2015 implementation is not only demanding and challenging.

2. Main provisions of the Care Act (April 2015 changes)

2.1. The Act introduces a number of new concepts into legislation as well as imposing new statutory duties and extending others.

2.2. At the heart of this legislation is a general duty on the Council to promote integration with health services and health related services. A key mechanism for achieving this is through the Better Care Fund (BCF). Our local plans for the BCF were agreed at

\footnote{As set out in Annex I of the Care and Support Statutory Guidance}
the Health and Wellbeing Board on 09 September 2014 and have now achieved full approval at a national level.

2.3. The Act also introduces the concept of ‘wellbeing’ and requires councils to have regard to this in designing and arranging all services – not only adult social care services. Alongside a requirement to prevent, reduce or delay the need for more intensive care services.

2.4. A wide range of changes are being made as to how individuals will access care and support and what local authorities are expected to do in terms of supporting residents. A new national eligibility criteria is introduced together with detailed requirements on how decisions are made and communicated. All individuals and carers will have the right to a personal budget. Attached at Appendix 1 is a summary of how the Care Act 2014 will affect individual residents.

2.5. The Act will put the Safeguarding Adults Board on a statutory footing and for the first time enshrines in legislation a duty for partner agencies to co-operate with the local authority (see also paragraph 4.6).

2.6. Whilst the main funding reforms will not come into force until April 2016 there are some financial matters that must be addressed this year. Elsewhere on this agenda are detailed reports on deferred payment agreements and a revised charging policy.

2.7. Another new area of legislation places responsibilities on local authorities to work with regulators and large providers of care and support to prevent business failure. Where there is a threat of business failure care; support providers must share commercial information with the Council and regulators so that plans can be made for continuing the care of their residents. In the event of provider failure Councils will have a temporary duty to meet the needs of individuals receiving care from that provider, this duty applies regardless of the person’s needs, status or ordinary residence.

3. Changes from April 2016

The Care Act 2014 responds directly to the Dilnot Commission (2011) which concluded that social care funding was unfair and unsustainable. From April 2016 the Act will introduce the following funding reforms:

3.1. Cap on care costs

3.1.1. Over a number of years campaigners have agreed that it is unreasonable that those people who have saved throughout their lifetime may find themselves having to use all their accumulated savings to pay for care and support. The Government have accepted this view and plan to introduce a cap on care costs; whilst at the same time introducing the concept that everyone should meet their own costs for accommodation and board.

3.1.2. The BBC has produced a care cost calculator which provides an indication of how this might work for individuals. http://www.bbc.co.uk/news/health-30990913

3.1.3. The introduction of the cap on care costs and changes to financial thresholds will have major implications for individuals that currently pay for their care and support.
3.1.4. The primary legislation gives a high-level description of the funding reforms however the draft statutory guidance on these areas of the Care Act 2014 has not yet been issued to local authorities. We expect consultation on the draft statutory guidance to begin shortly. Until such time we have limited information on the detail of the funding reforms and their implications for the Council. This will be subject to a later report to Cabinet.

3.2. **Appeals**

3.2.1. From April 2016 appeals may be made against decisions taken by a local authority in respect of individuals’ care and support. It will therefore be essential that needs assessment outcomes and eligibility determinations are sufficiently robust. Developing staff knowledge and application of the new assessment processes and eligibility criteria is key to avoid appeals once the mechanism is introduced.

3.2.2. As with the funding reforms the Department of Health has not yet issued the draft statutory guidance, this again means that we have limited information about what the appeals mechanism will cover and how the system will work.

4. **Implications for the Council**

Whilst the Care Act 2014 is principally focussed on adult social care functions there are implications for other directorates and service areas in meeting the duties and requirements of the legislation. The impacts across the authority are summarised below:

4.1. **Workforce training and development**

4.1.1. Because the new legislative changes are far more prescriptive about the assessment and care planning processes there are significant implications for council staff will need training and development to perform their roles in compliance with the law and in accordance with new approaches, processes, and in some cases IT systems.

4.1.2. A thorough needs analysis of training and development needs has been completed and this has led to the development of a three tier approach.

- **Tier 1** has already been delivered and comprised of briefings and activities to raise awareness of the changes giving an overview of the Act and its main provisions.
- **Tier 2** is designed to target the wider workforce focussing on changes to roles and responsibilities, the development of new local procedures, and changes to the adult social care pathway. This tier involves holding workshops on key subject matters (e.g. assessment, eligibility and care planning) and more specialist sessions for staff groups with unique roles.
- **Tier 3** is designed to test and refine learning from previous tiers and to road test newly developed processes and procedures. Learning will be through a rigorous simulation approach to identify and address issues as well as reinforce learning.
4.1.3. The Workforce Development Programme covers over **280 staff** across directorates including Housing, Children’s, Legal, Finance, and staff from integrated teams and the NHS. We are also targeting 100 delegates from local providers in order to develop knowledge within the local care and support sector.

4.2. **Housing**

4.2.1. Housing plays a key role in the health and wellbeing of an individual, or households, in a number of ways. Homes that are well built, safe, warm and affordable, in attractive neighbourhoods and settings, are cornerstones to the physical and mental wellbeing of people. Decent and suitable accommodation can also be an important factor which enables and allows engagement in work, training and education as well as family and social relationships. Adaptations and modifications as well as housing related support services are also critical in enabling people to live as independently as possible whilst retaining control over their own lives.

4.2.2. The Care Act 2014 places great prominence upon housing services and states that the provision of suitable accommodation is an integral element of care and support. Suitability of living accommodation is defined by the Act as one of the principles of wellbeing and is one of the matters which must be taken into account as part of the duty on a local authority to promote wellbeing. Housing also has a central role to play in prevention, safeguarding, and in working in an integrated and cooperative environment.

4.3. **Children’s Services**

4.3.1. The Care Act 2014 impacts on Children’s Services in four key areas related to transitions of young people into the adult social care system. Those four areas are:

- Outcomes and wellbeing
- Assessment and planning
- Joint commissioning and personal budgets
- Information and advice

4.3.2. The work to align the transitions duties/requirements in the Care Act 2014 with complementary duties in the Children and Families Act 2014 is being taken forward through the Council’s Transitions Strategy Group. Key pieces of work in this programme include:

- Developing capacity and competency in outcome focused support planning across children’s and adults’ services.
- Ensuring that the process for adults’ needs assessment and care and Support plan for young people post-18 are aligned to the assessment and planning process for the care element of an Education and Healthcare Plan.
- Ensuring more effective use of personal budgets (from age 16) that lead to better outcomes for young people moving into adult service provision.
- Producing an indicative personal budget for adult care and support as part of the children’s needs assessment.
- Ensuring there is a strategic approach to developing good information and advice for young people moving into adulthood.
• Strengthening the Local Offer by developing the provision of information and advice for disabled young people (aged 18-25) and those with special educational need and their families.

4.4. **IT development**

4.4.1. The range of legislative changes have significant IT implications which given the very short lead-in times are proving challenging for all IT system suppliers. Another round of changes will be required for 2016 and may also have short lead-in times. It should be noted that these changes impact not only on our electronic social care record system but also have implications for our web presence, financial systems and online applications.

4.4.2. Our current social care record system IT contract runs to April 2017. Officers are therefore now reviewing its ability to meet the future needs of both adult and children’s social care.

4.5. **Policy changes**

4.5.1. The Care Act 2014 has required the Council to review its policies and practice in a number of areas to ensure compliance with the new legislative requirements. In addition to the two reports elsewhere on this agenda there have been previous reports to the Health and Wellbeing Board (see background papers at paragraph 12).

4.5.2. In March 2015 the Health and Wellbeing Board will consider reports as to how the Council will discharge its responsibilities to improve information and advice on care and support to local people. It will also consider a report proposing a revised Carers’ Strategy.

4.5.3. Later, in May 2015, the Health and Wellbeing Board will be asked to consider not only the revised Health and Wellbeing Strategy but also a new strategy setting out the Authority’s approach to the new prevention duty.

4.6. **Safeguarding**

4.6.1. The Care Act 2014 places Safeguarding Adults Boards (SAB) on a statutory footing. In light of this the SAB has been developing new governance arrangements based on a model that was agreed by the SAB in December 2014. Whilst the principles of how the SAB will be governed have been agreed there is much work in hand to consolidate those arrangements. The Cabinet Member for Adult Social Care and Health will be consulted as the Chair of the SAB along with other key stakeholders to refine and embed new and developing governance arrangements. This includes developing a new assurance framework, reviewing local safeguarding procedures and protocols, and compacts/agreements to ensure co-operation between agencies.

4.6.2. The SAB will also be responsible for producing an annual strategic plan to co-ordinate safeguarding activities and an annual report to demonstrate its impact and delivery of the annual strategic plan. The Council will therefore play a key role in producing these important documents with input from other SAB member agencies.
4.6.3. The guidance introduces a new relationship between the Chair of the SAB and the local authority chief executive bringing this into line with the arrangement for local safeguarding children’s boards.

5. **Implications for partner organisations**

5.1. The Care Act 2014 has wide ranging implications for a number of partner agencies but most specifically for NHS organisations. These new provisions require not only action from individual NHS bodies but will also require both policy and commissioning alignment of partnership working to deliver the expected outcomes.

5.2. The Council’s implementation team has offered support to partner agencies and the Health and Wellbeing Board has sought assurance from partner bodies about system readiness by means of a report to its February meeting.

6. **Approach to implementation**

6.1. Due to the scale and scope of the Care Act 2014 the Council has established a cross Directorate Care Act Programme Board chaired by the Corporate Director of Adult and Community Services to oversee implementation. This work is supported by a small programme team.

6.2. Wherever possible the Council has drawn on national and regional implementation work. Officers have actively participated in all the regional fora and led some workstreams. An example of this is the national communications materials.

6.3. The Department of Health in partnership with Public Health England have launched a public awareness campaign to help people understand the changes and spread key messages. The national campaign features radio advertising, door drops, newspaper and magazine features, and information provided to GP surgeries. A local communications plan has been developed to supplement those activities. To this end the Council is using a Department of Health toolkit to produce locally specific messages and materials.

6.4. Nevertheless, the lateness of regulations and detailed statutory guidance (which differed significantly from earlier drafts) means that the timetable and workload is extremely challenging.

6.5. It is anticipated that the Council will be able in all material matters to discharge its new responsibilities from 01 April 2015. However, some system development and work to fully embed the changes will require further work post-April to delivery efficiently.

7. **Financial Implications**

Implications completed by Roger Hampson, Group Manager, Finance

7.1. Following the Chancellor’s Autumn Statement in December, the Department of Health (DH) has now published information providing additional details of specific grants and other funding streams to support the implementation of the Care Act 2014. In addition, some existing budgets within base are being refocused to support implementation as appropriate where the current activity directly impacts on the
delivery of the Care Act 2014. The Care Act Programme Board is working through the identification of implementation costs and allocating these against funding streams. Further details of these funding streams are provided below. Once this process is complete Members will be asked to make decisions about how those funding streams are to be spent for the purpose of implementing the Care Act 2014.

7.2. The major financial impact for local authorities as a result of the Care Act 2014 is from 2016/17 with the raising of ceilings where individuals will pay less towards their care costs, and the local authority will pay more. Further draft guidance is expected to be published shortly, and further financial modelling work then will be undertaken to estimate the likely impact on the Council. Provisionally, this is calculated at £4.5m; details of additional funding from central government may not be announced until after the General Election, possibly in December 2015.

7.3. One-off funding streams to support the implementation of the Care Act in 2014/15 are:

- DH Development Fund - £125k available to each local authority
- Allocation from Regional Training resources - £16k
- Call on departmental reserve already agreed by Cabinet - £500k.

7.4. Funding streams available in 2015/16 are:

- New Burdens Grants for early assessments (£331.1k), deferred payments (£230.5k), and for Carers (£211.1k)
- Social Care Capital grant of £508k of which £200k has been nominally allocated for IT aspects of the Care Act 2014
- Better Care Funding from the CCG of £513k subject to finalisation of the s75 agreement (including funding for Independent Mental Health Advocacy and Disregards for Guaranteed Income Payment for Veterans).

7.5. However pressure and demand for services and resources is impossible to determine. The pressure points are:

- Demand for assessments and services, and demand from carers given their new rights to services.
- Increased expectations for prevention and wellbeing services/interventions.
- From April 2016, demand for services from self-funders. Notably managing care accounts and supporting systems for the cap on care costs.

8. Legal implications

Implications completed by Dawn Pelle, Adult Care Lawyer

8.1. The legal implications for the authority will be immense if the Care Act 2014 processes are not adhered to. The statute requires written confirmation in a number of areas. Further there are clear processes which if not followed could lead to challenges by way of appeal when it is operative, or for now challenges in the High Court. This means that there has to be meticulous recording and documentation by staff as they will have to justify decisions they make in their assessments. All teams that will be working with the statute should have at least one copy of the Care Act Manual\(^2\) as Community Mental Health Teams have the Mental Health Act Manual.
9. Other implications

9.1. Risk Management - The Care Act implementation programme carries risk in several areas. Major risks include:

- Short timescales in which to deliver the reforms compounded by late issuing of statutory guidance
- Affordability of meeting the Care Act 2014 requirements
- Legal challenge due to non-compliance with regard to social care practice/procedure
- Implementing changes to IT systems by 01 April 2015
- Workforce capacity and skill

Risks are managed through the Care Act Programme Board through the Programme Risk Log which is reviewed regularly. Care Act 2014 implementation also features on the Corporate Risk Register to ensure oversight of risk and escalation of issues if needed.

9.2. Corporate Policy - Further to policy implications highlighted in section 5 of this report, the Care Act 2014 will require the Council to develop its approaches to commissioning. The statutory guidance on market shaping introduces new requirements that promote choice and control (personalisation), wellbeing, higher quality standards for services, and improved competency levels for commissioning. The guidance recommends that authorities develop strategies to demonstrate how the commissioning function aligns with legal duties, corporate plans, local needs analysis, and market intelligence in order to deliver outcomes for the individual and collectively. In light of this requirement a prevention strategy is being developed, it will be presented to the Health and Wellbeing Board for agreement in May 2015.

9.3. Customer Impact - A central tenet of the Care Act 2014 is to put the individual in control of decisions about their care and support and to achieve personal outcomes to that individual through care and support services (and universal service provision). Work to develop approaches to assessing need, managing transitions between children’s and adult’s services, and changes to how we will conduct financial assessments are examples of how implementing the Care Act will contribute to improving the overall customer experience.

9.4. Health issues - New duties around promoting wellbeing and taking steps to prevent and delay the onset of care and support needs will contribute the overall health of residents.

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2 Tim Spencer-Lane (Sweet & Maxwell, 22 Sept. 2014)
Public Background Papers Used in the Preparation of the Report

- Care Act Statutory Guidance
- Health and Wellbeing Board reports (09 December 2014, 29 July 2014, 11 February 2014)
- Care Act Programme Board documentation

List of appendices

- Appendix 1: Care Act Briefing
Introduction

This briefing focuses on how individual residents will be affected by the provisions of this new legislation from 01 April 2015.

The Care Act 2014 is the most comprehensive piece of social care legislation since 1948. It consolidates and modernises all social care law into a single framework.

As well as consolidating the legislation since that date it sets out a new focus for social care policy and practice. This starts with prevention, wellbeing and personalisation. In doing so it builds on the integration necessary to achieve these outcomes between health and adult social care. It also responds to the failures at Winterbourne View, Mid-Staffordshire NHS Trust, and the collapse of a major residential and nursing care provider and the need to provide for a stable market for vulnerable people. The Care Act also takes up the recommendations of the Dilnot Commission by placing a cap on the amount a person will pay for care in their lifetime.

At a practice level there a number of key changes to achieve the requirements of the legislation and a summary of these are set out on the pages that follow. With those practice changes in mind this briefing also sets out the key changes for the Council and a short summary of actions that are in place to implement the Care Act.
Wellbeing applies to us all. It is very individual. The Care Act defines it as:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal
- suitability of living accommodation
- the individual’s contribution to society

What is different

- Wellbeing is about all aspects of the individual and their family, friends, social lives and hopes for the future
- It is a new requirement for the Council, and its partners. It impacts on policy, procedure, practice and services

What are we doing

- Applying the wellbeing principle in assessments of need
- Considering how all Council services demonstrate their contribution to wellbeing
- Developing the workforce (over 300 staff and 100 third sector partners) to apply wellbeing principles in care and support interactions
Prevention

Prevention is at the heart of every assessment and requires the direct cooperation of key partners and other areas of the council (e.g. leisure).

We will be setting out our prevention strategy in March 2015 on the basis that prevention starts with the individual and their family, friends and neighbourhood. It is based on the Council’s principle of enabling social responsibility.

Where more help is needed, then the wider community, other organisations and the role of the Council will be combined to focus on delaying or reducing the impact of care needs. The intention is to enable people to remain in the community with friends and family for as long as possible.

What is different

- Prevention is essential in all information and advice
- It is a key part of the Health and Wellbeing Strategy
- We have a duty to reduce and delay the impact of care needs
- Duty applies to all council services, with support from care and support sector

What are we doing

- Developing a comprehensive prevention strategy based on the Council’s priority of encouraging social responsibility
- Working with partners to reinforce the prevention responsibilities
- Working with the NHS and others to develop local provision of preventative support services
- Developing the workforce to identify the need for preventative support and to signpost to appropriate services
**Care Act 2014**

**What’s new and what does this mean**

### Information and advice

Information and advice must be available to everyone who may need care and support even if the local authority is not providing the care services. Information must:

- be accessible
- be clear about services and financial information and advice
- be clear about prevention services
- be available to individuals and carers
- set out our approach to assessment and eligibility
- cover the subject of keeping safe and safeguarding
- signpost to independent advocacy

### What is different

- Information and advice is available to everyone - including those who pay for their care
- All those who enquire will need a personal and directed response
- The Council must co-ordinate local provision of information and advice
- The Council must ensure comprehensive financial advice is available about the costs of care and options for paying

### What are we doing

- Developing a plan to ensure quality, access and appropriate content
- Developing IT systems, particularly our online presence
- Working with the Contact Centre and the Intake and Access Team to develop approaches
- Working across the Council, and with service users and local providers, to develop materials
Assessment

Assessment should start with what the individual and their carer can do and their expectations. It should not be based on available services only, or their ability to pay.

It must:

- start with the individual and their family or networks
- consider wellbeing and prevention at the outset
- be combined with health where needed
- include the individual’s self assessment
- provide speedy and accurate financial assessment
- be joined up wherever possible, especially with the NHS

What is different

- Anyone, regardless of funds, can ask for an assessment
- Carers have a right to an assessment and subsequent services
- Must look at the wider family and social networks for support
- Outcomes of the assessment must be reported to the individual
- Assessments can be proportionate
- Consider fluctuating needs and look into the future

What are we doing

- Developing social care practice and IT systems to support practitioners
- Re-designing financial assessments for timely information about notional costs and contributions
- Working with the NHS and Joint Assessment and Discharge (JAD) Team to align processes
Eligibility

National eligibility criteria will be in place to ensure consistency. The criteria set a minimum threshold for adult care and support and individual carer support which all local authorities must meet. This means that eligibility is portable from place to place.

In summary, eligibility is determined by how well the individual can:

- look after themselves (food, washing, toileting, clothing)
- be Safe in their home and keeping the home habitable
- develop and maintain family or personal relationships to help avoid loneliness or isolation
- engage in work, training, education or volunteering (where appropriate)
- use local community or public facilities
- care for a child

What is different

- National eligibility for all
- Eligibility for carers
- People must be told of eligibility decision
- Achieves fair and consistent system

What are we doing

- Workforce development to ensure consistent approach to eligibility determinations – this includes integrated teams
**Personal budgets**

Personal budgets and direct payments are now set out in law giving people choice and control about how their care and support is provided. They must be offered to everyone. The individual may ask the Council to arrange their care and support.

**Self-funders**

Local authorities now have responsibilities to people who can pay for their care. This means providing information and advice, assessment, and advocacy. Funding reforms that come into effect from April 2016 will introduce a cap on care costs and care accounts to manage progress towards that cap. Self-funders can also ask for advice and options about their care costs.

**Deferred payments**

The borough must have a sound system for all individuals to defer their payments for residential or nursing care. This means that where they own a property they will not be required to sell it at that time (from April 2016 these costs will be capped). Full guidance is awaited and this is a complicated area of work.

**What is different**

- Personal budgets are now mandatory
- Self-funders are entitled to assessment, if eligible then they will need a notional personal budget and care account
- Deferred payments are available to all those who meet criteria

**What are we doing**

- Revising the Fairer Charging Policy to bring up to compliance with the Care Act
- Developing a new deferred payment agreement, and supporting systems
- Working with practitioners to ensure effective use of personal budgets and Direct payments
- Considering approaches for working with self-funders from April 2016
Safeguarding

The Care Act strengthens safeguarding of vulnerable adults in several ways:

- Under the Care Act Safeguarding Adults Boards are now statutory. The core membership of the Board is prescribed in the legislation.

- Partner agencies or persons have a duty to co-operate with the Council on safeguarding matters and to supply information upon request.

- Enquiries must be conducted by agencies where there is risk or suspicion of abuse or neglect.

- Serious Case Reviews have been given a statutory status in circumstances where there is serious neglect, abuse or death.

- Ensures peer challenge between board members.

What is different

- Duty on partners to report concerns
- Duty on Council to act, or ask others to act
- Stronger monitoring of all agencies' performance through the statutory Safeguarding Adults Board
- Must strategically plan safeguarding activities based on local priorities

What are we doing

- Re-organising the Safeguarding Adults Board (SAB) as a statutory body.
- Changing sub-groups of the SAB to reflect and support new arrangements
- Establishing principles of financial contributions from SAB members
- Outlining collective and individual responsibilities of SAB members and working on commitments and agreements to ensure performance and accountability
Individual advocacy

The Care Act sets out criteria for providing independent advocacy. These are:

- Where the person may have substantial difficulty being involved – tested by:
  - understanding relevant information
  - Retaining information
  - using, evaluating or ‘weighing’ the importance of information or choices
  - communicating their wishes or feelings (through whatever method)

- Advocates are to be used in:
  - supporting initial information
  - assessment of needs
  - safeguarding enquiries and reviews
  - care planning
  - care and support reviews

What is different

- Existing advocacy will not be sufficient for the new tasks
- Advocacy will be required at very early stages of service user involvement
- Advocates will need some training and accreditation

What are we doing

- Reviewing current use of existing advocacy
- Developing interim commissioning arrangements for 2015/16
- Working through longer term commissioning approach for independent advocacy
- Exploring training options for independent advocates
### Outline of key terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td><strong>Wellbeing</strong></td>
<td>This is about the individual and what most affects their life and feelings.</td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td>This is about the practical steps that could delay, or reduce the need for more intensive services.</td>
</tr>
<tr>
<td><strong>Information and advice</strong></td>
<td>People must be offered information and advice regardless of their financial means to help them to make choices about the care and support that is best for them.</td>
</tr>
<tr>
<td><strong>Advocacy</strong></td>
<td>This means an advocate who can support the person to put forward their views, wishes and feelings, where this is needed.</td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td>This means the way in which social workers and others will gather information about someone’s needs and circumstances. Assessment of need is for both individuals and for carers.</td>
</tr>
<tr>
<td><strong>Eligibility</strong></td>
<td>This is nationally set out and determines who should receive services or personal budgets (also applies to carers).</td>
</tr>
<tr>
<td><strong>Personal budgets</strong></td>
<td>Must be offered to all, but individuals can ask the Council to arrange and/or provide care and support.</td>
</tr>
<tr>
<td><strong>Care plan and review</strong></td>
<td>This is the way in which the required services will be used and responsibilities of all those who are working with the individual. Annual reviews must be held and take into account changes in circumstances or need.</td>
</tr>
<tr>
<td><strong>Deferred payments</strong></td>
<td>The borough must have a sound system for all individuals to defer their payments for residential or nursing care. This means that where they own a property they will not be required to sell it at that time.</td>
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</tbody>
</table>
# HEALTH AND ADULT SERVICES SELECT COMMITTEE

## 4 March 2015

### Barking & Dagenham HealthWatch Enter and View

<table>
<thead>
<tr>
<th>Open Report</th>
<th>For Information</th>
</tr>
</thead>
</table>
| **Report Author:** Masuma Ahmed, Scrutiny Officer | **Contact Details:**  
Tel: 020 8227 2756  
E-mail: masuma.ahmed@lbbd.gov.uk |

| **Accountable Divisional Director:** Bruce Morris, Adult Social Care |

| **Accountable Director:** Anne Bristow, Adult and Community Services |

### Summary:

The local HealthWatch, the consumer champion for both health and social care, aims to give local residents and communities a stronger voice to influence and challenge how health and social care services are provided within the Borough. The role of the local HealthWatch is to undertake local research about what people who use services are looking for and identify gaps in service.

Legislation, including the Health and Social Care Act 2012, gives local HealthWatch bodies the power to carryout ‘enter and view’ of health and social care premises to see for themselves how services are provided. After conducting an enter and view, HealthWatch bodies may produce a report and recommendations for the service provider to action.

On 8 October 2014 Barking and Dagenham HealthWatch carried out and ‘enter and view’ of Fern Ward, King George Hospital. The report resulting from the enter and view, the response from the provider, BHRUT, and the action plan arising from the visit are appended to this report.

### Recommendation(s)

The Health and Adult Services Select Committee (HASSC) is recommended to note the report and provide its comments on the enter and view to the HealthWatch representative at the meeting.

### Reason(s)

It is good practice for HealthWatch to share its information about health services with the HASSC to support the Committee in its ‘critical friend’ function.
Background Papers Used in the Preparation of the Report:

None

List of appendices:

Appendix 1  HealthWatch Enter and View Report
Appendix 2  BHRUT response letter dated 22 Jan 2015
Appendix 3  Action Plan arising from the visit
Enter & View Visit
Fern Ward
Medicine and Elderly Care Ward
King George Hospital

For further copies of this report, please contact

Info@healthwatchbarkinganddagenham.co.uk or
Telephone: 020 8526 8200

www.healthwatchbarkinganddagenham.co.uk
<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Summary</td>
<td>4</td>
</tr>
<tr>
<td>Details of the Visit</td>
<td>5</td>
</tr>
<tr>
<td>The Wards’ Services</td>
<td>6</td>
</tr>
<tr>
<td>Patients Experiences</td>
<td>7</td>
</tr>
<tr>
<td>Additional Information</td>
<td>10</td>
</tr>
<tr>
<td>Conclusion and Recommendation</td>
<td>14</td>
</tr>
</tbody>
</table>
Introduction

Healthwatch Barking and Dagenham is the local independent consumer champion for health and social care. We aim to give our citizens and communities a stronger voice to influence and challenge how health and social care services are provided for people in the borough.

Enter & View is carried out under the Health & Social Care Act 2012. It imposes duties on certain health and social care providers to allow authorised representatives of local Healthwatch organisations to enter premises and carry out observations for the purposes of Healthwatch activity.

Authorised representatives observe and gather information through the experiences of service users, their relatives/friends and staff to collect evidence of the quality and standard of the services being provided.

To do this we:

- Enable people to share their views and experiences and to understand that their contribution will help build a picture of where services are doing well and where they can be improved.

- Give authoritative, evidenced based feedback to organisations responsible for delivering and commissioning services.

- Are able to alert Healthwatch England or the Care Quality Commission, where appropriate, to concerns about specific service providers of health or social care.
Summary

Healthwatch Barking and Dagenham authorised representatives undertook the visit to speak with patients about three areas of care during their hospital stay: nutrition, personal hygiene and interaction between staff and patients. We spoke to 10 patients on the day of the visit.

Overall patients were satisfied with the meals provided and felt that they were given a choice of what they would like to eat. In terms of drinks, all patients were not aware that soup or a milk drink was available. There were concerns raised about catering staff asking if people want a drink only from the entrance of the bay. This was a problem for those who had hearing impairments and also for those who were in the bathroom or asleep at the time.

Patients highlighted that staff had a lot to do but do try their best to provide the care they can.

Although patients were satisfied with their bedding being changed and staff helping them with bathing, issues were raised by relatives about incontinence items not being changed overnight.

All patients have an information board placed behind the bed. Relatives indicated that these are not always updated to reflect the correct information.
Details of the Visit:

Date:
8th October 2014

Premises Visited:
Fern Ward, King George Hospital

Enter & View Authorised Representatives:
Barbara Sawyer
Val Shaw
Manisha Modhvadia (Healthwatch Officer)

Specific Areas Identified for Observation:
- Nutrition
- Personal Hygiene
- Interaction between Staff and Patients

Reasons for the Visit:
To visit wards that provide in-patient hospital services for older people - to gather the views and experiences of patients about the services being provided to them. This Enter & View visit is part of a wider programme being undertaken by Healthwatch Barking and Dagenham around issues concerning health and social care services for older people and is as a consequence of findings from the Francis Report. Healthwatch have undertaken a visit previously to Queens Hospital as part of this work programme and wanted to determine parity of care across the Trust.

Purpose of the Visit:
To ascertain patients’ views on the choice and quality of the food and drink they receive; to ask patients and their visitors about the staff interaction with them and to get views and comments about the quality of personal hygiene support that patients receive.

Healthwatch authorised representatives spoke to 10 patients on the day of the visit.
The Wards’ Services:

The ward has 30 beds: split into 4 units with 6 bays each, set up as single sex units. There are 4 side rooms.

It is a medicine ward for elderly care.

Visiting times start at 10.30am till 7.30pm and patients are provided with 2 cooked meals a day.

Staffing arrangements:

**Morning:** 6 Qualified Nurses and 3 Health Care Assistants

**Afternoon:** 4 Qualified Nurses and 3 Health Care Assistants

**Evening/Overnight:** 3 Qualified Nurses and 3 Health Care Assistants

During the weekend the staff numbers drop by 1, in all categories.

During the visit, the staff from the ward were very helpful and assisted by providing all information that was requested.

Healthwatch Barking and Dagenham would like to thank the staff for their assistance and co-operation during our visit.

On entering the wards, each one has a sink near the entrance to encourage visitors to wash their hands as well as use the alcohol hand rubs.

Information boards were observed on the wards’ reception areas.

We saw a system of red trays and water jugs with red lids being used to identify patients that required help with feeding and drinking.
Patients’ Experiences:

Nutrition:

Healthwatch representatives were not looking at nutrition on the wards from a Dietician’s perspective, but from the point of view of the patients.

The questions asked centred on the help patients get to eat and drink, whether they can choose the food they eat and if they feel it is of good quality.

On the day of the visit Healthwatch representatives spoke to ten patients.

Generally, patients found the quality of food to be satisfactory. Healthwatch Representatives observed a red tray and lid system being used. Every patient had a red tray and lid. A staff member told Healthwatch Representatives that all the patients in the ward had them as it’s an elderly ward.

Patients were asked if they are helped with food and drink, four patients told Healthwatch representatives that they did not need any help but were sure a member of staff would help them if they did. Five patients out of the ten said they received help.

Eight patients said they were happy with the size of food portions provided and two said they were not.

Patients’ opinions varied on the choices of food.

Comments included:

“I was given what the patient before ordered; there was no other alternative choice for me”.

“I am given a menu to choose from and the choices are good”

“Yes I am given choices by the menu”.

“I have had sandwiches the bread is too thick, Its needs to be thin bread”
In discussion with patients and relatives it came to light that some patients are not being helped with the menu options, the menu is left on their table to complete by themselves.

Comments included:

“Don’t always get what you want, not much help to fill out the menu option, there are a lot of the elderly people in here who are confused and are left to fill in the options.”

” I cannot read very well, as my sight is very poor, the staff do not always do the menu with me.”

Relatives highlighted that patients were not aware that they can ask for a milk drink or a cup of soup. It’s only when a patient or a relative ask staff that they become aware of this.

Healthwatch representatives spoke to patients about drinks. Out of the ten patients 5 mentioned that catering staff only came to the doorway and ask patients if they wanted a drink. One patient on the ward, who was hard of hearing, told us that she has missed out on drinks due to this.

Patients also told us that catering staff do come back to ask if they would like a drink. Patients who are asleep or in the bathroom miss out on having a drink.

One relative spoke about his mother’s care on the ward. His mother, he explained, his mother is a stroke victim and unable to use one side of her body. No staff member had helped her to have a drink and her jug was left on the side of the table where she was unable to reach it. No beaker was provided to the stroke patient until a relative asked for one.

Comments from patients

“You have a menu that you can choose from. I am happy with the choices, sometimes if I don’t like something, the staff will give me something else but it depends on if there is anything left”

“Not aware that soup is an option, unless you ask, you would not know that’s its available, it’s only a packet of soup, but people still need to know it’s an option”

“Yes food is hot enough for me”
“Two hot meals a day, but when I have had sandwiches the bread is too thick, it needs to be thin bread”

“Plenty of water in the jug”

“Always enough water and drinks”
Personal Hygiene:

Patients were asked for their views and experiences of personal care support: was it meeting their needs and was it being carried out in a way that preserved their dignity?

Overall, patients were satisfied with the way they were being cared for and said that they were treated with dignity and respect. All patients that were asked said that their bed linen was changed every day.

Patients and relatives commented on the call button: highlighting that it took a while for staff to attend to patients once they had buzzed.

One relative spoke to Healthwatch Representatives about his mother’s experience within the ward. He felt that the staff seem to be very busy but try their best. His concern was over the call buttons “I told the nurse that the call button does not work: the nurse told me that the button would be fixed the following day. I felt uncomfortable leaving my elderly mother without having a way to call for help overnight. The nurse then got some sellotape as a temporary measure. My mother has been here over two weeks and the problem has not been dealt with.”

Relatives were concerned that patients were not being asked about changing incontinence pads overnight. A relative commented, “One morning I came in my mother was drenched, although the nurses changed her and gave her a bed bath, this would not have happened if someone asked if she needed a change.”

Two patients told us that when they use a bedpan, they are left with the bedpan and the nurse goes to deal with something else and then they are left waiting until she comes back. The patients said the position is uncomfortable.

Comments from patients

“I wash everyday”

“I can use the toilets, wash every day, I do wear continence items.”

“Would help if asked, but can wash myself”

“Overnight no one asks if you need a change.”

“I had to wait a while before anyone came to take the bedpan”
“After using the buzzer there was no response and therefore her daughter had to go to the desk”

“It does take staff a while to come I know they have a lot to do”
**Staff interaction**

Healthwatch representatives wanted to explore the experiences that patients and relatives had when interacting with hospital staff.

We spoke with patients; we wanted to know if they had been treated with respect and dignity during their stay: that the staff responded to requests for assistance in a timely way and whether patients understood why they were in hospital and the treatments they were being given.

Overall patients were generally happy with their experience of the staff.

Patients felt that sometimes staff had a lot to do but tried their best. Feedback from some patients showed that staff treat them with respect and are approachable.

Comments from patients included
“Staff do treat me well”,
“Very pleasant”
“Yes staff are very nice”.
“Patients are put at the end of the queue”.

Comments from other patients and relatives however, were less favourable:

“I had to wait one and a half hours for them to set up a commode”.

Two relatives who were spoken to on the day felt that if they were not there, their relative would be left alone all day, they felt a befriending service of some sort would be of great help.

Some patients said they are given an explanation about their treatment and medication, whilst others said they were not told what was going on.

Relatives who were present on the day said doctors had explained what medication their relative was taking. One relative said “I am glad I know what is going on, as a carer I need to know what is happening with my mother or it will make things a lot worse when she comes home and I have no idea.”
Additional information

Representatives observed information boards above each bed, they consisted of patient information, including the patients name, the date, the nurse and consultant who were treating the patient.

Three relatives indicated issues with incorrect information being displayed on the boards.

One relative told Healthwatch Representatives that staff had swapped their relative and other patient between bays. However once this was done the information on the boards were left with incorrect details of the patient. Another relative said that although the boards are a good idea, at times the details of the nurse who is treating the patient are incorrect.

The third relative told us that there is vital information that nurses keep missing out such as their mother only being able to drink with a beaker. The relative felt this information should be on the board so that all staff are aware and catering staff know that the patient needs her water in the beaker.

Incorrect or incomplete information on these boards is inconvenient at the best, and could possibly be dangerous. This is particularly the case if the wrong name and details are mistakenly left over a bed when patients are moved.
Conclusion and Recommendations:

Overall feedback indicates that majority of patients were happy with the portions of food they receive. However issues were raised about catering staff and the communication with the patient when distributing drinks and the food menu.

Information boards were an issue raised by relatives in particular. Their feedback indicated that incorrect information was being displayed. Healthwatch Representatives felt that incorrect information could have serious implications, especially in terms of the wrong medication being given to the patient.

Patients did not have issues with bathing. However feedback that was received about the management of incontinence items show that improvements need to be made.

Taking into consideration the views of patients and relatives Healthwatch recommend:

- Catering staff distributing tea and coffee need to each individual patient and ask if they would like a drink. This is essential on an elderly ward, where patients could be confused and for those with hearing impairments.

- Before leaving the ward, catering staff should ask those who may have been having a wash/gone to the toilet if they would like a drink.

- All patients should be asked if they need help filling in the menus.

- Staff need to double check that patient information boards display the correct information at the beginning of their shift.

- Where patients are using a bedpan, staff need to wait for the individual to finish using the bedpan so they are not left waiting in a uncomfortable position longer then they need to.

- All call buttons on the ward need to be checked to ensure they are in working order. If a call button is not working an alternative method needs to be provided to ensure the patient has a way of calling staff when they need to.
Appended: BHRUT response to the enter and view and Action Plan arising from the enter and view visit
Ref: HWB&D/E&V007/2014/BHRUT/OP Fern Ward

22nd January 2015

Manisha Modhvadia
Healthwatch Officer
Healthwatch Barking & Dagenham
Harmony House CIC
Baden Powell Close
Dagenham, Essex
RM9 6XN

Sent via email

Dear Manisha,

Enter & View Report – Fern Ward

Thank you for your letter dated 15th December 2014, received on the 23rd December 2014, which has been passed on to me by Flo Panel-Coates, Chief Nurse.

I am writing to confirm that we agree with the content of your report and herewith attach an action plan which contains the recommendations made following your visit.

The Matron for Fern Ward, Connie Hughes will ensure that the recommendations are delivered and progress monitored.

If you require any further information, please do not hesitate to contact me.

Yours sincerely,

Gary Etheridge
Deputy Chief Nurse

Enc.

cc: Connie Hughes, Matron
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Healthwatch Barking & Dagenham carried out an Enter & View Visit on Fern Ward at King George Hospital on the 8th October 2014. The action plan below includes the recommendations that were made following the visit.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Lead</th>
<th>Timescale</th>
<th>Actions Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catering staff distributing tea and coffee need to go to each individual patient and ask if they would like a drink. This is essential on an elderly ward, where patients could be confused and for those with hearing impairments.</td>
<td>Mary Etchells, Senior Sister</td>
<td>With immediate effect</td>
<td>Recommendation discussed with Karen Burroughs from Sodexo. Ward Sisters to oversee that this is carried out for each patient in each bay daily. Sodexo Supervisors to monitor that the housekeeper is going into the bays and offering drinks to every patient, using the correct cup, beaker. Escalation to Matron Hughes in the event this is not being maintained.</td>
</tr>
<tr>
<td>Before leaving the ward, catering staff should ask those who may have been having a wash/gone to the toilet if they would like a drink.</td>
<td>Mary Etchells, Senior Sister</td>
<td>With immediate effect</td>
<td>Recommendation discussed with Karen Burroughs from Sodexo. Ward staff to ensure all patients receive appropriate drinks daily and escalation to Matron Hughes if housekeepers fail to deliver this action.</td>
</tr>
<tr>
<td>All patients should be asked if they need help filling in the menus.</td>
<td>Mary Etchells, Senior Sister</td>
<td>With immediate effect</td>
<td>Volunteers currently assist patients when on the wards with the support and guidance from the nursing and care staff on the ward.</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Lead</td>
<td>Timescale</td>
<td>Actions Taken</td>
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<tr>
<td>Health Care Workers need to ensure patients are supported to complete their menus daily and to ensure they are collected and given to the kitchen staff daily. To be monitored by Registered Nurses.</td>
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<tr>
<td>Staff need to double check that patient information boards display the correct information at the beginning of their shift.</td>
<td>Mary Etchells, Senior Sister</td>
<td>With immediate effect</td>
<td>Daily checks of patient boards to be undertaken by the Nurse in Charge. Matron to check compliance daily.</td>
</tr>
<tr>
<td>Where patients are using a bedpan, staff need to wait for the individual to finish using the bedpan so they are not left waiting in a uncomfortable position longer then they need to.</td>
<td>Mary Etchells, Senior Sister</td>
<td>With immediate effect</td>
<td>All staff are aware of the issues and have been instructed to remain by the patients when they are using bedpans, but far enough to ensure privacy. Call buzzers to be in easy reach of all patients.</td>
</tr>
<tr>
<td>All call buttons on the ward need to be checked to ensure they are in working order. If a call button is not working an alternative method needs to be provided to ensure the patient has a way of calling staff when they need to.</td>
<td>Mary Etchells, Senior sister</td>
<td>With immediate effect</td>
<td>The patient’s Named Nurse to ensure that they have call buzzers in easy reach. Matron to check on ward rounds Faulty equipment to be reported to the works department on 5702 and checked daily for completion. Concerns of continued faulty equipment to be escalated to Matron Hughes.</td>
</tr>
</tbody>
</table>

**Action Plan developed by: Matron Connie Hughes, January 2015**

**Action Plan to be reviewed monthly**

Report of the Corporate Director of Adult and Community Services

Open Report

Report Author: Gillian Mills, Integrated Care Director, North East London Foundation Trust

Contact Details:
Tel: 0300 555 1201 ext. 65053
E-mail: gillian.mills@nelft.nhs.uk

Accountable Director: Anne Bristow, Corporate Director of Adult and Community Services

Summary:

The Health and Adult Services Select Committee (HASSC) undertook a scrutiny review on the Potential Impact of the Recession and Welfare Reforms on Mental Health in 2013/14 which resulted in seven recommendations being actioned.

The summarised recommendations are:

- Better information and advice is needed for residents, practitioners and those already known to mental health services on issues of welfare reform, advocacy, and support for coping with stress/depression/anxiety
- Recovery and resilience can be supported/built up through training and volunteering opportunities
- Peer support opportunities must be developed to prevent isolation, provide emotional support, and share knowledge
- The primary care depression pathway should be reviewed to ensure it is holistic and not overly reliant on the prescription of anti-depressants
- The effects of the austerity and welfare reforms should be measured so that the Council and its partners understand the impacts on residents and levels of need
- Demand on local services (advocacy, local emergency support, credit unions, welfare rights) should be closely monitored
- The Mental Health First Aid training programme should be delivered to professionals across the partnership and other local employers. Additional mental health awareness training should be provided where appropriate.

The scrutiny review recommendations were first presented to the Health and Wellbeing Board (HWBB) at its meeting on 25 March 2014 and the Mental Health Sub Group was tasked with overseeing the development of the Action Plan to implement the recommendations.
A progress report against the Action Plan was presented to the HASSC in September 2014 where positive outcomes following the review were noted. A request was made that a further and final progress update should be presented back to the HASSC in March 2015.

This report will provide HASSC members with the further progress that has been achieved since September 2014.

The report will also inform members that the Scrutiny Review recommendations have now been synthesised into a single, overarching, thematic action plan that incorporates recommendations from the Barking and Dagenham Mental Health Needs Assessment, Closing the Gap, and the Mental Health Crisis Concordat.

**Recommendations**

The Health and Adult Services Select Committee is recommended to:

i. Note and discuss the action progress made to date to implement the seven recommendations

ii. To note that the scrutiny review recommendations have been 'synthesised' into an overarching thematic action plan that incorporates recommendations from the Mental Health Needs Assessment, and the national policy documents ‘Closing The Gap’ and Mental Health Crisis Concordat.

**Reasons**

It is best scrutiny practice for the select committees to monitor the progress of recommendations made as a result of investigations carried out previously to evaluate the impact of scrutiny reviews.

1. **Introduction and Background**

1.1 The Health and Adult Services Select Committee (HASSC) chose to conduct a scrutiny review on the impact of the recession and welfare reforms on mental health and wellbeing as their scrutiny topic for 2013/14. The review began in June 2013 and the final information gathering session was held in November 2013.

1.2 The review sought to answer three key questions:

- How are economic austerity and the Welfare Reforms impacting on our citizens?
- Will the austerity measures, reduction in income levels and increases in poverty lead to more mental ill health?
- What can we do, or what are we currently doing, to mitigate the likely impact?

1.3. Following the evidence gathering, HASSC arrived at four broad conclusions:

- Welfare reforms are a source of anxiety (especially to those with pre-existing mental health issues).
- Financial hardship is putting strain on residents and is the cause of emotional distress.
- There is increased demand for voluntary sector services.
- There is increased demand for health service interventions.

1.4. In response to the evidence and findings the HASSC made 7 recommendations which are summarised as follows:

- Better information and advice is needed for residents, practitioners and those already known to mental health services on issues of welfare reform, advocacy, and support for coping with stress/depression/anxiety.
- Recovery and resilience can be supported/built up through training and volunteering opportunities.
- Peer support opportunities must be developed to prevent isolation, provide emotional support, and share knowledge.
- The primary care depression pathway should be reviewed to ensure it is holistic and not overly reliant on the prescription of anti-depressants.
- The effects of the austerity and welfare reforms should be measured so that the Council and its partners understand the impacts on residents and levels of need.
- Demand on local services (advocacy, local emergency support, credit unions, welfare rights) should be closely monitored.
- The Mental Health First Aid training programme should be delivered to professionals across the partnership and other local employers. Additional mental health awareness training should be provided where appropriate.

1.5 The findings of the scrutiny review were first presented to the Health and Wellbeing Board (HWBB) at its meeting in March 2014, which resulted in a request that the mental health sub-group develop an implementation action plan to take forward the reports 7 recommendations and that this to be presented to the HWBB July 2014 meeting.

1.6 An update on progress was provided to the HASSC at its September 2014 meeting, where positive outcomes following the review were noted, and a request made that a further and a final progress update should be presented back to the HASSC in March 2015.

2. Implementation Progress

2.1 The implementation of actions to progress achievement of the recommendations has been overseen by the Mental Health Sub Group. Details given below summarise the progress that has been achieved since September 2014 for each of the seven recommendations.
2.1.1 Better information and advice is needed for residents, practitioners and those already known to mental health services on issues of welfare reform, advocacy, and support for coping with stress/depression/anxiety.

A Mental Health Needs Analysis (MHNA) has been completed and the report and findings will be presented to a future Health and Wellbeing Board.

As part of the Mental Health Needs Assessment information gathering process, a mapping exercise was conducted to identify gaps in current information and advice provision within Barking and Dagenham. Two public and service user engagement events were undertaken in September and November 2014 at which service user and carer feedback was gathered regarding what improved access and quality of information and advice about services offering benefits advice and advocacy would look like.

Work is being undertaken within the Mental Health sub group membership to ensure that all web-based and printed information regarding mental health services for adults and children/young people is consistent and up to date. The Time to Change website and free resources will be promoted throughout the health and social care system, including on websites.

2.1.2 Recovery and resilience can be supported/built up through training and volunteering opportunities.

There is evidence that Mental Health Sub Group member organisations have promoted volunteering opportunities over the last six months.

- Jobcentre Plus have been working with local employers and organisations to create work experience and volunteering opportunities available to various categories of benefit recipients. Specialist Disability Employment Advisers, and Employment and Support Allowance Advisers, have work experience or volunteering opportunities created for clients experiencing Mental Health problems.
- The London Borough of Barking and Dagenham volunteering team continues to promote volunteering through a regular newsletter and a new volunteering website. The council commissions the Richmond Fellowship, a specialist vocational support service, to promote volunteering opportunities and support people with mental health problems into volunteering, training and employment. Since the beginning of October 2014 they have supported 8 mental health service users to gain volunteering placements. They also support people to attend volunteer facilitated support groups and 37 service users were supported to do this since the beginning of October 2014. A forum of all Mental Health Providers is taking place in February 2015 and the Richmond Fellowship will be presenting their service to all Providers at the Forum.
- NELFT voluntary services are developing a volunteer training programme and liaising with neighbouring Trusts in order to share best practice prior to fully launching the redesigned training programme.
2.1.3 **Peer support opportunities must be developed to prevent isolation, provide emotional support, and share knowledge.**

A finding of the Mental Health Needs Assessment was that people with mental illness in Barking and Dagenham would greatly benefit from greater holistic support for their recovery.

NELFT provides a Recovery College which attracts Barking & Dagenham students. The college uses an educational approach to promote individual learning and development of expertise and recovery for people using mental health services and their carers. Peer trainers contribute to the co-production and delivery of the course curriculum. However, the Recovery College is not a commissioned service. Currently it is funded through NELFT discretionary funding until April 2015.

The Mental Health Needs Assessment service user engagement events stimulated much local enthusiasm to develop a peer programme similar to the highly successful Lambeth Peer Programme, to meet the needs of the people in Barking and Dagenham experiencing mental health problems. The Peer Programme enables people with mental health needs to work through difficult emotional issues and take more control of their own lives. Evaluation of the programme demonstrated the programme increase their coping skills, which in turn had increased their resilience and improved their well-being. As well as emotional support, peers were able to share practical information regarding welfare rights and other sources of useful information.

The Mental Health Needs Assessment has made a recommendation regarding the development and implementation of a Peer Support Programme within Barking and Dagenham. This is being considered by both mental health service commissioners.

2.1.4 **The primary care depression pathway should be reviewed to ensure it is holistic and not overly reliant on the prescription of anti-depressants.**

Recognising that patients presenting with depression may exhibit mild through to severe symptoms, work has been progressing with Barking and Dagenham practices to review the primary care depression pathway to provide a step care model that will offer an holistic approach to managing depression.

- Where depression presents as mild to moderate a range of psychological and social interventions will be offered e.g. cognitive behavioural therapy; benefits, housings, education/employment/training; peer and voluntary sector support.
- Where depression presents as moderate to severe, in addition to the range of therapies listed above, prescription of anti-depressants and referral to secondary care will be also be considered/offered.

Promotion of the ‘Increasing Access to Psychological Therapies’, (IAPT), has seen some increase in referrals to the service over the last three months. The service is working very closely with the GP lead for mental health and the practice improvement team within the CCG to liaise and support GP’s in the borough mainly to reiterate the Management of Depression pathway, referral pathways into IAPT, and increase written and verbal exchange of clinical information between GP’s and
IAPT. The rationale for this is to increase identification of common mental health presentations and signpost to IAPT.

2.1.5 The effects of the austerity and welfare reforms should be measured so that the Council and its partners understand the impacts on residents and levels of need.

The Mental Health Needs Assessment also considered the impact of austerity and welfare reforms as part of its remit and will report on this in Spring 2015.

There is recognition that through enhancing floating support, residents with mental health problems will be assisted to maintain tenancies and avoid homelessness. The London Borough of Barking and Dagenham currently commission 3 supported living schemes for mental health service users, all three are due to expire in September 2015. The commissioned mental health supported accommodation schemes will be subject to a re-design in 2015. A number of options are currently being explored, including how floating support can better support mental health service users. Consultation will begin with mental health service users, professionals and organisations from February 2015 on these new plans.

2.1.6 Demand on local services (advocacy, local emergency support, credit unions, welfare rights) should be closely monitored.

Through continual contract monitoring and evaluation, commissioning officers within LBBD have ensured that services commissioned by the Council remain fit for purpose and meet the needs of residents in the Borough, including those with mental health needs.

These services include:
- Enhanced Welfare Rights
- Specialist Advocacy
- Local Emergency Support services
- Credit Union

However, central government funding reductions from April 2015 to the Local Emergency Support Service will have an impact on level of services offered within Barking and Dagenham. To minimise this impact the Council has agreed to continue to fund a reduced service from Council reserves.

The Credit Union and the Enhanced Welfare Rights service will continue to be funded for 2015/16.

The specialist advocacy provision is funded for 2015/16 and council officers are working to ensure this complies with new Care Act legislation. The council will be reviewing all of their advocacy services in 2015, including mental health advocacy provision, to ensure there is a ‘joined up’ approach for everyone who needs statutory advocacy.
2.1.7 The Mental Health First Aid training programme should be delivered to professionals across the partnership and other local employers. Additional mental health awareness training should be provided where appropriate.

The Mental Health First Aid training programme is on track to meet the target for participants completing by the end of March 2015. To date 875 people across a range of services have received the training and evaluation of the two day programme has been extremely positive. Plans are being developed to continue training for 2015/16 which will be more tailored to Barking and Dagenham services and staff. This will include the possible development of mental health champions within services to provide additional front line support in raising awareness of mental health issues.

A recommendation of the Mental Health Needs Assessment is that as part of the primary care improvement plan, GPs and other primary care professionals should be supported to undertake training, such as Mental Health First Aid, and development in mental health. Ways of encouraging those who do not see that they have a specialist role in mental health should be identified, and a broad view should be taken of those professionals who would benefit from such development.

2.2 In order to ensure that the issues raised by the Scrutiny Review into Mental Health and austerity continue to receive priority they have been incorporated into the wider piece of work on a full needs assessment around mental health. This work led by Public Health incorporates the Borough’s response to Closing the Gap and the Mental Health Crisis Concordat.

2.3 At a recent development session members of the Mental Health Sub-group have reviewed the actions required by this wider needs assessment and developed a plan, which now includes the work identified by the Select Committee. The sub-group will take ownership for monitoring progress and provide reports as required to the Health and Well Being Board and other relevant committees.

3. Options Appraisal

3.1 Not applicable as this paper is to inform HASSC of progress made in the implementation of the Scrutiny Review action plan.

4. Consultation

4.1 Two service user and carer engagement events have taken place since September 2014 to gather information and feedback to inform the Mental Health Needs Assessment. Following these events the membership of the Mental Health Sub Group has widened to include a service user and a carer.

5. Financial Implications

There are no financial implications directly arising from this report.

6. Legal Implications

As this report is for noting, there are no direct legal implications relating to the report itself or in the action plan.
7. Other Implications

7.1 Customer Impact

The review found that residents were bewildered by the scale of the welfare reforms and did not always know where to go for support or understand the information they were given. Recommendation 1 should result in better information about welfare benefits advice and advocacy preventing the escalation of problems that might affect a person’s health and mental wellbeing.

It is expected that the delivery of recommendations 2 and 3, which seek to build resilience and support people’s recovery through training, volunteering and peer support, will have a positive impact on those experiencing emotional distress or mental ill-health.

7.2 Health Issues

The public’s mental health and well-being is a complex area of policy. It demands our attention because focusing more on mental well-being and improving people’s mental health is the right way to go. This report shows that improving mental well-being is a significant and growing priority in spite of, and because of, the poor economic situation we find ourselves in. It is clear that building community resilience and improving mental well-being will improve social, health and economic outcomes. The pending refresh of the Joint Health and Wellbeing Strategy should continue view the causes of our major health challenges with a mental health lens – from obesity to drug and alcohol misuse to smoking. Without a focus on how people think, feel, behave and relate (their mental wellbeing), we will not make the progress we need to.

Background Papers Used in the Preparation of the Report:

Health and Adult Services Select Committee’s scrutiny review on the ‘Potential Impact of the Recession and Welfare Reforms on Mental Health’: