MINUTES OF
HEALTH AND ADULT SERVICES SELECT COMMITTEE

Wednesday, 11 January 2017
(7:00 - 8:05 pm)

Present: Cllr Peter Chand (Chair), Cllr Sanchia Alasia, Cllr Abdul Aziz, Cllr Jane Jones, Cllr Eileen Keller, Cllr Hardial Singh Rai and Cllr Faraaz Shaukat

27. Declaration of Members' Interests

There were no declarations of interest.

28. Minutes - To confirm as correct the minutes of the meeting held on 2 November 2016

The minutes of the meeting held on 2 November 2016 were confirmed as correct.

29. Review of Continuing Healthcare Packages

Rob Meaker, Director of Innovation (the DI) for Barking and Dagenham, Redbridge and Havering Clinical Commissioning Groups (BHRCCGs), delivered a presentation on BHRCCGs’ planned review of Continuing Healthcare Packages. The DI stated that:

- Continuing Healthcare (CHC) packages were NHS packages of care for those who had been assessed and identified as having a continuing healthcare need.
- BHRCCCGs were in the process of reviewing CHC packages of people with learning difficulties with enhanced care needs (packages of over £1000).
- Historically, once a package was provided a reassessment may not have been carried out for some time (sometimes years) even though the initial assessment may have covered short-term care measures. The purpose of the review is to ensure that the packages are appropriate for the patient’s needs, which may have changed since they first became eligible to receive a CHC package.
- Barking and Dagenham CCG has employed a nurse assessor who is visiting everyone with a CHC package of over £1,000 in the borough. Once all patients have been reassessed anyone who has been identified as potentially needing a different package will have a full assessment by the CCG and the community learning disability team to assess their needs. Together they will use the ‘decision support tool’ to identify the most appropriate care package.
- 30 Barking and Dagenham residents had already been reviewed with ten people yet to be reviewed. 70 percent of those reviewed would have seen a change to their care package, not all of whom would receive a reduced package.
- If following the reassessment, the person was deemed not to require a CHC package, their needs would potentially be met by the Local Authority’s social care services, which may involve means testing. There was now a dispute resolution mechanism in place to ensure
that when there is a dispute as to whether the person’s needs should be met by a CHC package or social care services, a fair process was in place to resolve the matter. An independent chair for this was currently being recruited.

- In response to questions from members and officers, the DI stated that:
- He did not have information with him as to how many of the 40 Barking and Dagenham residents reassessed had had their CHC package reduced or removed all together, however he would provide it.
- The views of the individual’s family, their GP and other professionals involved in their care would be taken into account as part of the reassessment process. The decision would be made under a clear framework, after which a care plan would be developed with the family.
- After the reassessment, the individual’s needs would be reviewed again in three months’ time and annually thereafter, which could potentially lead to a smaller or larger package of care depending on their circumstances. Members asked whether affordability for social care was not a factor in the reassessment and the individual would need to discuss this with social services.
- People were aware of the appeal process and it was used regularly;
- The CCG had a duty to acknowledge receipt of the appeal correspondence within a week and to make a decision within a month of receiving the appeal;
- He was not certain of exactly which advocacy support service the CCG signposted people to, but he imagined that the social care service would provide advocacy support;
- The assessment process takes up to 28 days but can take longer if it is deferred and if the CCG breached NHS England (NHSE) specifications on timeline, it would need to report this to them.
- The decision on reassessment would be made by trained and experienced nurses, not managers.

The Council’s Strategic Director for Service Development and Integration (SDSDI) stated that it was the Council’s understanding that a multidisciplinary team would make the initial decision following the reassessment, which would be subject to change by a CHC Panel. The DI stated this was an old process and the current process was that the initial reassessment would be checked by a ‘Quality Assurance Panel’ (QAP) which was comprised of experienced nurses.

Members expressed disappointment that the BHRCCG could not offer assurance that service users were being sign-posted to advocacy services. They also asked whether it was possible that an individual who had complex behavioural problems as part of their learning disability, whose behaviour was being managed by a CHC package, could have their package removed or reduced after a re-assessment because it would appear to the assessor that the person no longer had a need for the package, when in fact, a removal of the package would result in that person manifesting their behavioural problems again. The DI stated in response to the comments around advocacy that he was personally not aware of the advocacy service individuals were being-sign posted to, but the CCG was.
In relation to an individual with complex behavioural problems, he would hope that the scenario described would not occur because the assessment would consider the consequences for the individual if the package was removed.

Members asked the DI how one would reconcile the fact that the decision of the nurse who meets with the individual and their family to undertake the initial reassessment, could be changed by the QAP, who although were experienced, did not meet the individual or their family. The DI stated that in most cases the QAP would not be overturning the nurse assessor’s decision, rather they would potentially be changing the particulars of the package recommended, such as the number of skilled nurses required to support the individual with a particular aspect of their health and wellbeing. He felt that this was the correct process as the nurses who formed the QAP were very skilled and experienced in this field of work.

Members asked whether there were leaflets explaining the right to appeal for people with learning difficulties who were having their CHC packages reviewed. The DI stated that there was no leaflet; however, there was a letter which was sent to the individual after the reassessment which included the decision, and the procedure for appealing. **He stated that he would share the template letter with the Committee.**

In response to a question from the Integrated Care Director of North East London Foundation Trust, the DI stated that so far, safeguarding issues had not arisen as a result of the historical delay in reviewing packages and that systems had been put in place to ensure reviews are done in a timely fashion in future because BHRCCGs acknowledged that delay was not beneficial to them as organisations and nor to the individual.

A member of the public suggested to the DI that people who were the subject of current and future reviews be advised that they could contact carers of Barking and Dagenham for support and advice, which the DI stated he would take on board.

### 30. Localising Healthy Lifestyle Services

The Council’s Consultant in Public Health (CPH) delivered a presentation on the Localising Healthy Lifestyle Services Project Development and the Mayesbrook ward Park Pilot. Members noted:

- The aims of the project;
- Overview of the service;
- Key achievements and milestones of the pilot;
- Key elements of the service model
- Next steps.

The PHC stated that evaluation of the project would take place in March 2017, after which it would be decided to what extent the project would be rolled out in other wards.

Members asked who was meeting the cost of the pilot and who would be meeting the cost if the project was rolled out further. The CPH stated that there is no additional cost, other than the project manager cost, as the services covered are already provided by the lifestyle service. The cost of
the project manager was being met by the Public Health grant and that as part of the pilot, project workers were reviewing how to make the project more cost-effective for the potential future roll out of the service.

Members asked how members of the public would find out about the pilot and get involved. The CPH stated that people would get referred through a number of community routes e.g. GP, leisure services and schools, for example through the child weight management scheme. An important part of the service is also outreach into the local community and part of the reason for basing the pilot in parks was so that the service would be much more accessible to the public who could enquire about the service directly.

Members asked whether the project was designed in a way that would meet the needs of the diverse communities in the borough. CPH stated that it was fundamental to the project that it would attract members of all communities and providing services in the community parks would help with this, and furthermore, the community health champions, who were a core part of the project, were volunteers from the community itself, which meant that they would encourage a diverse group of people to take part.

The local Healthwatch representative asked how the Council would know whether the pilot was effective. The PHC stated that project workers already had some baseline information from a feedback event, which they were using to develop a set of indicators that would help them measure what local people thought about the pilot and its effectiveness in encouraging them to become more active and, eat more fruit and vegetables, for example. A member of the public who was also a community health champion stated that the community health champions were also looking to gather feedback on their role, which would help with the overall evaluation of the pilot.

31. Update on System Wide Health Integration: the Sustainability and Transformation Plan and the Accountable Care Organisation Devolution Pilot

The Council’s Commissioning Director for Adult’s Care and Support (CDACS) presented a report which updated the Committee on system wide health integration initiatives; the Sustainability and Transformation Plan (STP) and the Accountable Care Organisation (ACO) Devolution Pilot.

Members noted that the STP is a new planning framework for NHS services which is intended to be a local blueprint for delivering the ambitions NHS bodies have for a transformed, more cost-efficient health service. This Committee had received a presentation at its meeting on 19 July 2016 where members were informed that the boroughs of Barking and Dagenham, Havering and Redbridge (BHR) had agreed to run a pilot to develop an ACO, where primary and secondary care would be more closely integrated and patient pathways redesigned. It was explained that for BHR, the detail of the local contribution to the STP for north east London (NEL) has been developed through the established programme to draft a business case for an ACO.

The CDACS went on to summarise the extensive work that had been carried out since then to form a Strategic Outline Case (SOC) for an ACO. Following this, the SOC had recommended a new model of service delivery
supported by more effective joint strategic commissioning arrangements; however, made it clear for reasons detailed in the report, that the BHR system does not support a direct move to an ACO. Therefore, the work on developing the ACO Business Case as part of the health devolution pilot has not progressed as anticipated and a new organisational form for delivering health and social care across the BHR area would not be forthcoming in the near future. There has been a shift in language from an ACO to an Accountable Care Partnership (ACP), reflecting this. The CDACS assured members that while a new organisational form in the shape of an ACO would not happen soon, the work undertaken represents significant progress in terms of developing approaches for integration for BHR and understanding the needs of the local population.

The CDACS explained the structures being put in place to develop and deliver this work which included a strong emphasis on a locality based delivery model, built around the key principle of organisations working together to manage common resources and designed to radically alter the way that residents access health and wellbeing services across BHR. He stated that for Barking & Dagenham, the work to develop the detail underpinning the STP is still being taken forward jointly with Havering and Redbridge through the work around devolution via an ACP.

Members noted the work described in the report to develop the STP, the organisations involved, its vision and the priorities it would deliver.

The SDSDI explained that there has been significant national concern about transparency and local political legitimacy of the STP process. There have been ongoing concerns expressed by local authorities across NEL, and particularly by BHR at the level of engagement of local authorities in the STP process. Although the basis of the BHR contribution to the STP is work that has been shaped through good engagement across BHR, the pace and complexity of reinterpreting this at NEL level has meant that local authorities have had limited engagement in the final product. She added that NHSE does not require that local authorities ‘sign off’ the plan, which is a disappointing step in a plan which is intended to address whole system functioning. There has been an effort made by the NEL STP team to address concerns of local authorities, which has been appreciated, but there are fundamental flaws in the process that remain a concern.

Members noted the other concerns described in the report, shared by some partners in the NEL system, which were discussed at the Health and Wellbeing Board meeting on 22 November 2016.

The SDSDI stated that early thinking about governance of the STP has been shared with councils, and in response the Leaders of BHR councils have written to their counterparts in the other NEL boroughs making a suggestion of an alternative approach which gives greater prominence to the system-level governance arrangements over a cumbersome all-NEL tier of governance. A key principle for all BHR partners, is that decision making should lie at the local system and borough level as a starting point, with decisions and approaches taken at a NEL level where this is necessary. There is a concern that as the STP grows, more decisions will flow towards the NEL-level, and early sight of the governance options has reinforced this concern.

Members noted the next steps for moving forward with the STP which
included the positive step of local joint work by local Healthwatch organisations to gather and understand the views of local people to ensure engagement is relevant to local needs. Officers stated that the Health and Wellbeing Board would be kept updated on the progress of the STP and that they would be also happy to attend future meetings of the HASSC for this purpose.

32. Work Programme

The latest version of the Work Programme was agreed.