Minutes

SOCIAL SERVICES, HOUSING AND PUBLIC HEALTH POLICY OVERVIEW COMMITTEE

2 November 2016

Meeting held at Committee Room 4 - Civic Centre, High Street, Uxbridge UB8 1UW

	Committee Members Present: Councillors Wayne Bridges (Chairman),Jane Palmer (Vice-Chairman), Shehryar Ahmad-Wallana, Teji Barnes, Peter Davis, Beulah East, Tony Eginton, Becky Haggar and Kuldeep Lakhmana. **Apologies for Absence:** Councillor Peter Money (Councillor Kuldeep Lakhmana substituting) and Co-opted Member, Mary O'Connor. **Officers:** Gary Collier (Health & Social Care Integration Manager), Nigel Dicker (Deputy Director Residents Services), Nina Durnford (Head of Social Work, Adult Social Care Services), Sandra Taylor (Head of Service - Early Intervention & Prevention) and Khalid Ahmed (Democratic Services Manager). **Also Present:** Caroline Morison (Chief Operating Officer, Hillingdon Clinical Commissioning Group) and David Muann (Clinical Team Leader for the Continuing Healthcare Team).	
24.	**MINUTES OF THE MEETING HELD ON 4 OCTOBER 2016** Agreed as an accurate record.	
25.	**TO CONFIRM THAT ALL ITEMS MARKED PART I WILL BE CONSIDERED IN PUBLIC AND THAT ANY ITEMS MARKED PART II WILL BE CONSIDERED IN PRIVATE** It was confirmed that all items on the agenda would be considered in public.	
26.	**MAJOR REVIEW - HOSPITAL DISCHARGES** For this witness session, the Committee was provided with evidence from the Chief Operating Officer of Hillingdon Clinical Commissioning Group and from the Clinical Team Leader for the Continuing Healthcare Team. Members were informed that the Chief Executive of Hillingdon Healthwatch was not in attendance at this meeting because the report of the Healthwatch review into Hospital Discharges at Hillingdon Hospital had not been completed. The Committee was informed that they would be sent a copy of the report when it was available.	**Action By:** **Khalid Ahmed / Gary Collier**

	Clinical Commissioning Groups' Perspective on Hospital Discharges The Committee was informed that the Clinical Commissioning Group were clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. Commissioning was about getting the best possible health outcomes for the local population, by assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, clinics, community health bodies, etc. The Chief Operating Officer, Hillingdon Clinical Commissioning Group attended the meeting and reported that there had been a 12% increase in the over 80s age group attending Accident & Emergency at Hillingdon Hospital. With an ageing population and the increase in the number of dementia cases, the planning of hospital discharges had become challenging. It was important that the needs of the patients were clearly identified and there needed to be a consistency of processes to enable all agencies to identify who was accountable for providing particular elements of care and support. Care Planning was vital with an overarching Care Plan for each person. This required close working with social care professionals and the timely carrying out of processes. As hospitals were busy, often there was reactive rather than proactive responses to people's needs. The aim should be to work closely with partners to get patients home sooner and help combat the growing pressures the hospital was experiencing, which were being exacerbated by delayed transfers of care. The transfer of care planning requirements should improve patient experience and quality of care and enable all medically fit patients to be discharged with appropriate care and support at home, wherever possible. This would reduce delayed transfers of care and lower the readmissions of patients. **Continuing Healthcare Team perspective on Hospital Discharges** The Clinical Team Leader for the Continuing Healthcare Team reported that Continuing Healthcare (CHC) was the name given to a package of care which was arranged and funded solely by the NHS for individuals outside of hospital who had on-going health care needs. Adult Continuing Healthcare was provided when an individual had been assessed by a multi-disciplinary team and they had	**Action By:** **Action By:**

	been deemed to have a primary health need. After this had been defined, a package of care would be developed. Members were informed that continuing healthcare was available in any setting to meet assessed needs, including the patient's own home or a care home. Reference was made to assessments for continuing healthcare being triggered when a person was admitted to hospital. A person who was eligible for CHC would typically have complex health conditions and would be eligible for NHS care. If a person was not entitled to NHS care they would be eligible for means tested local authority social care. Reference was made to the decision-making process which should always be centred on the person requiring the care. This meant putting the individual and their views about their needs and the care and support required at the centre of the process. Reference was made to the use of the Checklist Tool, which was a screening tool used to assess whether a full assessment of eligibility for continuing healthcare was required. Once the Checklist had been completed and it indicated that there was a need to carry out a full assessment of eligibility for NHS continuing healthcare, the individual completing the Checklist would contact the Clinical Commissioning Group (CCG) who would arrange for a multidisciplinary team to carry out an up-to-date assessment of the person's needs. Unfortunately hospitals were very busy so it was inevitable that there would be delays. It was important that families of patients and the hospital were involved in discussions regarding eligibility for care but that expectations of families should be managed due to issues of choice of care and the cost of care packages. A lack of clarity for patients and their families about care choices, including the funding of care, was identified as a cause of some delays in discharge. It was recognised that this could be addressed by the availability of better information at an earlier stage in order to manage expectations. The Committee was informed that addressing this was included within the DTOC action plan for 2016/17. Eligibility criteria assessments had to be completed within 30 days, but disputes between parties sometimes resulted in delays. Making decisions on a relative with health needs was a stressful and upsetting time for family members, with disagreements sometimes taking place in relation to making the right health care choices for their elderly relative. The important role of Advocacy Services in the process was noted.	**Action By:**

	Discussion took place on the changing demographics of the population with an increasing number of dementia cases in the elderly age group. The number of these cases, made the process of discharge challenging. It was generally noted that the provision of care homes for dementia was a difficult area, in terms of costs and affordability. Members asked for details on what the proportion of delays of transfer from hospital were dementia cases. Reference was made to the provision of "step down" beds which were used for patients who were awaiting discharge, but where final decisions on care had not been decided. There were inconsistencies in how quickly the discharge process started which meant that sometimes the complexities about a person's personal circumstances and their health and care needs were not identified at an early stage to enable them to be discharged quicker from hospital. An example was given of where adaptations were required in people's homes, which would enable people to remain in their own homes and retain some independence. In the main, adaptations could be installed the next day, however, more complex adaptations could take time, which could delay a discharge. **RESOLVED –** **1. That the witnesses be thanked for the information they had presented and the evidence be used as part of the review.**	**Gary Collier**
27.	**UPDATE ON HILLINGDON SHARED LIVES SCHEME** Members were reminded that this Committee had carried out a review into Hillingdon's Shared Lives Scheme in 2014/15. The review examined the effectiveness of the current arrangements for the Shared Lives Scheme and to propose improvements which could be made to enhance this important aspect of independent living to the Borough's residents. The Head of Service - Early Intervention & Prevention reported that the scheme had grown in size, with from January 2015 to present, 42 service users having accessed the scheme. Reference was made to the Care Quality Commission which took place in September 2016. Positive feedback had been received in relation to the caring nature and effectiveness of the scheme. Carer Development days took place which also received positive feedback. **RESOLVED –** **1. That the update report be noted and officers be congratulated for the good work.**	**Action By:**

	2. That an update report be submitted to the Committee in 12 months time.	**Sandra Taylor**
28.	**UPDATE ON STROKE PREVENTION REVIEW** Members were provided with a progress report on the Committee's Stroke Prevention review. The Committee was reminded that two witness sessions had taken place which had provided Members with details of what Hillingdon Council's interventions were in respect of Stroke Prevention. In addition, the review had received evidence from the Stroke Association and Members had attended a Stroke Association social event to enable the views of stroke sufferers to be taken into consideration. Discussion took place on other areas which Members requested further information. These included: • Additional information on preventative initiatives which were taking place from Public Health and the Wellbeing Team and anything further the Council could do to publicise these further (TVs in GP Surgeries, Heart Month, Stroke Awareness days, focus on BMEs, blood pressure machines in libraries, further publicity regarding health-checks etc). • Networking with other local authority public health teams to see other approaches which Hillingdon could use. • Arranging a visit for Members of the Committee to visit Hillingdon Hospital's Stroke Unit. **RESOLVED –** **1. That officers be asked to undertake the actions outlined above and bring back the information for the Committee to consider, to enable the review to be completed.**	**Steve Hajioff /Shikha Sharma /Nigel Dicker /Khalid Ahmed**
29.	**FORWARD PLAN** Noted.	
30.	**WORK PROGRAMME** Members asked that the Chairman of the Adult Safeguarding Board be invited to attend the Committee's meeting on 21 February 2017 to present the Board's Annual Report. Noted.	

	Meeting commenced at 7.00pm and closed at 8.10pm **Next meeting: 14 December 2016 at 7.00pm**	

These are the minutes of the above meeting. For more information on any of the resolutions please contact Khalid Ahmed on 01895 250833. These minutes are circulated to Councillors, Officers, the Press and Members of the Public.