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A

Social Services, Housing and Public Health Policy Overview Committee

Date: **WEDNESDAY, 14 DECEMBER 2016**

Time: **7.00 PM**

Venue: **COMMITTEE ROOM 6 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW**

Meeting Details: Members of the Public and Press are welcome to attend this meeting

Councillors on the Committee

Wayne Bridges, (Chairman)
Jane Palmer, (Vice-Chairman)
Beulah East (Labour Lead)
Shehryar Ahmad-Wallana
Teji Barnes
Peter Davis
Becky Haggar
Tony Eginton
Peter Money

Co-Opted Member

Mary O'Connor

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SOCIAL SERVICES, HOUSING & PUBLIC HEALTH

To perform the policy overview role outlined above in relation to the following matters:

1. Adult Social Care
2. Older People's Services
3. Care and support for people with physical disabilities, mental health problems and learning difficulties
4. Asylum Seekers
5. Local Authority Public Health services
6. Encouraging a fit and healthy lifestyle
7. Health Control Unit, Heathrow
8. Encouraging home ownership
9. Social and supported housing provision for local residents
10. Homelessness and housing needs
11. Home energy conservation
12. National Welfare and Benefits changes

Agenda

CHAIRMAN'S ANNOUNCEMENTS

1	Apologies for Absence and to report the presence of any substitute Members	
2	Declarations of Interest in matters coming before this meeting	
3	To confirm that the items of business marked in Part I will be considered in Public and that the items marked Part II will be considered in Private	
4	To receive the minutes of the meeting held on 2 November 2016	1 - 6
5	Social Services, Housing and Public Health Policy Overview Committee - Major Review 2016/17 - Hospital Discharges	7 - 24
6	Major Review - Stroke Prevention in Hillingdon - Update	25 - 28
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Minutes

SOCIAL SERVICES, HOUSING AND PUBLIC HEALTH POLICY OVERVIEW COMMITTEE

Wednesday 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	**Action By:**

	on-going health care needs. Adult Continuing Healthcare was provided when an individual had been assessed by a multi-disciplinary team and they had 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	**Action By:**

	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. 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.**	**Action By:** **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.** **2. That an update report be submitted to the Committee in 12 months time.**	**Action By:** **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.

Social Services, Housing and Public Health Policy Overview Committee - Major Review 2016/17 - Hospital Discharges

Contact Officers: Khalid Ahmed
Telephone: 01895 250833

REASON FOR ITEM

The Committee is continuing its review into Hospital Discharges from Hillingdon Hospital for people 65 years old and over and who were registered with Hillingdon GPs.

OPTIONS OPEN TO THE COMMITTEE

The Committee is asked to hear the evidence given by a number of witnesses who have been invited to this meeting and to ask questions as part of the Committee's review into Hospital Discharges.

INFORMATION

1. This is the final witness session into the Committee's review into Hospital Disharges. For this meeting, Members will hear from **Graham Hawkes** of **Healthwatch** who will provide a general overview of the Healthwatch Hospital Discharge Review for the Committee. A copy of the report is attached as Appendix A.

2. Also for Members information, there is a paper which provides a summary of population figures for older people in Hillingdon (Appendix B), together with information on the local care home market for older people (Appendix C).

Witnesses

3. For this final witness session Members will hear from a number of witnesses:

Healthwatch Hillingdon

Graham Hawkes - Chief Executive Officer

Hillingdon Hospital

Julie Wright - Director of Integrated Care.

Melissa Mellett - Director of Operational Performance.

Vanessa Saunders - Deputy Director of Nursing.

Julie Vowles - Consultant Geriatrician.

Central North West London NHS Foundation Trust

Kim Cox - Borough Director.

Claire Eves - Head of Adult Services.

Hillingdon Clinical Commissioning Group

Caroline Morison - Chief Operating Officer.

London Borough of Hillingdon

Nina Durnford - Head of Older People's Services, Occupational Therapy and Mental Health, Adult Social Care.

Gary Collier - Health and Social Care Integration Manager.

Hospital Discharge Project 2016

Report for

Social Services, Housing and Public Health Policy Overview Committee

Social Services, Housing and Public Health Policy Overview Committee

14 December 2016

PART I – MEMBERS, PUBLIC AND PRESS

CONTENTS:

Rising demand for services, combined with restricted or reduced funding, is putting pressure on the capacity of local health and social care systems.

The number of people aged 65 and over in England is increasing rapidly. The relative growth in numbers of older people is important. The number of older people with an emergency admission to hospital increased by 18% between 2010-11 and 2014-15. In 2014-15, the percentage of older people admitted to hospital after attending accident and emergency (A&E) was 50% compared with 16% for those aged under 65.

Although overall length of stay for older patients following an emergency admission has decreased from 12.9 to 11.9 days between 2010-11 and 2014-15 – suggesting improved efficiency – the overall number of bed days resulting from an emergency admission has still increased by 9% from 17.8 million to 19.4 million days.

Put simply, without major change, these recent trends indicate that the more older people there are, the more pressure there will be on hospitals.

While NHS spending has grown by 5% in real terms between 2010-11 and 2014-15, local authority spending on adult social care has reduced by 10% in real terms since 2009-10.

Extract from "Discharging older patients from hospital" published by National Audit Office May 2016

https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital.pdf

INTRODUCTION:

Healthwatch Hillingdon has been carrying out a 'Discharge from Hillingdon Hospital' project with the aim of identifying and engaging Hillingdon residents who have recently gone through the discharge process at Hillingdon Hospital. Through their experiences we have gained a greater understanding of being discharged from hospital, ascertaining what works well and where improvements may be required.

The project has focussed on Adults over the age of 65 with complex needs or long term conditions who have been recently discharged from The Hillingdon Hospital, to home, or another care facility.

Healthwatch Hillingdon have been working closely with The Hillingdon Hospital NHS FT and we would like to thank them for facilitating access to the patients we have spoken to during our engagement program.

We also express a special thank you to all the patients and their carers or families that have taken the time to tell us about their experiences.

The findings of our engagement program have been summerised into this report for the Social Services, Housing and Public Health Policy Overview Committee and will inform our final report, which will be published in the New Year.

The Patient and Carer experience outlined in this report has been shared with local Partners who either commission or provide care to give them an opportunity to:

- assess the quality and effectiveness of discharge and the follow-up care we provide in the community
- consider how this evidence can inform current work streams
- consider how we can use this evidence to develop better services for Hillingdon's residents.

During our research we have identified possible solutions and outline these as recommendations for Partner organisations to consider.

If implemented, these recommendations may help towards improving:

- the patient/carer experience
- staff experience and job satisfaction
- quality and safety of care
- length of stay
- readmissions

METHODOLOGY:

Stage 1

172 patients were interviewed and completed a survey on 17 different wards (including the Discharge Lounge), over a period of 2 months. Patients gave written permission for Healthwatch to follow up the survey with another survey once they had been discharged from hospital. The second survey would ask about their experience of the discharge and how they were coping post discharge.

The survey was sometimes completed by a patients advocate, and permission was given for us to follow up with this contact.

The survey data was then recorded into a database for analysis.

Stage 2

Patients interviewed on the wards were then phoned at home 30 days after their on ward interview, or their advocates, to ask how the discharge process had gone, and if adequate care was in place for their needs. This was a more challenging aspect of the project as some patients were still in hospital, some had died, and some were no longer at the contact number.

52 discharged patients/advocates completed the second survey. These were recorded into the database for analysis.

Stage 3

We met with over 20 organisations, who commission, or provide care services for the over 65's in Hillingdon, within hospital and the community. This engagement, with senior managers and frontline staff, looked to identify and understand the processes and procedures involved in discharge; and the factors, barriers and enablers that contribute to providing patients with a safe transfer from hospital to being cared for in the community.

SUMMARY FINDINGS

The over 65's express an overwhelming feeling of pride in the NHS and hospital services. They are quick to praise Hillingdon Hospital for their caring and attentive staff, and give individual examples of exemplary conduct.

They are largely from a generation where they just 'get on with it' and 'don't want to cause trouble', and as such some were reluctant to say anything against their care. We found that they were far more comfortable speaking to us after discharge, than they were on the ward.

There is no doubt that staff are strongly committed to their work. They do however feel under pressure and are wary that they cannot always necessarily deliver care to the standard they would like to and this is effecting moral.

Initial analysis of the data shows that, although we have seen that there are transfers of care which go well, the satisfaction rate for discharge and the follow up care is varied. Patients expectations vary considerably resulting in polarised views on the same subject. There is higher satisfaction on some wards than others, as there is with differnet care providers in the cimmunity.

It highlights that service delivery is not always consistant and there are a number of areas which impact upon the patient/carer experience, including specific comments directed at individual service delivery, that would normally be addressed by contract monitoring.

In general, impact broadly falls in to 3 catergories:

1. Communcation and information

Patient/carers say they want to be fully informed across the whole pathway. They state that the communication between them and professionals and the information provided to them is often poor. They have illustrated where they have been unable to speak to a doctor, forgotten or become confused about what they have been told, do not know what medicines to take, who is coming to see them at home, or how to arrange a private care home placement, or care package. This leads to them being uncertain and anxious which becomes a barrier between them and staff. This promotes a situation which is not positive for either party. When uninformed, patients/carers persistently seek answers and this increases the number of interactions with staff, which in turn impacts negatively upon already stretched staff, by taking them away from other activities.

Evidence would suggest that by providing clear written information to inform patient/carers and support them to make decision and would empower them to become partners in the discharge process. This will improve outcomes for both patients, partner organisations and their staff.

Recommendations

a. The Trust has a booklet titled 'Working Together'. This was a trust wide initiative which commenced in September 2014 with the aim of issuing this booklet to all admitted patients. This booklet would then be filled in during the inpatient stay, and would be completed on discharge complying with many of the details listed in the NICE requirements.

   We would recommend that this booklet is reviewed and updated to produce a 'Patient Journey' booklet that keeps patient/carer fully informed and acts as a method of communication between patient/carers and professionals in hospital and in the community.

b. We would recommend that patient/carers are provided with written information about social care and continuing health care assessments in line with the Care Act. This should clearly outline, entitlement, assessment process, financial implications and support and information to make decisions on the selection of private care. Where an individual has substantial difficulty in being involved in the assessment process, the need for independent advocacy should be provided.

2. Process and procedures

Throughout the course of our engagement patient/carers informed us that during their inpatient stay the staff were working hard to provide them with good care.

There was a general observation that they often felt staff were stretched and did not have the time they would like to attend to the patients needs. They also perceived a variation in care between the day and night shifts, and permanent and agency staff.

Our researchers saw a marked difference in the discharge proceedures on each ward and a number of patient/carers who had experienced multiple inpatient stays also identified this to us. This is exampled by the discrepancy in how patients

awaiting medication and transport are processed. Depending upon which ward, patients of a similar condition, could either, wait in their bed, be asked to sit in the ward's day room, or will be sent to the discharge lounge.

From the conversations we had in the discharge lounge we found that patients often waited for many hours, without hot food or other facilities. This was particularly apparent for those awaiting patient transport.

Although waiting for medication at discharge remains a frustration for both patients and staff, on the whole all patients went home with the medication they required. Some patient/carers did highlight to us that they were confused about their medication; especially those who were dispensed multiple drugs at discharge.

Recommendations

a. We would recommend that the hospital looks to standardise the discharge process across all wards. A compulsory uniform process could provide many benefits to improve the patient and staff experience.

   When identical and consistant, a process becomes natural and this can only positively affect the pressures on staff. Applying the same process may also assist the hospital in its compliance with the 'Safer Staffing' initiative. Staff and agency staff can seamlessly transfer between wards. Resulting in bank staff able to work on any ward with confidence, agency staff training and induction becomes easier, returning agency staff become familiar, and escalation wards can be opened quickly. This in turn may help with staff recruitment and retention and positively affect the quality of care provided to patients, as staff have more time and opportunity to care for patients in the way they want to. Possibly improving staff moral and encouraging agency staff to become substantive.

b. We would recommend a review of the discharge lounge be carried out, to assess how effective it is in meeting the needs of patient/carers who are

   waiting there. Without any pre-emption of this assessment, we would suggest the scope includes looking at facilities/amenities available to patients, food and drink, and timely information on their medication or transport.

c. We would recommend that in addition to written instructions for those patients being prescribed multiply medications, that the hospital also looks to provide

dosette boxes. This will mitigate against possible unintentional overdose and improve patient safety

3. Closer integration and joined up working

We have already spoken about communication and how written clear information is needed to aid patient/carers in the discharge process. Patient/carers also pointed out to us that organisations do not necessarily communicate with each other well, or work as closely together as they could. They have told us about their GP not receiving a discharge summary, not being accepted on transfer to intermediate care and being sent back to the hospital, assessments being carried out separately by social services and hospital staff, not all relevant partners being invited to multi-disciplinary team meetings and domicialiary carers not knowing how to contact district nursing.

Timely communication between organisations is something the 'system' has been striving to achieve for sometime. Patients tell us it is something they want too. The 'Patient Journey' booklet we propose could go part way to connecting organisations who are currently providing care for an individual, but more work needs to be done to connect up the whole 'system' and for the 'system' to have a joint way of keeping patients/carers involved and informed.

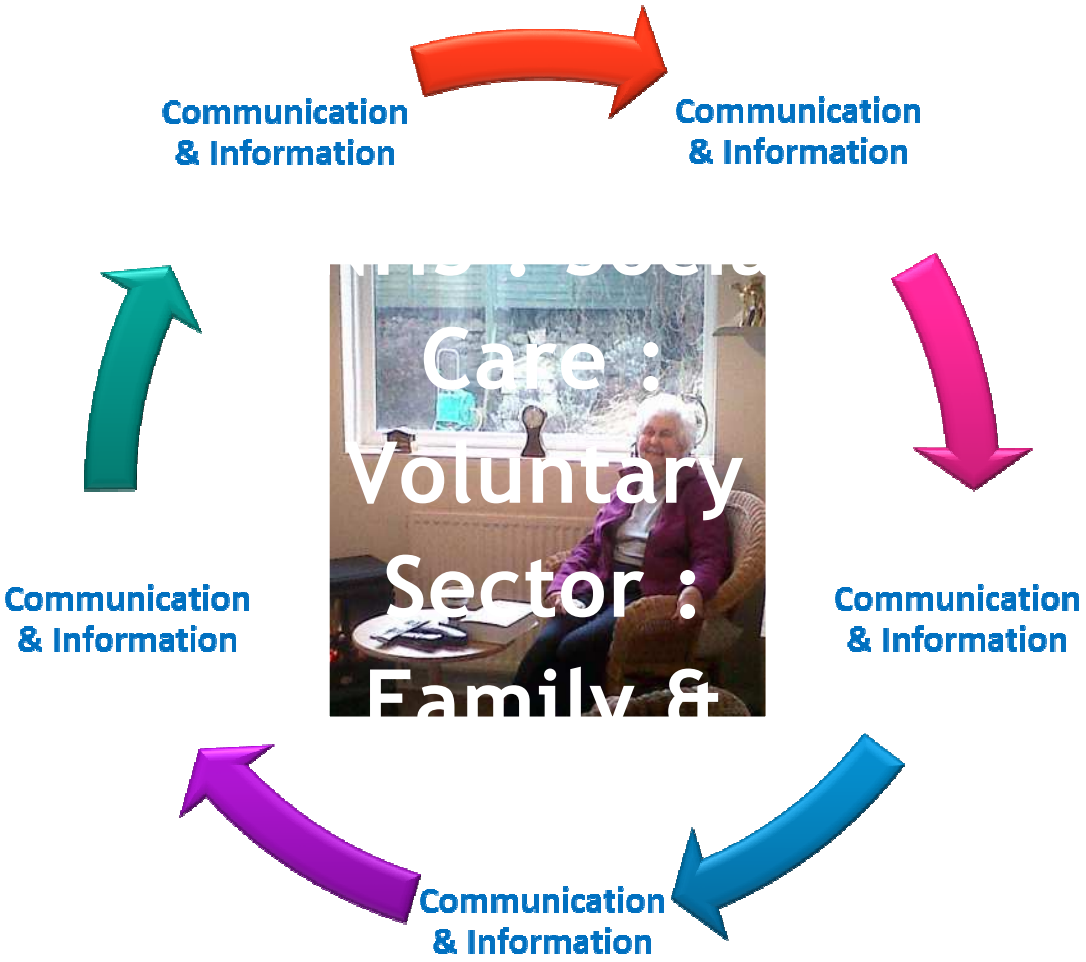
Ensuring the organisations that will be providing care, are all involved in the discharge process is a key element for patients and their ongoing care. Patients and their families do not always see this and that needs to be embedded in the discharge process. Patients/carers tell us they want this to include domiciliary care agencies and care homes directly.

Although not picked up in our conversations with patients it should also be noted that our researchers were told of confusion amongst ward staff of the function of the Joint Discharge Team, and it was questioned whether it was being fully effective.

Organisations need to know about each other's services and know how to signpost patients/carers effectively to each other.

The Accountable Care Partnership is an opportunity to deliver this closer understanding of the different organisations and improve our joint working but again close working relationships need to be built with organisations providing 'social' care.

Although currently we would not see this as one of our recommendations, we would like to see the ***single point of access for discharge*** explored further, as a possible solution to providing wrap around and integrated care for the patient/carer and as an information hub for professionals.



Appendix B

Hillingdon's Older People Population Summary

Overview

Sub-national population projections (SNPP) by the Office of National Statistics (ONS) estimate that in 2016 38,900 of Hillingdon's residents are aged 65 years and over. SNPP estimates suggest that the older people population will increase by 9% in the period to 2020 to 42,500 and by 19% in the period to 2025 to 47,900. The 80 + population is projected to increase by 12% in the period to 2020 to 12,500 and 22% in the period to 2025 to 14,000.

43% of Hillingdon's 65 + population live in the Ruislip and Northwood locality, 31% in Uxbridge and West Drayton and 25% in Hayes and Harlington, which represents the part of the borough with the youngest population profile.

Census information showed that there were 23,423 households comprising only of people aged 65 + and of these 15.7% considered themselves to be frail.

At the time of the 2011 census 73.5% of Hillingdon's older population aged 65+ were owner occupiers and of those 89% owned their home outright. Approximately 20% of older people lived in the social rented sector and only 6% in private rented.

In 2015/16 the Council supported 2,415 older residents in addressing their long-term social care needs.

Dementia

POPPI (Projecting Older People Population Information) projections suggest that the number of people with dementia is likely to increase by 14% to 3,133 between 2015 and 2020 and by 25% to 3,606 in the period between 2015 and 2020. 67% of the increase can be attributed to the increase in the population of people aged over 85.

In 2015/16 the Council supported 643 older residents living with dementia in addressing their long-term social care needs. 11 people aged under 65 living with dementia were also supported.

Ethnicity

The 2011 census showed that for each five year period over the age of 65 the less diverse Hillingdon's population became. In 2016 79% of Hillingdon's older people population is estimated to be white and this is projected to reduce to 73% by 2021.

Health

The 2011 census showed that 14% of the 65 + population considered that that they had bad or very bad health, although 50% considered that they had good or very good health. 26% (9,020) of older residents said that their day to day activities were

limited a lot, 25% (8,970) said that their day to day activities were limited a little but 49% said that their activities were not limited at all.

Hillingdon's Older People Care Home Market Profile

1. Introduction

The purpose of this briefing is to summarise the profile of Hillingdon's current care home market for older people. Some of the information contained in this report is based on a report produced by Care Analytics Ltd for the Council in December 2015.

2. Summary: Key Headlines

The key headlines of this briefing are:

a) As at 30/09/16 Hillingdon had 49 care homes comprising of 1,482 beds.
b) 31 homes comprising of 1,353 beds are for older people.
c) There are 16 nursing homes in Hillingdon comprising of 749 beds.
d) There are 18 care homes for younger adults comprising of 129 beds.
e) 45% of older people placements are of self-funders, which compares to an average of 30% for London.
f) Providers owning more than 40 homes nationally own approximately 40% of the older people care home market in Hillingdon; 40% is also owned by providers owning between 2% and 5% of the older people market nationally.
g) 55% (27) of Hillingdon's care homes are in the south of the borough, e.g. below the A40, but 52% (773 beds) of bed capacity is in the north of the borough.

3. Care Home Market Overview

All Adult Care Homes

Category	Number of Care Homes	Number of Beds
All adult care homes	49	1,482
Registered nursing homes	16	749
Residential homes without nursing	33	733

Care Home for Older People

Category	Number of Care Homes	Number of Beds
All care homes for older people	31	1,353
Registered nursing homes	16	749
Residential homes without nursing	14	496

Care Homes for People Living with Dementia

Category	Number of Care Homes	Number of Beds
All care homes for people living with dementia	28	789
Registered dementia nursing homes	12	347
Registered dementia residential homes	16	442

4. Market Share Estimates

Estimated market share in older people care homes in Hillingdon

Placement Source	Percentage
LBH	35%
Other London councils	9%
London Continuing Healthcare	7%
Other public sector authorities	5%
Self-funders	45%

5. Provider Market: Nationally

LaingBuisson's Care of Older People: UK Market Report (September 2015) showed that just four providers control just over 15% of the care home market in England and these are:

- Four Seasons
- Bupa Care Homes
- HC-One Ltd
- Barchester Healthcare

6. Provider Market: Locally

Older People Care Homes

Company	Hillingdon			London			England (all care homes)		
	Beds	Care Homes	Market Share	Beds	Care Homes	Market Share	Beds	Care Homes	Market Share
Care UK	201	3	16.8%	1,816	28	5.9%	6,288	101	1.5%
Lifestyle Care (2011) PLC	134	2	11.2%	1,211	16	3.9%	1,669	22	0.4%
HC-One Ltd	90	2	7.5%	581	9	1.9%	7,926	153	1.9%
Lifestyle Care PLC	85	1	7.1%	245	2	0.8%	857	10	0.2%

7. Key Issues for Hillingdon's Care Home Market

Debt - The buy and lease financing model, particularly for the larger providers, leaves them with a considerable debt to service and this makes them vulnerable to market fluctuations. The Southern Cross collapse of 2011 illustrates this.

National Living Wage - Introduction of the NLW has increased staffing costs and this has filtered down into increased placement fees.

Staff recruitment and retention - Hillingdon is a high employment area and most homes experience difficulties in recruiting and retaining staff for what continues to be low paid work. The issue is particularly pressing in nursing homes, which are not regarded as an attractive working environment for nurses. There is a national shortage of nurses and providers are also competing with local NHS providers, e.g. Hillingdon Hospital and CNWL.

Regulation - All care homes are required to register with the Care Quality Commission (CQC) and are subject to inspections to ensure compliance with statutory standards issued under the Health and Social Care Act, 2008. CQC has the power to serve improvement notices and place embargoes on further placements where required to give providers time to improve standards. Non-compliance with an improvement notice is a criminal offence.

Quality Assurance Team - Hillingdon is unusual for London in that LBH has a Quality Assurance Team that supports CQC in making announced and unannounced visits to care homes and providing support to the providers improve standards. The team acts as an early warning system for CQC. The Team works closely with the CCG's safeguarding lead. The frequency of visits is determined by a risk assessment process that is informed by intelligence such as complaints and concerns from residents and their families and/or friends, as well as other professionals.

Market standard rooms - Some of the smaller care homes in Hillingdon do not have rooms that satisfy the market standard, e.g. do not have en suite bathrooms. This is mainly those in converted houses and makes them very vulnerable to changes in demand, as they cannot easily be converted to meet the required standard.

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Major Review - Stroke Prevention in Hillingdon - Update

Contact Officers: Khalid Ahmed
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REASON FOR ITEM

The Committee will be provided with an update on information which was requested at the last meeting of the Committee relating to the Stroke Prevention in Hillingdon review

OPTIONS OPEN TO THE COMMITTEE

The Committee is asked to consider the additional information which will be provided as part of the evidence for the Committee's review into Stroke Prevention.

INFORMATION

1. At the last meeting of the Committee held on 2 November 2016, the Committee was provided with a progress report on the Stroke Prevention review which the Committee began in April 2016.

2. 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.

Preventative Measures

3. The review was informed that with regard to preventive measures, the best way to prevent strokes was through healthy eating, being physically active, smoking cessation, keeping weight down and sensible drinking. It was noted that although exercise was an important element in reducing weight and managing stroke risk, 80% of the management of obesity was through better nutrition.
4. In 2016/17, a Pilot Programme investigating the early detection of people with stroke would be taking place under the Better Care Fund. Identifying atrial fibrillation (AF), one of the risk factors for stroke, was added to the programme, and checking adequate numbers of residents was likely to increase the Council's capacity to prevent more strokes.

5. With regards to the work being conducted by GPs, the Hillingdon Clinical Commissioning Group currently had a working group investigating stroke prevention, and in terms of treating stroke, GPs were working with the CCG and looking at anti-coagulation. When blood was thinner, there was less prevalence of stroke among AF-afflicted people. Furthermore, scoping work was taking place at Hillingdon and Harefield Hospitals to see how the stroke prevention service could be delivered in a different way.

6. **NHS Health Check** - This was a mandatory programme commissioned by local authorities for early detection of vascular diseases for those who might have an illness but were not aware of it. Hillingdon Council commissioned the NHS Health Checks programme via local pharmacists and GPs, and it was aimed at the population group aged 40-74 years for identifying the risk of vascular diseases, including strokes. In 2015/16, there were 72,893 Hillingdon residents and people registered with Hillingdon GPs who were considered eligible for the NHS Health Check programme.

7. 11,435 residents received their First Offer of an NHS Health Check in 2015/16, an increase of 22% from the previous year. Of those offered the Health Check, 7,700 (67.3%) took up the offer in 2015/16, which equates to 10.6% of all those eligible. While the First Offer of an NHS Heath Check increased from 2014/15, there was a 2.7% decrease in those who took up the offer in 2015/16.

8. However, one of the earlier studies found that NHS Health Checks averted 1,800 strokes per year in England, and since then, the programme has been rolled out nationally, with the identification of atrial fibrillation added to the programme.

9. Regulations made in 2013 set out legal duties for local authorities to make arrangements for NHS Health Checks to be offered to each eligible person aged 40-74 once every five years, and for each person to be recalled every five years, if they remained eligible, so that the risk assessment includes specific tests and measurements, as well as ensuring that the resident having their health check was told their cardiovascular risk score and their other results.

10. The Committee heard evidence during the review from the Stroke Association who promoted secondary prevention through:

    - Providing generic information about lifestyle and risk factors to stroke survivors and their families;
    - Identifying individual risk factors, providing specific information and, where appropriate, referring to statutory and voluntary agencies such as smoking cessation, stroke rehabilitation classes, physiotherapy, Age UK active ageing, GPs and others;
    - Inviting representatives from health and fitness organisations to give information talks at Long Term Communication Group; and,
    - Looking to arrange some activities to promote a healthier lifestyle such as a walking group, walking football and swimming after stroke lessons.

11. For this meeting, Members will be provided with 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).

Other approaches from other local authority public health teams

13. Officers have contacted neighbouring local authorities to look at their approaches to stroke prevention and here are some examples:

London Borough of Harrow:

- Standard initiatives to improve health and wellbeing (improve diet and exercise, reduce alcohol and smoking etc.)
- Free blood pressure checks as part of health checks are **key** (available to staff and residents)
- Include risk assessments incorporating lifestyle, family history etc.
- Know Your Numbers campaign - http://www.bloodpressureuk.org/microsites/kyn/Home
- Collaborative working between LA's (Brent, Harrow and Hillingdon) and local charities/organisations e.g. blood pressure association http://www.bloodpressureuk.org/BloodPressureandyou?gclid=CO7M0NOBrdACFY0y0wodLhUCRw
- Local organisations often willing to run sessions put on by LA for staff/residents, for free
- Diabetes can cause variety of underlying cardiovascular issues including strokes. Blood Pressure checks etc can be incorporated into diabetes reviews - low, moderate, high risk = referral to GP
- The use social media to raise profile/information - campaigns
- Online tools such as self-checks - inexpensive way to raise awareness and prompt action in residents http://www.nhs.uk/Tools/Pages/bloodpressurequiz.aspx ; https://www.nhs.uk/conditions/nhs-health-check/pages/check-your-heart-age-tool.aspx
- Training for nurses to check for Atrial Fibrillation
- Dieticians from local charities/bodies
- Inexpensive monitoring equipment for home - http://bhsoc.org//index.php?cID=246

City of London:

- The City of London have used the services of a health promotion and wellness service to run insight lunches in the past covering stroke awareness / prevention and general cardiovascular health which is closely linked. These events are for staff as the Council does not have responsibility for residents.

London Borough of Bexley

- Specific stroke prevention does not really take place in Bexley but mandated NHS Health Checks are carried out, which look at Cardio Vascular Disease risk assessment and prevention. This includes checking atrial fibrillation for increased risk of stroke.

Primary Care Intelligence Packs provided by National Cardiovascular Intelligence Network

15. For Members information and for additional background reading the link here http://www.yhpho.org.uk/ncvinintellpacks/Default.aspx This provides details on Stroke and stroke prevention and treatment specific to local areas.

Visit to Hillingdon Hospital's Stroke Unit

16. On 8 December 2016, Members of this Committee were invited to attend the Stroke Unit at Hillingdon Hospital to enable Members to see the work of the Unit and to discuss issues surrounding the review, with patients in the Unit.

CABINET FORWARD PLAN

Contact Officer: Khalid Ahmed
Telephone:01895 250833

REASON FOR ITEM

The Committee is required to consider the Forward Plan and provide Cabinet with any comments it wishes to make before the decision is taken.

OPTIONS OPEN TO THE COMMITTEE

1. Decide to comment on any items coming before Cabinet

2. Decide not to comment on any items coming before Cabinet

INFORMATION

1. The Forward Plan is updated on the 15th of each month. An edited version to include only items relevant to the Committee's remit is attached below. The full version can be found on the front page of the 'Members' Desk' under 'Useful Links'.

SUGGESTED COMMITTEE ACTIVITY

1. Members decide whether to examine any of the reports listed on the Forward Plan at a future meeting.

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Ref	Upcoming Decisions	Further details	Ward(s)	Final decision by Full Council	Cabinet Member(s) Responsible	Officer Contact for further information	Consultation on the decision	NEW ITEM	Public / Private Decision & reasons
SI = Standard Item each month					Council Departments: RS = Residents Services	SC = Social Care	AD = Administration		FD= Finance
Cabinet - 15 December 2016									
129b	**Housing Allocation Policy**	Following a full consultation process approved by Cabinet in July, Cabinet will consider the responses and the way forward for the Council's Social Housing Allocation Policy.	All		Cllr Philip Corthorne	AD / RS - Raj Alagh / Dan Kennedy	Full consultation		Public
156	**Integrated Sexual & Reproductive Health Services with HIV Prevention & Support**	Cabinet will consider the award of a contract to the recommended service provider for the Integrated Sexual & Reproductive Health Services with HIV Prevention & Support.	All		Cllr Philip Corthorne	RS / FD - Nigel Dicker / Joyce Jones / Steve Hajioff			Private (3)
157	**Void Property Repair Service Contract**	Cabinet will consider entering into an agreement to provide a comprehensive Void Property Repair Service contract predominantly for general building fabric repairs in all trades to Hillingdon's housing properties, dwellings and outbuildings.	Various		Cllr Jonathan Bianco	RS - Gary Penticost / Michael Breen			Private (3)
145a	**The Council's Budget - Medium Term Financial Forecast 2017/18 - 2021/22 BUDGET & POLICY FRAMEWORK**	This report will set out the Medium Term Financial Forecast (MTFF), which includes the draft General Fund reserve budget and capital programme for 2017/18 for consultation, along with indicative projections for the following four years. This will also include the HRA rents for consideration.	All	23-Feb-17	Cllr Ray Puddifoot MBE & Cllr Jonathan Bianco	FD - Paul Whaymand	Public consultation through the Policy Overview Committee process and statutory consultation with businesses & ratepayers		Public
Cabinet - 17 January 2017									

Ref	Upcoming Decisions	Further details	Ward(s)	Final decision by Full Council	Cabinet Member(s) Responsible	Officer Contact for further information	Consultation on the decision	NEW ITEM	Public / Private Decision & reasons
SI = Standard Item each month				Council Departments: RS = Residents Services		SC = Social Care AD = Administration			FD= Finance
165	**Replacement of Communal Boilers - Mandela Court (Cowley), Heathfield Rise (West Ruislip) & Oakwood Road (Northwood Hills)**	A recommended tender to replace the communal boilers at Mandela Court, Heathfield Rise & Oakwood Road properties will be presented to Cabinet. This works project will provide reliable heating and hot water services to residents.	Uxbridge South, West Ruislip, Northwood Hills		Cllr Jonathan Bianco	RS - Gary Penticost		NEW	Private (3)

WORK PROGRAMME 2016/17

Contact Officer: Khalid Ahmed
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REASON FOR ITEM

This report is to enable the Committee to review meeting dates and forward plans. This is a standard item at the end of the agenda.

OPTIONS AVAILABLE TO THE COMMITTEE

1. To confirm dates for meetings

2. To make suggestions for future working practices and/or reviews.

INFORMATION

All meetings to start at 7.00pm

Meetings	Room
21 June 2016	**CR 4**
28 July 2016 (CANCELLED)	**CR 6**
6 September 2016	**CR 5**
4 October 2016	**CR 6**
2 November 2016	**CR 4**
14 December 2016	**CR 6**
18 January 2017	**CR 6**
21 February 2017	**CR 6**
23 March 2017	**CR 5**
19 April 2017	**CR 5**

Social Services, Housing and Public Health Policy Overview Committee

2016/17 - DRAFT Work Programme

Meeting Date	Item
21 June 2016	Major Reviews Topics 2016/17
	Work programme for 2016/17
	Cabinet Forward Plan

28 July 2016 (CANCELLED)	Budget Planning Report for SS,Hsg&PH
	Scoping Report for Major Review
	Work Programme
	Cabinet Forward Plan

6 September 2016	Major Review - Hospital Discharges - background information
	Cabinet Forward Plan
	Annual Report: Adult Safeguarding Board
	Annual Complaints Report
	Work Programme

4 October 2016	Presentation and Scoping Report for Major Review - Hospital Discharges
	Update on Stroke Prevention review
	Annual Report: Adult Safeguarding Board - Officer responses to questions from Members
	Cabinet Forward Plan
	Work Programme

2 November 2016	Major Review - Hospital Discharges - Witness Session
	Update on previous review recommendations (Shared Lives Review)
	Cabinet Forward Plan
	Work Programme

14 December2016	Major Review - Hospital Discharges - Witness Session
	Stroke Prevention Review - Update
	Consideration of Second Major Review
	Cabinet Forward Plan
	Work Programme

18 January 2017	Budget Proposals Report for 2016/17
	Major Review - Hospital Discharges - Draft Final Report
	Major Review - Stroke Prevention - Draft Final Report
	Cabinet Forward Plan
	Scoping report for Second Review
	Work Programme

21 February 2017	Cabinet Forward Plan
	Minor Review - Employment of People with Disabilities
	Work Programme
	Witness Session

23 March 2017	Cabinet Forward Plan

	Work Programme
	Witness Session

19 April 2017	Cabinet Forward Plan
	Major Review Second Final report