BRIGHTON & HOVE CITY COUNCIL

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE

4.00pm 4 FEBRUARY 2015

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Rufus (Chair)

Also in attendance: Councillor C Theobald (Deputy Chair), Bennett, Bowden, Cox, Marsh, Meadows and Sykes

Other Members present: co-optees from Healthwatch; Older People's Council; Youth Council

PART ONE

23 PROCEDURAL BUSINESS

23.1 There were no declarations of substitutes.

23.2 Councillor Bowden declared an interest in Item 27, he has carried out some work for the Health and Social Care Information Centre.

23.3 There were no declarations of party whip.

23.4 Press and public was as per the agenda.

24 MINUTES OF PREVIOUS MEETING

24.1 The minutes of the previous meeting were agreed. Councillor Marsh commented on the item reporting on the PLACE inspection of the Eye Hospital, she has attended there recently in a personal capacity and wanted to record her thanks for the excellent service that she had received.

Councillor Theobald also drew Members' attention to the free Healthchecks that were being offered.

25 CHAIR'S COMMUNICATIONS

25.1 Sussex Community Trust had sent HWOSC a letter for information- they will be introducing a managed parking scheme at their Elm Grove site. The letter would be circulated to members for information.

25.2 There had been a pan –Sussex health scrutiny meeting at Sussex Partnership Foundation Trust; minutes would be circulated in due course. SPFT are holding a 2020 vision event on Friday 6 February, all were invited to attend.

25.3 The Chair welcomed the new representative for the Older People's Council, Colin Vincent.

26 INTRODUCTION TO THE CARE ACT

26.1 Philip Letchfield, Head of Modernisation and Performance, Adult Social Care, gave a presentation on the Care Act.

26.2 Mr Letchfield said that the Care Act would bring the biggest change to statutory duties since 1948, it was the consolidation and modernisation of a great deal of existing legislation. It is bringing some existing policy into statute including safeguarding and personalisation. It is also introducing new legislation. It does not cover the Mental Health act or Deprivation of Liberty legislation. Most of the Act is due to come into effect in April 2015, with the remainder in April 2016.

The guidance guides people through the customer journey from the first contact. It is very person centred, it does not talk about 'services' but it is about users, with choice and control the main drivers.

26.3 The key changes for April 2015 include:

1 – the local authority has to meet a person's needs when they are deemed 'substantial'. Brighton and Hove City Council (BHCC) already works to this standard
2 – Carer's eligibility – the threshold for assessment and support is significantly reduced but Brighton & Hove has been taking an active approach to identifying and supporting carers for several years.
3 – Safeguarding – BHCC already has most of these elements in place
4 – Independent advocacy; this is new
5 – Deferred payments - BHCC has had this in place for two years, the only change is the Council can now charge an administration fee and interest on the loan.

26.4 The funding of care will change in April 2016, in response to the Dilnott enquiry. There is currently a limitless cost to care but the indications are that from 2016 people will not pay more than £72000 for care in their lifetime. For people who eligible care needs when they reach 18 years of age there will be no charges for care in their lifetime. The cap is on care costs not total costs, the resident in care homes will stay pay up to £12000 per annum for associated costs.

The cap will not be retrospective; costs will start accruing in April 2016. Everyone who wishes to be included will have to have a Care Account, following an assessment by BHCC social workers; predictions are that there will be another 2000 people who will be eligible for assessments in 2016.

Funding towards the care cap will be based on the usual cost that BHCC will pay, so if the care home is above that threshold, the resident will not count towards the cap. This has led to discussions with providers which are likely to continue.

26.5 The threshold at which the local authority makes a financial contribution is also changing. Currently if people have over approximately £23000 in assets, the council does not have a duty to make any contribution. From April 2016, this threshold will rise to £118000 – if someone has less than this in assets, the council will have some contribution.

A report has been presented to the Health and Well Being Board re charging for services, it is not proposed to charge carers for support services.

Finance modelling has taken place to assess the ten year impact of the Care Act. Every local authority has been given £125,000 to help with the implementation in 2014/15.

26.6 Locally, the Modernisation Board meets every fortnight to plan the implementation of the Care Act, with a number of workstreams and actions shared with the Better Care Fund. There are a number of elements that have been put in place and that are still to be implemented, including increasing the online offer, increasing training and development for staff, mapping the business processes and a need to engage with people who had not previously been eligible for assistance.

26.7 Members commented and asked questions:

- In response to a query about the scope of the Act, Mr Letchfield said that the Care Act applies to England only. There is guidance given for situations if people move cross-border.
- There will be an administration fee to set up deferred payment schemes and interest will be interest charged
- The CCG currently fund the free nursing care element of nursing home places and there are no plans to change this
- Members queried what would happen to people with low/ moderate needs. Mr Letchfield said that investment in preventative services is a key part of the strategy. They are looking at how to work in partnership with the CCG and Public Health amongst others
- Members asked how users were involved in setting up the implementation systems and how user feedback was incorporated? Mr Letchfield said that there has been user group testing of information provision, which will be a sustainable model going forward. There are regular bulletins and a communications campaign to include user involvement information.
- Members asked whether the £125000 was ringfenced; Mr Letchfield confirmed that it was. The money is to enable programme management and is for this year only.

26.8 The Chair thanked Mr Letchfield for his presentation –clearly the budgetary implications would be of concern to the whole council so he asked Mr Letchfield to circulate the financial modelling figures when they are available. This was agreed. The presentation was noted.

27 ADULT SOCIAL CARE PERFORMANCE MONITORING

27.1 Philip Letchfield presented a report on Adult Social Care performance. He explained that the performance framework had been dramatically changed in recent years, where existing performance measurements had been scrapped. The new system is based on sector-led improvements. BHCC has performed very well on the annual user survey results.

Mr Letchfield said that the council took part in a number of voluntary engagement events, including the City Summit and events in Jubilee Library to reach as wide a range of people as possible. Mr Letchfield said that they were all very valuable schemes but they did have a resource implication so they would be reviewed on a case by case basis.

With regard to the Local Account document, Mr Letchfield said that this had moved from being a purely data driven piece to include more case studies and personal stories. This change had been made following user feedback.

27.2 Members commented and asked Mr Letchfield further questions:

- How many people completed the user survey? Mr Letchfield said that there was a response of between 400 – 450 returns which gives a statistically representative response
- There was a discussion about the Delayed Transfer of Care figures. It was pleasing to see the improvements in service. Denise D'Souza, Executive Director, Adult Services, commented that last year was a particularly good year. This year was more challenging as the system was working at full capacity. There was still positive news – on average people are coming out of hospital care six days earlier this year than last year.
- How do we compare with East Sussex County Council in Delayed Transfers of Care? Mr Letchfield said that East Sussex was not part of BHCC's comparator group, but that Adult Social Care works closely with colleagues across West and East Sussex to share information and learning.
- Members asked whether care providers paid the Living Wage (rather than minimum wage)? Ms D'Souza said that when the contracts were retendered, the commitment to paying a Living Wage was included in the tender. This would be included in future tendering processes. However it should be noted that the council does not have any influence over contract arrangements for residential care.
- Ms D'Souza also commented that 'sector-led' improvement was very challenging, and neighbouring authorities would be ask to report on one another, there is a robust infrastructure. HWOSC members might like to hear more about this at a later date, to understand benefits and weaknesses in the system. This was welcomed.

27.3 The Chair thanked Ms D'Souza and Mr Letchfield for the report and agreed to table a report on sector-led improvement at a future meeting.

28 CCG REVIEW INTO PREMATURE MORTALITY

28.1 Kate Gilchrist, Head of Public Health Intelligence, and Dr Katie Stead, GP Lead for Primary Care Quality and Public Health presented a report with their initial findings into premature mortality in the city. The audit has involved all of the GPs in the city, which is the first time that all practices have agreed to be involved in a piece of research in this way.

The audit had focussed on three diseases, diabetes, chronic obstructive pulmonary disease (COPD) and cardio-vascular disease. Brighton and Hove has a higher mortality rate from causes considered preventable than England and the South East, and in particular under 75 mortality from respiratory disease. Each person who had died before the age of 75 of one of these diseases has had their medical records audited; there is now an in depth audit of each person's GP notes to add further information. The emerging themes from the in practice audit confirms some of the trends that had been identified in the first wave of research. There is a trend of socially isolated patients, with high incidence of depression.

Ms Gilchrist and Dr Stead presented some very early findings to HWOSC members; these included a link to deprivation although this was not the only contributing factor. There were higher rates of deaths for men between 55 and 74. In all categories, smoking, obesity and alcohol consumption rates were higher than average. Exception reporting was also high for those with diabetes and COPD.

Some actions have already come out of the audit; these include extra funding of Health Trainers by Public Health and the Clinical Commissioning Group, bringing the total to ten FTE health trainers. There has also been some peer to peer information sharing, for example looking at practices with low levels of exception reporting.

28.2 Members commented on the report and asked questions:

- Members asked for more information on health trainers. Ms Gilchrist said that health trainers are very successful at engaging with men on health matters as well as people from more deprived areas – two key groups identified in the audit. They offer behaviour change programmes. There is a national evidence base for their effectiveness and cost effectiveness.
- How do you measure deprivation? Ms Gilchrist said that they use the index of multiple deprivation, to assess areas in groups of 1500 households.
- Has average life expectancy increased or decreased over time and can this be made available online? Ms Gilchrist said that on average, life expectancy has increased by three months per year. Inequalities have reduced for the first time. Life expectancy at small area level is already available through the partnership data site http://www.bhconnected.org.uk/content/local-intelligence
- Members asked work with licensing, given the links with alcohol consumption? Ms Gilchrist said that public health was working increasingly closely with licensing now that they are part of the same Directorate under Tom Scanlon, the Director of Public health, and the team are involved in monitoring and addressing alcohol consumption. For example with the public health alcohol licensing framework, Dr Scanlon giving evidence at licensing, and input to the policy review. There is a Healthy Weight programme board too, which is looking at healthy food matters.

- Members asked whether drug consumption was assessed? Ms Gilchrist said that it had not been particularly high, though it was notable in the homeless practice.
- Will the audit be extended to other diseases? Dr Stead said that it was not planned at present as the current audit still has a lot more work to undertake. Ms Gilchrist said that there had recently been a separate cancer audit so it was not included here and there are annual audits for drug related deaths and deaths from suicide.
- Dr Stead commented that NHS England are using this audit as a way of showing other CCGs how to address health inequalities as part of a series of regional workshops.

28.3 The Chair thanked Ms Gilchrist and Dr Stead and wished them luck with the further audit and outcomes.

29 HEALTHWATCH BRIGHTON AND HOVE - ACHIEVEMENTS OVER THE LAST TWELVE MONTHS

29.1 Frances McCabe, Chair of Healthwatch Brighton & Hove (HWBH) spoke to HWOSC members about their work over the last 12 months. She explained that HWBH has a small staff team, working to build relationships with partners to influence health provision. There are a large number of volunteers, who feed back intelligence to the wider organisation. HWBH has a place on the Health and Wellbeing Board.

HWBH has worked on a number of local health issues including most recently the closure of the Eaton Place GP surgery.

HWBH has a statutory right to Enter and View premises; they have just done this at Royal Sussex county Hospital, along with East Sussex Healthwatch. They have taken part in PLACE inspections of hospital sites; following concerns that they raised about the Eye Hospital, a large refurbishment programme was introduced.

Other aspects of HWBH's work includes a helpline, which tends to receive calls about primary care; they have a large research database, which they use to ensure that no issues are being overlooked – the scrutiny of the database led to recent work on CAMHS. HWBH has set up a Community Interest Company.

29.2 Members commented and asked questions:

- How does HWBH make sure it doesn't become part of the health system? Ms McCabe said that she is always explicit about the fact that she is there to reflect the voice of the service users. HWBH can be sympathetic of service pressure on organisations but they are in place to speak for users.
- How do you prioritise your work? Ms McCabe said that HWBH looks at all of the data and intelligence available, listens to soft intelligence and makes a priority decision. Some of their client groups are given higher priority for example older people who are vulnerable and isolated.
- How does HWBH avoid duplication with other health watchdogs? Ms McCabe said that it was decided by whether HWBH could have an impact on an issue.
- Members asked whether Ms McCabe was getting sufficient support from paid staff as she is contracted for part time hours only. Ms McCabe said that it is a small staff team

with a lot of demands to attend meetings. It is hard to balance everything out, but it is an ongoing issue.

- Where are the completed reports publicised? Ms McCabe said that it is included on the HWBH website and circulated to partner organisations. They send any recommendations to the main organisations at an early stage to see whether they can be incorporated to their work plans. If the recommendations are taken up, this is reflected in the final report. If you have a good working relationship with a provider, helpful criticism can have a positive impact on their working practices.
- Ms McCabe added that there is more potential for HWOSC and HWBH to synergise their work from a user perspective; it was agreed that she would meet with the HWOSC Chair to discuss this further.

29.3 The report was noted and Ms McCabe thanked for her attendance.

The meeting concluded at 6.30pm

Signed Chair

Dated this day of