Adult Social Care, Health and Wellbeing Sub-Committee

5 November 2015

Present: Councillor P Brooks (Chair)
Councillors K Barrie, L Bell, J Cassidy, K Clark (Deputy Chair), C Davis, M Green, L Miller, J O'Shea, T Mulvenna, M Reynolds

Also Present: Councillor L Spillard, Cabinet Member for Public Health

ASCHW31/11/15 Apologies

Apologies for absence were received from Councillors W Lott, D McMeekan, A Percy .

ASCHW32/11/15 Substitute Members

Pursuant to the Council's constitution the appointment of the following substitute Members were reported:-

Councillor J O'Shea for Councillor W Lott
Councillor T Mulvenna for Councillor D McMeekan

ASCHW33/11/15 Declarations of Interest and Dispensations

The following declarations of interest was made:

Councillor J Cassidy declared a non-registerable personal interest in item 6 - Children and Young People's Mental Health and Emotional Wellbeing Strategy as a family member attended CAMHS.

Councillor K Barrie declared a registerable personal interest in item 6 Children and Young People's Mental Health and Emotional Wellbeing Strategy and item 7 – Health Informatics as he was employed by Northumbria Healthcare Foundation Trust.

ASCHW34/11/15 Minutes

The minutes of the meeting held on 8 October 2015 were confirmed.

ASCHW 35/11/15 Better Care Fund update

The sub-committee received an update report on the Better Care Fund (BCF). The Programme Manager, Adult Social Care introduced the report and gave an update on progress against the key outcomes outlined in Appendix 1 of the report.

Members were informed that since the last report there had been no change for some outcome measures, this was due to performance data being collected on a quarterly basis.

At the last meeting the sub-committee requested supplementary information in relation to the effectiveness of reablement, in particular the percentage of clients reporting a 'better' outcome following reablement. Members were informed that a briefing note had been produced and circulated.

The End of Life Clinical Lead and the Commissioning Manager, North Tyneside Clinical Commissioning Group attended the meeting to give a presentation on End of Life Care in North Tyneside. End of Life Care is an important element of the BCF.

The presentation gave details of the progress that had been made in relation to end of life care services and identifying people at their end of their life so that co-ordinated care can be planned.

A number of initiatives had been put in place including a GP Palliative Care Register. The sub-committee noted that approximately 1% of patients die each year; therefore each GP practice is expected to have 1% of their patients on the register. It was explained that predicting a death is very difficult and that the inaccuracy rate is currently 30%. The register will result in better quality of care for patients and increases their chance of dying in their preferred place of death, it also provides vital information for other care providers. In 2012, North Tyneside had 0.3% of patients on the GP Palliative Care Register which was higher than the national average of 0.2%, 2015 data shows that this has increased to 0.52%, in relation to the percentage of deaths at home, in 2012 this was 49% which again was higher than the national average of 41.6%, 2015 data shows this has increased further to 51.6%.

It had been identified that the highest need was in nursing homes, as the average life expectancy of residents in nursing homes was 18 months. Members noted that £120,000 had been invested in a team to support nursing homes; this included a part-time Macmillan nurse, full-time district nurse and admin support. Their main aims of the team are to:

- Facilitate education and care in nursing homes to enable staff to start to have end of life conversations with patients linking in with the primary care team
- Support nursing home staff to reduce inappropriate admissions to hospital
- Review any inappropriate admissions and learn from them

The team have also been helping nursing homes to establish and maintain their own palliative care register. They use the Gold Standard Framework, traffic light ratings to define the status of their residents, for example red identifies residents who have 'days prognosis' and are in the 'terminal phase'. The percentage of nursing home residents dying at their home as opposed to hospital is currently 87%. The team have now starting to work with residential homes, and benchmark data shows that the numbers of residents dying at their home as opposed to hospital has increased from 58% - 79%.

Evaluations of the service show that there had been huge benefits to the workforce and patient and carer feedback so far been very positive. The End of Life Clinical Lead offered to bring back future results as and when they are available. As at August 2015, reduced hospital admissions from care homes as a result of the End of Life care work has resulted in £100,000 of savings.

The sub-committee were informed that as part of another initiative 2 Macmillan social workers had been employed for North Tyneside and that they get referrals from Adult Social Care, the Trust, community teams and GPs.

The presentation also gave information about the Rapid Response Hospice at Home Service which was due to start in December 2015. This will be consultant led and offer direct access for professionals and patients/carers Monday – Sunday between 8am to 10pm and the service aims to respond within the hour.

A Patient Carer Voice Survey carried out in June 2015 in relation to Palliative/End of Life Care in North Tyneside produced positive results and provided lots of useful feedback on End of Life care.

The presentation concluded by outlining what is planned for 2015/16, this includes:

- Rapid response service
- Enhanced Summary Care Record
- Who we are what we do and how to get in touch booklet available electronically with an option to download a hard copy
- Adult Social Care website to introduce an End of Life on line information resource
- Learning together from each other- a suite of End of Life training accessible to all
- New models of care

During questioning, the sub-committee asked a range of questions which were responded to appropriately. This included the sub-committee seeking clarification regarding the number of GPs using the GP Palliative Care Register. It was explained that all GPs are committed and using the register, however use is variable between practices. One of the biggest challenges is getting GPs to have the right amount of patients on their register. There has also been some issues in relation to coding, particularly coding differences between GP practices and care homes, it was explained that this isn't a big issue and that it is more important to get the planned cared and the right co-ordinated support in place for those patients rated as red or amber.

There was some discussion in relation to the GP Alliance which aligned all residential home patients to GP practices and how this alignment has resulted in higher levels of care for residents. Previous to the alliance it wasn't unusual for a care home to have 12 different GP practices going in. Members noted that the Macmillan work showed these inconsistencies and that it made sense to have one GP at each care home.

A Member expressed concern about the extra pressure put on care home staff now they are expected to provide end of life care as well as carry out their normal duties. It was explained that although staffing care homes is a challenge they are supported by the end of life team who go in and provide practical care and also sometimes the district nurse. The Clinical Commissioning Group are also putting in support mechanisms to help care home staff such as training in particular areas, for example, fluids and hydration; they are also ensuring that training is better co-ordinated so they do all training over one day rather than disparate training courses.

The Chair thanked the Programme Manager from Adult Social Care, the End of Life Clinical Lead and the Commissioning Manager from North Tyneside Clinical Commissioning Group for attending the meeting and their presentation.

ASCHW 36/11/15 Children and Young People's Mental Health and Emotional Wellbeing Strategy

The Acting Director of Public Health presented a report which updated the sub-committee on the development of the Children and Young People's Mental Health and Emotional Wellbeing Strategy and links with the Local Transformation Plan.

The report mentioned that the strategy is currently in development and sets out North Tyneside's multi-agency approach to promoting the emotional well-being and mental health of children and young people, along with an action plan which sets out what will be done to achieve this.

In August 2015, NHS England produced guidance for health and care economies on the development of the Local Transformation Plans, which will be a key part of the local strategy to improve children and young people's mental health and wellbeing. The intention is to significantly reshape the way services are commissioned and delivered across all agencies over the next 5 years.

The Transformation Plan was led by the Clinical Commissioning Group and developed by an existing partnership group, the CAMHS Interface Group. The plan was signed off by the Chair of the Health and Wellbeing Board and submitted to NHS England on 16 October 2015.

It was explained that the local strategy must strike the right balance between commissioning services for those children and young people with mental health problems (linked to the Transformation plan), whilst working to achieve the broader priorities of universal services, building resilience, effective education and prevention alongside early identification and intervention.

Some priorities for early delivery had been identified, and these are supported by additional national funding, these are:

- Build capacity and capability across the system
- Roll out the children and young people's improving access to psychological therapies programme (IAPT)
- Develop evidence based community eating disorder services for children and young people
- Improve perinatal care
- Bring education and local children and young people's mental health services together around the needs of the individual child

The new funds announced (approximately £447,000 for North Tyneside, including £127,000 for eating disorders) will be made available by NHS England to the CCG, subject to local transformation plans being assured in a national process.

North Tyneside's local transformation plan proposes to move away from a tiered model of service and adopt the THRIVE model which focuses on the needs of the child or young person. Priorities have been configured around each quadrant of the THRIVE model: Coping, Getting Help, Getting More Help and Risk Support.

Members learned that to ensure that as many stakeholders can participate in consultation on the wider strategy development, a combination of online surveys and focus groups/workshops will be employed during October and November 2015.

The sub-group noted that a Children and Young People's Emotional Health and Wellbeing Strategic Group will be established to replace the existing CAMHS Interface Group. This group will take forward the development of the Children and Young People's Mental Health and Emotional Wellbeing Strategy and will oversee the implementation plan arising from the local transformation plan.

During questioning, the sub-committee asked a range of questions which were responded to appropriately. There was some discussion in relation to how a child or young person accessed CAMHS and the waiting time to get treatment. It was explained that service operated a triage system and has priority and urgent referral criteria. It was stressed that to improve access to services it is crucial that we build capacity across the system. It is also envisaged that the roll out of the children and young people's IAPT will help to ease pressure on the system.

With regard to eating disorders, the sub-committee were assured that although the number of young people with eating disorders has gone up slightly we are not an outlier. The additional funding of £127,000 for this service was crucial because of the limited number of inpatient beds (12 in total) which are based in Middlesbrough and making it more difficult to access a bed.

As the additional funding of £447,000 is only for one year, the sub-committee expressed concern about the sustainability of this funding. It was explained that this is the reason why it is crucial to concentrate on the wider strategy particularly the role that other services can play and to capacity build within the resources we have.

The Cabinet Member for Public Health welcomed the fact that the survey/consultation included the views of families and stressed the importance of family members receiving the support and advice needed to care for their child.

There was some discussion in relation to understanding the risk factors which may make children and young people more vulnerable to mental health problems so they can be identified and receive support and early intervention to stop their mental health problems escalating.

A Member mentioned that a looked after child from Northumberland and being fostered in North Tyneside, wasn't allowed to access North Tyneside CAMHS and had to go to the one in Northumberland. The Acting Director of Public Health mentioned that cross boundary issues has also been reported by schools and agreed to note this issue as part of the strategy consultation.

The Chair thanked the Acting Director for Public Health for attending the meeting.

It was **agreed** to note the report and the progress that had been made.

ASCHW 37/11/15 Health Informatics

The Director of Health Informatics at Northumbria Healthcare Foundation Trust attended the meeting and presented a report which outlined the progress that has been made towards integrated care through the delivery of the detailed primary care record solution to support patient care at the point of care.

The sub-committee were informed that in 2014, NHS England invited NHS Trusts to bid for match funding from the Integrated Digital Care fund. A collaborative bid was submitted on behalf of the health economy to develop electronic information sharing. Although the bid was unsuccessful it did bring together the organisations that wished to collaborate for the benefit of patients/clients across the region. The interoperability project team continued to meet after the unsuccessful bid as there was still the will to make this happen.

It was explained the largest problem remains that at the time systems were procured across the economy, the emphasis on integration and interoperability was not embedded due to the national programme and are now left with systems that met individual business needs, but in isolation.

Given the scale of the integration problem it was decided to concentrate on sharing primary care information with clinicians (initially) at the point of care. The sub-committee were reminded that this is the first stage of a plan to allow appropriate access to information which will include, for example, social care, end of life and special notes.

The interoperability project team including the Clinical Commissioning Groups (CCGs) and foundation trusts chief clinical information officers as well as directors of informatics has extensively researched the market place to assess tools available to facilitate the ability to securely transfer consistent, robust primary care information to other providers involved in patient care and at this time there is only one developed solution that can meet the needs of a TPP and EMIS mix of primary care systems. It was recommended that the solution offered by Healthcare Gateway, Medical Interoperability Gateway (MIG) is procured for the population of North Tyneside and Northumberland to expedite safe and effective sharing of this information and so it is delivered in advance of the winter pressures.

Members noted that the pricing model is based on each CCG securing the right to share information for their patients and provider organisations being responsible for the configuration of their systems with appropriate information governance in place to view the information.

The sub-committee were informed that there had been no objections received and 6 practices have now signed up. Once 50% of GP practices sign up/agree it will be released to Northern Doctors.

The sub-committee expressed concerns regarding the sharing and storing of electronic patients data particularly about how secure the system would be. The Director of Health Informatics gave assurance that the system would be secure and explained some of the security aspects of the system. It was also clarified that patients already have the right to view their own health records.

A Member queried why Newcastle Hospitals weren't included on the list of organisations who were working collaboratively. It was explained that Newcastle Hospitals had withdrawn of the day of the submission but are involved. It was stressed that it is important that there are no barriers to sharing information across boundaries, and we are working closely with Newcastle Gateshead Clinical Commissioning Group who are also using this system.

There was some discussion about how the patient portal would work. It was explained that all of the information stored on the TPP and EMIS system would be MIG coded data and brought together in a single view.

The Chair thanked the Director of Health Informatics at Northumbria Healthcare Foundation Trust for attending the meeting.

It was **agreed** to note the report and progress that has been made.

ASCHW 38/11/15 Alcohol Related Violent Crime Study

The Democratic Services Officer introduced a report which updated the sub-committee on the implementation of the recommendations made in the Alcohol Related Violent Crime Study.

Members were reminded that during 2013/14 as part of it's work programme the Adult Social Care, Health and Wellbeing Sub-committee carried out a study into alcohol related violent crime, with an emphasis on domestic violence. The main objective was to examine the effectiveness of strategies, interventions and support in place by the Council and its partners, and to identify gaps in service and areas for improvement.

In total the sub-group made 12 recommendations, 11 were directed to Cabinet and 1 to Northumbria Healthcare Foundation Trust. All recommendations were accepted.

Section 3.8 of the report outlined each recommendation and the associated action, along with a progress update which was provided by the responsible officer.

In relation to Recommendation 4, which was to explore a potential model and commission a Perpetrator Programme in North Tyneside. Clarification was sought on the proposed in-year cuts to local authority public health ring fenced grants, which had resulted in this service not being procured. The Cabinet Member for Public Health explained that due to Government proposals to cut the public health grant in-year for 2015/16 by 6.2%, the Perpetrator Programme unfortunately hadn't been able to go ahead. It was also clarified that it wasn't a statutory service and no contract had been signed.

A Member expressed concern about the number of off-licenses opening outside of school premises. It was explained by a Member of the Licensing Committee that a process is in place which allows councillors to put their objections forward about any licensing applications, and that a full list of licensing applications is included in the weekly newsletter which goes to all Members.

It was **agreed** to note the report and the progress made.