LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH & ADULTS SCRUTINY SUB-COMMITTEE

HELD AT 6.35 P.M. ON MONDAY, 8 JULY 2019

COMMITTEE ROOM ONE - TOWN HALL MULBERRY PLACE

Members Present:

Councillor Kahar Chowdhury (Chair)

Councillor Shad Chowdhury	Councillor Marc Francis
Councillor Denise Jones	Councillor Gabriela Salva Macallan

Co-opted Members Present:

David Burbidge	Healthwatch Tower Hamlets Representative
Sue Kenten	Health & Adults Scrutiny Sub-Committee Co-optee

Other Councillors Present:

Councillor Amina Ali	Cabinet Member for Health Adults & Community

Apologies:

Councillor Andrew Wood

Officers Present:

Somen Banerjee	Director of Public Health
Claudia Brown	Divisional Director Adult Social Care
Rushena Miah	Committee Services Officer – Democratic Services
Denise Radley	Corporate Director Health Adults Community
Joanne Starkie	Head of Strategy & Policy - Health Adults Community
Ashton West	Strategy & Policy Officer – Health Adults Community

1. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS

There were no declarations of pecuniary interests.

2. HEALTH & ADULTS SCRUTINY SUB-COMMITTEE TERMS OF REFERENCE, MEMBERSHIP AND DATES OF MEETINGS 2019/20

The Chair welcomed Members and officers to the Committee. It was noted the vacant co-optee member role was filled by Sue Kenten.

Members queried why there was a large gap between the November and March meetings. Officers explained that these were the best available dates in the Corporate Calendar. In addition to this, the Overview and Scrutiny Committee decided to reduce the number of meetings from six to five in a year; this resulted in a provisional date for early January 2020 being dropped. It was suggested that the period between November 2019 and March 2020 could be used to schedule in scrutiny review sessions, Members agreed to the suggestion.

RESOLVED:

1. To note the Committee Terms of Reference, dates of meetings and work programme tabled at the meeting.

3. APPOINTMENT OF VICE-CHAIR

Councillor Denise Jones nominated Councillor Marc Francis as Vice-Chair of the Committee. Councillor Shad Uddin Chowdhury seconded the nomination. Members voted to appoint Councillor Francis as Vice-Chair.

RESOLVED:

1. To appoint Councillor Marc Frances as Vice-Chair of the Health & Adults Scrutiny Sub-Committee.

4. APPOINTMENT OF INEL JHOSC REPS

The Chair sought two additional Members to represent Tower Hamlets on the Inner North East London Joint Overview and Scrutiny Committee (INEL JHOSC). Councillor Gabriela Salva Macallan was appointed as the primary representative and Councillor Shad Uddin Chowdhury was appointed as a substitute to the INEL JHOSC.

RESOLVED:

1. To appoint Councillor Gabriella Salva Macallan as the Committee's representative to the Inner North East London Joint Overview and Scrutiny Committee.
2. To appoint Councillor Shad Chowdhury as a substitute representative to the Inner North East London Joint Overview and Scrutiny Committee.

5. REPORTS FOR CONSIDERATION:

6. HEALTHY LIFE EXPECTANCY IN TOWER HAMLETS - ANNUAL PUBLIC HEALTH REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2018

The Committee received the report of Somen Banerjee (Director of Public Health) on Healthy Life Expectancy in Tower Hamlets.

Key points raised in the presentation:

- Data analysis from the Annual Report would inform the new Health and Wellbeing Strategy and Strategic Plan.
- Healthy life expectancy was defined as the period in a person's life in which they experience good health. This period was consistently lower in Tower Hamlets compared nationally. The healthy life expectancy in Tower Hamlets was around 56 years, for example, whereas it was 71 years in Woking.
- Healthy life expectancy was lower for women in Tower Hamlets. As of 2014 the healthy life expectancy for men in Tower Hamlets increased and the trend had continued. Reasons behind this would be explored.
- There was a correlation between multiple deprivation and healthy life expectancy. Tower Hamlets still had high levels of concentrated deprivation despite the perception that the borough had risen in affluence.
- Stroke, cancer and respiratory disease were the biggest killers in the borough. High rates of diabetes continued to affect the South Asian community. It was estimated that three thousand people remained undiagnosed.
- The Primary Care Morbidity Survey showed Tower Hamlets had the highest levels of self-rated anxiety and depression in London but not the highest level of GP diagnosed mental health conditions.
- Tower Hamlets was an outlier in maternal health, smoking cessation and healthy diet. Wider factors such as crime, poverty, low income, insecure housing, overcrowding, poor adult literacy also impacted on wellbeing and healthy life expectancy.
- That the health and care system needed to understand who was using its services, address inequalities and consider intervention.
- Tower Hamlets had the highest level of obese 10-11 year olds. It was suggested a family approach should be taken to support healthy behaviours.
- That smoking continued to be a driver of health inequality and was prevalent in areas of deprivation.
- The borough was experiencing significant population growth and building development. Health impact assessments had been introduced for major planning and development applications.
- The Tower Hamlets Together Board was a key partner in the strategic planning of health services.
- The cycle of deprivation and inequality could be addressed by providing support at the start of the life course during the early years.
- The framework underpinning the Health and Wellbeing Strategy addressed three key priorities, these were: safety, a sense of purpose and a connection to other people.
- Bhutan's 'gross national happiness' gauge was praised as an innovative wellbeing indicator. Comparatively, the Thriving Cities

Framework in Bristol could provide insight into taking forward such a strategy in the UK.

Summary of Member questions and officer response:

With regard to the figures on page 49 of the report, you mentioned the differential and healthy life expectancy across the Olympic boroughs in men shoot up in 2014-16, but this table shows a pattern of ebb and flow. Was this due to how the data was collected or something else? Is the trend similar for 2017-19?

The Public Health team had also noted this pattern and queried it with data analysts. It was confirmed that the data was accurate and showed a significant improvement. The most recent data, which was not tabled at the meeting, showed that the improved trend was continuing.

Do we have the data by ethnicity and if not can we obtain it from the survey? Officers agreed to send Members the national breakdown by ethnicity because the ethnic breakdown for Tower Hamlets would be too small to identify significant trends.

What was the source of the data for those who self-reported with mental health issues?

The first source was a local survey about mental health. The second source came from GP held mental health registers.

Which projects can practically make a difference and where will the council put its money?

The Framework outlines the health strategy's overarching priorities which are in line with the council priorities. This includes things like secure housing, feeling safe, a sense of community. The biggest challenge is how to move into co-production and how to engage and connect people in a growing urban environment with populations in flux.

The Tower Hamlets Together partnership has a work stream called 'Measuring What Matters'. This is an impact based accountability framework and it has been used to monitor services around loneliness and physical activity. Outputs are being measured via a series of 'I Statements' and will be monitored by the Tower Hamlets Together partnership.

Are we doing enough to pump in resources to improve healthy life expectancy in deprived areas? Do you have any examples where you have made an improvement in a deprived area?

The Communities Driving Change programme is an example. The programme is a conscious co-production approach targeted to the twelve most deprived wards in the borough and aims to find out what matters to residents and what will support their health and wellbeing. Residents have reported feeling safer is a key issue as it would enable them to take part in healthier activities such as walking.

There is new funding for child and adolescents mental health. There are conversations happening around whether we should change the pattern of spend towards more intervention and early support services. Currently a significant portion of funds are being spent on treatment as opposed to prevention. Social prescribing has also proven to be effective and requires increased investment.

RESOLVED:

1. To note the report.

7. ADULT SOCIAL CARE CHARGING IMPACT ASSESSMENT - FOLLOW UP

The Committee received the report of Joanne Starkie (Head of Strategy and Policy for Health Adults and Community) on the Adult Social Care Impact Assessment follow up.

Summary of key points:

- Charging came in at end of 2017. The original impact assessment identified nine key areas for improvement. The assessment was conducted by a stakeholder panel that included carers. The Panel oversaw the strategy and came up with an action plan. Areas for improvement included: communications, future approach to charging and respite, clarity on charging, improving support to maximise income and avoid debt, direct payments, developing an appeals policy, approach to impact assessments and approach towards those who might end support due to charging.
- Communications was a critical issue and the council had since produced an easy read guide, produced clearer letters for correspondence, the financial assessment team offered surgeries at the carers centre to provide face to face support. REAL was consulted again to advise on making the assessment clearer. Pre-paid cards were also rolled out.
- With regard to respite care, the service was looking into alternative financial modelling to see if free respite was feasible and whether this would negatively impact other parts of the service.
- The Panel had agreed a core set of measures to measure the impact of charging.
- The situation at end of last April was similar this April; over half are being charged, 171 people have not completed an assessment form yet and so are being charged the full rate. Last April this figure was at 240.
- Last April 129 people were being charged the full amount capped at £250.00. This time it was 78 people.

- Last April 950 people were not paying for care; this had gone up to 1070.
- 171 had not filled in a financial declaration form by this April compared to 240 people last April. These people are being charged.
- On average 54 people have requested reassessment compared to 147 requests when charging was first brought in.
- Older people and those from a white background are more likely to be charged the full amount. Those from a South Asian background and those with learning disabilities are being charged at a lower rate or not at all.
- The number of people getting an assessment per month reduced. It was difficult to establish cause and effect due to other factors so need to look into this more.
- In the original impact assessment 47 care packages stopped due to charging this went up to 88 as of this April. Some of this was due to starting and stopping a package.
- There is a process in place to manage risk of those who want to end their package. There is a charging waver panel chaired by Divisional Director of Adult Social Care.
- Impact on wellbeing and satisfaction is ambiguous. Wellbeing gone down by 2 points but satisfaction gone up by 4 points. Last time this was reversed.
- Next steps are to continue looking at the core set of measures. It is important to note the action plan is still in progress. Communications will remain a top priority.

Summary of Member questions and officer response:

What is considered a 'close family member' in the charging policy? Would a son-in law be considered close family? Officers said they could check the policy wording.

How many people are employing carers? There were approximately 500 people who employed their own care staff. Officers agreed to provide the exact figure post meeting.

The drop from 204 to 154 seems large is that in line with what was expected? The report had noted this and the issue would be further explored.

Nine cases going to debt panel is shocking. Last meeting councillors were given the impression that officers would do the utmost to prevent people going to the debt panel. Can we have more information on the following?

- **Reasons why the nine cases went to debt panel and three issued a county court judgement**
- **The Framework for the Charging Waver Panel**
- **Details on what support is provided to people to avoid debt and county court judgements.**

Officers agreed to provide the information.

Councillor Francis expressed concern over the figures that were presented. He said some of the data was different to what was shown to Council when setting the budget, in particular the figures around the proportion of people who would have to pay. At the budget meeting councillors were told that two-thirds would not have to pay for care and one-third would, however, six months later the proportions had reversed. The figures in the follow up report showed that approximately 45% were not paying and 55% were. This amounted to around 1200 people paying for care and 1000 not paying. Over 250 people were paying over £100.00 a week. He said overall the situation was fundamentally at odds with what councillors agreed to in the budget.

Moreover, with regard to income generation and cost to this authority, he said councillors were told net savings would amount to £1.05 million to the council but in actuality there was significant income generation over and above what was budget for. Councillors should have been made aware of this.

Members also challenged the independence of the review. They said Councillors were led to believe there would be independence in the review but the review seemed to have been internally commissioned with little input from councillors or constituents. Some Members said that a truly independent review would have acknowledged that the policy may have required a fundamental alteration, such as reducing charges or scrapping the charges altogether.

The Committee requested information on the number of people who received Attendance Allowance and Personal Independence Payment. Officers agreed to provide this.

Members recommended that the action plan should be outcome based and clearly indicate how an improvement had been made for residents. They said they could not meaningfully scrutinise the information presented as it was.

The Committee requested to view the survey results from REAL, officers said they could provide this.

The Committee requested information on the approach to spouses in the Charging Policy, especially debt recovery in relation to spouses.

The Committee asked for financial data showing the amount being raised from charging and the amount being spent to administer charging since inception.

In response to Member concerns, officers said they were willing to provide additional data to enable councillors to better scrutinise. With regard to the terms of reference for the review user group, officers explained that due to the follow up being on a smaller scale a core set of measures were selected by the user group to be reported against. If councillors were interested in other measures officers could provide the information. The information on Attendance Allowance would be picked up.

What is the timeline for the respite financial modelling? Officers said this was a budgetary issue and would have to be addressed during the Medium Term Financial Strategy Refresh which was due to take place in October 2019. Officers said the Committee would be given an opportunity to comment on the strategy in advance of its publication.

ACTIONS:

1. Officers to check the charging policy wording for clarification on the definition of close family member.
2. Officers to provide the Committee with figures on the number of people employing care staff.
3. Officers to provide the Committee the Framework for the Charging Waver Panel, details of the support provided to help people avoid debt and county court judgements.
4. Officers to provide the Committee with the number of people claiming Attendance Allowance and Personal Independence Payments.
5. Officers to provide the Committee with the survey results from REAL.
6. For Members to inform Officers which additional measures they wish to scrutinise.
7. Officers to provide the Committee with information on the charging policy approach to spouses and debt recovery in relation to spouses.
8. Officers to provide the Committee with the financial data showing the amount being raised from charging and the amount being spent to administer charging since the inception of the charging policy.
9. For officers to involve the Committee in the Medium Term Financial Strategy discussion around financial modelling for respite.

RESOLVED:

1. For officers to provide the information requested by councillors for further scrutiny.

8. ANY OTHER BUSINESS

Members queried the outcome of the migrant healthcare issue that was raised by members of the public at the last meeting. The Chair explained that this had been passed on to the Mayor and Lead Member for Health for response and that it was placed on the agenda to be discussed at the INEL JHOSC. The Chair agreed to provide feedback on the discussion at INEL JHOSC.

A Member raised a concern regarding the management of local dental services. Officers advised that the dental contracts were commissioned by NHS England who could be approached for a response.

The meeting ended at 8.35 p.m.

Chair, Councillor Kahar Chowdhury
Health & Adults Scrutiny Sub-Committee