HEALTH SCRUTINY SUB-COMMITTEE

Thursday, 29 June 2017 at 6.30 p.m.

C1, 1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

This meeting is open to the public to attend.

Members:
Chair: Councillor Clare Harrisson
Vice-Chair**:**

Councillor Dave Chesterton, Councillor Peter Golds, Councillor Muhammad Ansar Mustaquim, Councillor Abdul Asad and Councillor Shiria Khatun

Substitues:
Councillor Rajib Ahmed, Councillor Mahbub Alam, Councillor Md. Maium Miah, Councillor Denise Jones, Councillor Candida Ronald, Councillor Andrew Wood and Councillor Shafi Ahmed

Co-opted Members:

David Burbidge	Healthwatch Tower Hamlets Representative
Tim Oliver	Healthwatch Tower Hamlets

[The quorum for this body is 3 voting Members]

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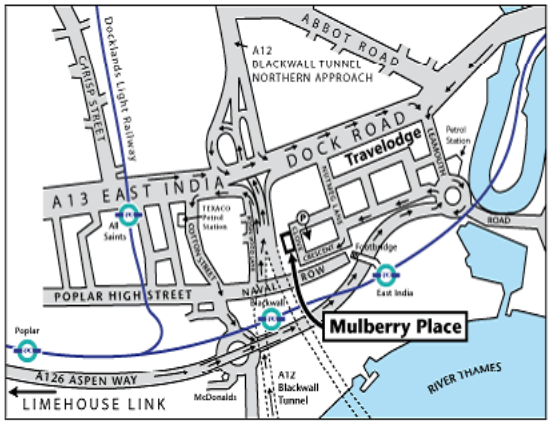

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PAGE NUMBER(S)

APOLOGIES FOR ABSENCE

1. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS — 1 - 4

To note any declarations of interest made by Members, including those restricting Members from voting on the questions detailed in Section 106 of the Local Government Finance Act, 1992. See attached note from the Monitoring Officer.

2. MINUTES OF THE PREVIOUS MEETING(S) — 5 - 12

To confirm as a correct record the minutes of the meeting of the Health Scrutiny Panel held on 14 March 2017.

3. REPORTS FOR CONSIDERATION

3 .1 HEALTH SCRUTINY SUB-COMMITTEE TERMS OF REFERENCE, QUORUM, MEMBERSHIP AND DATES OF MEETINGS - TO FOLLOW

3 .2 NHS CYBER ATTACK UPDATE

3 .3 REABLEMENT SERVICE SCRUTINY REVIEW REPORT — 13 - 64

3 .4 ACCESS TO HEALTH AND SOCIAL CARE SERVICES TOWER HAMLETS — 65 - 84

3 .5 HEALTH SCRUTINY SUB-COMMITTEE 2017/18 FORWARD PLANNING

4. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

Next Meeting of the Sub-Committee
The next meeting of the Health Scrutiny Sub-Committee is to be rearranged and further details will follow.

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DECLARATIONS OF INTERESTS - NOTE FROM THE MONITORING OFFICER

This note is for guidance only. For further details please consult the Members' Code of Conduct at Part 5.1 of the Council's Constitution.

Please note that the question of whether a Member has an interest in any matter, and whether or not that interest is a Disclosable Pecuniary Interest, is for that Member to decide. Advice is available from officers as listed below but they cannot make the decision for the Member. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending a meeting.

Interests and Disclosable Pecuniary Interests (DPIs)

You have an interest in any business of the authority where that business relates to or is likely to affect any of the persons, bodies or matters listed in section 4.1 (a) of the Code of Conduct; and might reasonably be regarded as affecting the well-being or financial position of yourself, a member of your family or a person with whom you have a close association, to a greater extent than the majority of other council tax payers, ratepayers or inhabitants of the ward affected.

You must notify the Monitoring Officer in writing of any such interest, for inclusion in the Register of Members' Interests which is available for public inspection and on the Council's Website.

Once you have recorded an interest in the Register, you are not then required to declare that interest at each meeting where the business is discussed, unless the interest is a Disclosable Pecuniary Interest (DPI).

A DPI is defined in Regulations as a pecuniary interest of any of the descriptions listed at **Appendix A** overleaf. Please note that a Member's DPIs include his/her own relevant interests and also those of his/her spouse or civil partner; or a person with whom the Member is living as husband and wife; or a person with whom the Member is living as if they were civil partners; if the Member is aware that that other person has the interest.

Effect of a Disclosable Pecuniary Interest on participation at meetings

Where you have a DPI in any business of the Council you must, unless you have obtained a dispensation from the authority's Monitoring Officer following consideration by the Dispensations Sub-Committee of the Standards Advisory Committee:-

- not seek to improperly influence a decision about that business; and
- not exercise executive functions in relation to that business.

If you are present at a meeting where that business is discussed, you must:-

- Disclose to the meeting the existence and nature of the interest at the start of the meeting or when the interest becomes apparent, if later; and
- Leave the room (including any public viewing area) for the duration of consideration and decision on the item and not seek to influence the debate or decision

When declaring a DPI, Members should specify the nature of the interest and the agenda item to which the interest relates. This procedure is designed to assist the public's understanding of the meeting and to enable a full record to be made in the minutes of the meeting.

Where you have a DPI in any business of the authority which is not included in the Member's register of interests and you attend a meeting of the authority at which the business is considered, in addition to disclosing the interest to that meeting, you must also within 28 days notify the Monitoring Officer of the interest for inclusion in the Register.

Further advice

For further advice please contact:

Melanie Clay, Corporate Director of Law, Probity & Governance & Monitoring Officer, Telephone Number: 020 7364 4800

APPENDIX A: Definition of a Disclosable Pecuniary Interest

(Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012, Reg 2 and Schedule)

Subject	Prescribed description
Employment, office, trade, profession or vacation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	Any payment or provision of any other financial benefit (other than from the relevant authority) made or provided within the relevant period in respect of any expenses incurred by the Member in carrying out duties as a member, or towards the election expenses of the Member. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
Contracts	Any contract which is made between the relevant person (or a body in which the relevant person has a beneficial interest) and the relevant authority— (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land	Any beneficial interest in land which is within the area of the relevant authority.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the relevant authority for a month or longer.
Corporate tenancies	Any tenancy where (to the Member's knowledge)— (a) the landlord is the relevant authority; and (b) the tenant is a body in which the relevant person has a beneficial interest.
Securities	Any beneficial interest in securities of a body where— (a) that body (to the Member's knowledge) has a place of business or land in the area of the relevant authority; and (b) either— (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

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LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY SUB-COMMITTEE

HELD AT 6.35 P.M. ON TUESDAY, 14 MARCH 2017

MP701, 7TH FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Clare Harrisson (Chair)	
Councillor Sabina Akhtar (Vice-Chair)	
Councillor Dave Chesterton	
Councillor Shah Alam	Substituting for Cllr Asad

Co-opted Members Present:

David Burbidge	Healthwatch Tower Hamlets
Tim Oliver	Healthwatch Tower Hamlets

Other Councillors Present:

Apologies:

Councillor Abdul Asad

Others Present:

Dianne Barham	Director of Healthwatch Tower Hamlets
Simon Hall	Acting Chief Officer, NHS Tower Hamlets Clinical Commissioning Group
Edwin Ndlovu	Borough Director for Tower Hamlets East London Foundation Trust
Jackie Sullivan	Managing Director of Hospitals, Bart's Health Trust
Helen Callaghan	Associate Director of Nursing, Barts Health NHS Trust
Craig Chalmers	Interim Operational Service Manager Mental Health
Michelle Kabia	MIND in Tower Hamlets and Newham

Public Attendees:

Stephanie Clark	Tower Hamlets – Keep our NHS Public
Jan Savage	Tower Hamlets – Keep our NHS Public
Carol Saunders	Tower Hamlets – Keep our NHS Public

Officers Present:

Daniel Kerr	Strategy, Policy & Performance Officer
Dr Somen Banerjee	Director of Public Health

Carrie Kilpatrick	Deputy Director for Mental Health and Joint Commissioning
Joseph Lacey-Holland	Senior Strategy Policy & Performance Officer
Fiona Bateman	Legal Services, LBTH
Farhana Zia	Committee Services Officer

1. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS

The Chair, Councillor Clare Harrisson welcomed everybody to the Health Scrutiny Sub-Committee meeting and asked everyone to introduce themselves.

Cllr Harrisson also welcomed the 'Tower Hamlets Keep our NHS Public' delegation who posed the following questions to the Sub-Committee, in relation to the North East London Sustainability and Transformation Plan (NEL STP).

Carol Saunders addressed the sub-committee, stating the following:

Firstly, Simon Stevens told the House of Commons Public Accounts Committee this month: "We are going to formally appoint leads to the 44 STPs. We are going to give them a range of governance rights over the organisations that are within their geographical areas, including the ability to marshal the forces of the CCGs and the local NHS England staff."

In this context, can the Tower Hamlets Scrutiny Committee tell us who will in future be accountable for the planning and commissioning of health services within Tower Hamlets and the NEL footprint, given that – as we understand it – the statutory duty for this rests with the local CCGs or, in the case of public health, with the local authorities?

Secondly, if current arrangements are being rewritten, what role will remain for local authority health scrutiny committees? Does the committee share our concern that local authorities may lose their powers to scrutinise and influence local health service provision and, if so, does it intend to express this view to NHS England?

Cllr Clare Harrisson thanked Carol Saunders for her questions and stated she shared the concerns raised however the issues would be fully addressed at the next INEL JHOSC meeting scheduled for the 19th April 2017. She invited the group to attend the next joint health scrutiny meeting.

Moving to the agenda, she stated the Sub-Committee would be considering the Healthwatch survey report on access to GP services, a verbal update on the outcome of the Barts Health Trust's Care Quality Commission summit and inspection report on Mile End Hospital and a report on access to mental health services in the borough.

Apologies for absence were received from Cllr Abdul Asad. Cllr Shah Alam was substituting for Cllr Asad.

No member of the Sub-committee declared an pecuniary interest.

2. MINUTES OF THE PREVIOUS MEETING(S)

The Chair referred members of the Sub-Committee to the minutes of the previous meeting held on the 17th January 2017. The Sub-Committee agreed and approved the minutes as an accurate record of the meeting subject to the following amendment and matters arising:

Page 7 - The reference made to Kirkless Council as an example of good practise relates to their work on the Carers Charter and not the identification of carers.

Matters Arising - Denise Radley, Corporate Director of Adults informed members the two named carers who had attended the previous meeting of the Health Scrutiny Sub-Committee, had also attended the Cabinet meeting when the Carers strategy was presented to Cabinet. The carers said they had enjoyed the experience and felt they had been listened to.

3. REPORTS FOR CONSIDERATION

4. HEALTHWATCH GP ACCESS REPORT

Dianne Barham, Chief Executive of Healthwatch Tower Hamlets presented her report on 'Accessing GP services in Tower Hamlets'.

She informed members of the Sub-Committee the report highlighted the main issues that local people experience in accessing GP appointments across the Borough, the impact this has and how access might be improved.

Healthwatch Tower Hamlets visited ten GP Practices across Tower Hamlets in October 2016 and spoke to 134 patients about their experience of accessing GP appointments in order to:

- Highlight what is working well and what is not working well so well from the patients perspective;
- Understand how patients believe access could be improved;
- Identify best practice; and
- Suggest potential opportunities for improvements.

Useful suggestions have been made and the 10 recommendations on page 18 of the agenda have been put forward to the Clinical Commissioning Group (CCG) and GP practices.

Simon Hall, Acting Chief Officer of the CCG added the report had been considered by the CCG's Primary Care Committee and the GP Care Group, who support GP's and patients would be working to co-produce a response to the report.

He said in comparison to other Boroughs, Tower Hamlets was well funded for Primary Care however there are challenges and issues in Primary Care that need to be resolved. For example, current allocation from NHS England means there is pressure on budgets and this is a challenge.

The shortage of GP's and other health professionals is also an issue and the CCG is taking steps to recruit, retain and train staff such as Physician Associates.

Some of the issues highlighted such as improved telephone access, standardised GP registration are things the CCG is working to improve and it's hoped the Tower Hamlets Health club, (rolling out 1st April) where patients register once will assist in signposting patients to accessing GP and primary care services.

This was followed by the questions and comments from Members:

- Welcomed the standardised registration process
- Executive summary states 'fewer than half of the 134 people… had a positive experience of accessing appointments at their GP practices.' Does this reflect more widely in the experience of Tower Hamlet's residents?
- What is the CCG doing to incentivise GP's to stay in the borough?
- How are alternatives such as Physician Associates, paramedics being imbedded into the primary care offer?
- Has the CCG undertaken an impact assessment of GP Practices with regard to GPs retiring and potential closures of practices? Plus the recruitment and hiring of new health professionals?
- What plans are in place to promote the patient experience groups at GP surgeries? They do not attract many patients and should be networked to cover a larger footprint.

Following discussion, the Health Scrutiny Sub-Committee **NOTED** the report and recommendations, namely

1. Understand some of the issues and potential solutions to problems residents face in accessing GP services in Tower Hamlets and note the report recommendations;

2. Note that the GP Care Group and the Clinical Commissioning Group are working collaboratively with Healthwatch and local patients to develop a joint response to the recommendations; and

3. Consider how the Sub-Committee could be involved in supporting a patient partnership approach to tackling the current over demand for GP services.

5. BARTS HEALTH CQC SUMMIT

Royal London Hospital

Jackie Sullivan, Managing Director for Royal London Hospital, Bart's Health NHS Trust provided an update on the summit meeting held on the 23rd January with the Care Quality Commission (CQC).

She informed Members the Hospital's Leadership team and specialist faculties had developed a high level regulatory plan which set out the tasks that each area needed to undertake. Staffing levels, in particular for midwifery, flow through the hospital, critical care and security in the Maternity ward were areas the hospital was working hard to improve.

The overall staffing levels by the end of March would be at 90%, with the Maternity ward running its own recruitment campaign every month.

The pathways to move along patients within the hospital as well as speeding up discharge were being trialled and the hospital was looking to create capacity for 26 beds, which would be used as rehabilitation beds, which is a particular challenge.

Many of the new ways of working have been tested on a major incidence basis, with formal testing of how staff would react and cope in a lock-down situation.

A peer review was undertaken on the 6th March and staff had an opportunity to critically review each other and provide high level recommendations. The feedback was positive and the learning from that day will be included in the plans.

Mile End Hospital

Helen Callaghan, Associate Director of Nursing, Barts Health NHS Trust made her presentation in relation to the unannounced CQC inspection of Mile End Hospital in May 2016 and the published findings of the CQC in January 2017. The CQC has inspected two inpatient wards, Gerry Bennett and Jubilee and had identified a number of areas for improvement.

Members of the sub-committee made the following comments

- Individual Trust's should promote their 'expert by experience' groups to comment and assist with CQC inspection reports and patient engagement.

- Dignity and respect are hugely important factors of care and the Maternity Review undertaken by the Sub-Committee last year made a number of recommendations regarding this, which other areas can learn from.

- What steps have been taken to address the CQC criticism of lack of clothing for patients on the two wards?

- Members enquired what would happen to the Mile End Hospital site, now that the Gerry Bennett ward has been closed and only Jubilee operates from the site.

The Chair thanked the officers for their updates and presentation and the Sub-Committee **NOTED**

1. The outcome of the Inspection; and

2. Developed an understanding of the performance of the Royal London Hospital (RLH) across all areas inspected and where improvements are required.

6. ACCESS TO CARE FOR PEOPLE WITH MENTAL HEALTH PROBLEMS

Carrie Kilpatrick, Deputy Director of Mental Health and Joint Commissioning, together with her colleagues Craig Chalmers, Interim Operational Service Manager Mental Health, Edwin Ndlovu, Borough Director for Tower Hamlets ELFT and Michelle Kabia - Chief Executive Officer, Mind in Tower Hamlets and Newham, made a presentation to the Sub-Committee on 'Access to Care for People with Mental Health problems'.

The presentation gave an overview on the main barriers people face in accessing services and the detail plans in place to improve mental health provision from both a commissioning and delivery perspective.

Edwin referred Members to page 61 of the agenda which described the referral pathways from primary care to secondary care mental health services. He said the four Community Mental Health teams worked with primary care providers to ensure those with long term mental health conditions were fast tracked to the services they needed, whilst supporting others to lead more independent lives within the community.

It was recognised early intervention was required for the student population, in particular the 18 – 35 age group, as mental health problems within this age group were increasing. Work was also being undertaken to ensure the transition pathways from Child to Adult services are smoother and effective.

The following questions and comments were made by the Members of the Sub-Committee:

- How do Mental Health services within the borough link and work together with other public bodies, such as the Youth Offending Teams, the Criminal Justice system and Children in Care? Many people who find themselves in contact with these public bodies have underlying mental health issues either themselves or within the family dynamics and the presentation doesn't address this.

- The five year forward plan sets a target of reducing suicides by 10%. Given the increase in the student population experiencing mental health issues and the pressures they face – exam pressure, social media etc, more needs to be done to achieve this target.

- Members concurred more information and signposting was required especially as they come across mental health issues through their casework. MIND agreed to provide information and awareness training to Councillors.

- What choice and access to primary care do mental health patients have within the services provided. For example, if someone does not take the offer of Cognitive Behaviour Therapy (CBT) what are the alternatives? How do third sector organisations support those with mental health issues?

- What has been the take up of Personal Budgets?

The Chair, thanked the presenters for their presentation and the Sub-Committee **NOTED**

1. The key barriers restricting access to mental health services

7. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

There was no other business discussed.

The meeting ended at 8.40 p.m.

Chair, Councillor Clare Harrisson
Health Scrutiny Sub-Committee

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Non-Executive Report of the: **Health Scrutiny Sub- Committee** 29/06/2017	TOWER HAMLETS
Report of: Graham White, Acting Corporate Director Governance and Interim Monitoring Officer	**Classification:** Unrestricted
Reablement Service Scrutiny Review	

Originating Officer(s)	Sharon Godman, Divisional Director strategy, policy and partnership Daniel Kerr, Strategy, Policy and Partnership Officer
Wards affected	All Wards

1. SUMMARY

1.1. This paper submits the report and recommendations of the Health Scrutiny sub-committee's review of the LBTH Reablement Service for consideration by the Health Scrutiny Sub-Committee.

2. RECOMMENDATIONS:

2.1. The Health Scrutiny Sub-Committee is recommended to note the report and recommendations.

3. DETAILS OF REPORT

3.1. Over the course of 2016-17 the Health Scrutiny Sub-Committee has taken a thematic approach to its work programme and focussed on issues relating to the access of health and social care services in Tower Hamlets. As part of this, the Sub-Committee identified the performance of the Council's Reablement Service as the subject for a Scrutiny Review, as it is a key gateway into the social care system from both acute and community health services. The ever increasing pressure on the NHS and adult social care arising from the needs of a growing, older population and continued public spending restraint, means the performance of the Reablement Service is an issue of major importance to the sustainability and effectiveness of the boroughs social care services.

3.2. The Reablement Service offers a short-term, six week Occupational Therapy-led intervention that supports people to regain their abilities to manage everyday tasks following an accident, ill health, disability or a stay in hospital, enabling them to live as independently as possible in the community. An effective Reablement Service is beneficial for residents, local authorities, and the NHS as it assists individuals to lead full and independent lives whilst reducing the overall cost of provision. Reablement can play a decisive role in helping people to regain their independence and maximising their health and wellbeing following hospitalisation or ill health. It can also reduce the amount of time a person needs to stay in hospital, therefore aiding faster recovery.

3.3. The Sub-Committee wanted to review the performance of the Reablement Service in Tower Hamlets to understand whether the current service offers accessible and effective care, and determine whether this is delivered to the right people, in the right place and at the right time. Moreover the Sub-Committee wanted to review the service user experience to ensure it was supportive, safe and compassionate

3.4. The review is underpinned by four core questions:

- How is the Reablement Service delivered and how does it perform in Tower Hamlets?
- What is the patient experience for residents of Tower Hamlets being supported by the Reablement Service?
- How do partner organisations view the Reablement Service in Tower Hamlets and what level of integration exists across services?
- How does the Reablement Service in Tower Hamlets compare to London and national benchmarks, and what can be learnt from areas of good practice in London?

3.5. The report with recommendations is attached at Appendix 1. 18 recommendations have been made:

Recommendation 1: That the Reablement Service delivers additional training to social care staff in strength based practice to ensure they are able to convey the aims of the service and the reablement approach positively to service users and their families/carers.

Recommendation 2: That the Reablement Service works with Real to review cases where concerns were raised, and use this information to improve service delivery for disabled service users via tailored training for specific teams or individuals in association with Real.

Recommendation 3: That the Reablement Service develops a communications plan linked into the launch of the new integrated single pathway to educate the community on the role and aims of the Reablement Service so they are better advocate for themselves, and identify and challenge poor practice.

Recommendation 4: That the Reablement Service explores options to provide emergency provision for supplies through pre-payment cards and food vouchers to assist those who are discharged from hospital into the service.

Recommendation 5: That Barts Health reviews its discharge procedures so that all patients are provided with dosette boxes when they leave hospital and medication is accompanied by a Medicine Administration Record (MAR) chart.

Recommendation 6: That Barts Health reviews its discharge planning process to ensure that the appropriate quantity of correctly fitted continence pads are provided to the at the point of discharge.

Recommendation 7: That Barts Health reviews its discharge planning process to ensure that discharge does not take place at the end of the week without advance communication to the Reablement Service, allowing for better planning that takes account of service users full range of needs and smoother handovers.

Recommendation 8: That the Reablement Service reviews service user data to identify which hospital wards require further training to educate staff members on the purpose of the Reablement Service, its referral pathways and how it aligns with other rehabilitation provision.

Recommendation 9: That the Reablement Service examines the procedures for liaison with environmental health so that response times to address issues faced by some patients upon discharge, such as bed bugs, are improved.

Recommendation 10: That the Reablement Service improves its engagement with service users by working with the Third Sector to help strengthen the transparency of its performance monitoring process, including closer involvement of the OPRG.

Recommendation 11: That the Reablement Service establishes procedures for contacting service users by phone or in person within 24hrs of discharge to ensure they are safe and have no immediate issues about their care and support.

Recommendation 12: That the Reablement Service learns from observed good practice in Greenwich and introduces a questionnaire for all Reablement service users within the first 5-10 days after discharge from hospital.

Recommendation 13: That the Reablement Service learns from observed good practice in Greenwich and explores how they could use ICT systems to improve the coordination and efficiency of staff planning and rostering

Recommendation 14: That the Reablement Service explores options to link the Reablement Service into existing mental health provision to provide more integrated physical and mental health support as part of the six week reablement intervention.

Recommendation 15: That the Reablement Service explores the possibility of performing a social prescribing or commissioning function to refer people on to appropriate community support/activities at the end of its formal intervention.

Recommendation 16: That the Reablement Service develops a forum to share information on ongoing projects, available services, and opportunities for partnership working between the third sector and statutory services, perhaps building on the multi-agency meetings of each of the GP localities.

Recommendation 17: That the Reablement Service explores options to train formal and informal carers and volunteers to support the reablement process and promote the principles of recovery and independence.

Recommendation 18: That the Reablement Service reviews how social care staff introduce reablement positively to residents and their families and examines how the annual re-assessment procedure for people with long term care packages to establish how reablement may assist service users.]

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The Council's Reablement Service, which is funded from the Better Care Fund (BCF), has a base budget of £2.4m in 2017/18 and is required to deliver efficiency savings of £0.85m by 2019/20 as agreed in the 2017/18 budget approved by Full Council on the 22nd February 2017. The recommendations within this report will need to be delivered in the context of these budget reductions.

5. LEGAL COMMENTS

5.1 The Council is required by section 9F of the Local Government Act 2000 to have an Overview and Scrutiny Committee and to have executive arrangements that ensure the committee has specified powers. Consistent with this obligation, Article 6 of the Council's Constitution provides that the Overview and Scrutiny Committee may consider any matter affecting the area or its inhabitants. The Committee may also make reports and recommendations to the Full Council or the Executive in connection with the discharge of any functions.

5.2 Section 2 of the Care Act 2014 imposes a duty on the Local Authority to provide or arrange for the provision of services, facilities or resources, or take other steps, which it considers will—

(a) contribute towards preventing or delaying the development by adults in its area of needs for care and support;
(b) contribute towards preventing or delaying the development by carers in its area of needs for support;
(c) reduce the needs for care and support of adults in its area;
(d) reduce the needs for support of carers in its area.

5.3 Section 3 of the Care Act 2014 imposes an additional obligation that local authorities must exercise its social care functions with a view to ensuring the integration of care and support provision with health provision and health-related provision where it considers that this would—

(a) promote the well-being of adults in its area with needs for care and support and the well-being of carers in its area,
(b) contribute to the prevention or delay of the development by adults in its area of needs for care and support or the development by carers in its area of needs for support, or
(c) improve the quality of care and support for adults, and of support for carers, provided in its area (including the outcomes that are achieved from such provision).

5.4 The Care and Support (Preventing Needs for Care and support) Regulations 2014 make further provisions relating to reablement support which is defined as a 'facilities or resources provided by an adult… which consist of a programme of services, facilities or resources are for a specified period and have as their purpose the provision of assistance to an adult to enable to maintain or regain the ability needed to live independently at their home.' These regulations require that the local authority must not charge the adult for any services, facilities or resources provided for the first 6 weeks of the specified period.

5.5 The Care Act guidance, which the local authority is obligated to follow unless there are cogent reasons to disapply, sets out additional consideration for the Local Authority when designing reablement services so as to ensure that these are able to fulfil additional duties, including the provision of information and advice under s.4 Care Act 2014, duties under s.5 Care act to promote the efficient and effective operation of a market in services for meeting care and support needs and under s6-7 to cooperate with relevant partners including health bodies. It should also be noted that, in providing these services, the Local Authority must have regard to the duty to promote the wellbeing of the individual in line with the duty set out in s.1 Care Act 2014.

5.6 The review explored the current offer within the borough and made the recommendations set out within this report. Whilst it will be for statutory

partners to implement some of these recommendations, the recommendations reflect the duty for those partners to cooperate with the Council in fulfilling their statutory functions under s6 of the Care Act 2014. It should be noted that, under this provision, partners are expected to comply with any request, including in relation to provision in specific cases (section 7 Care Act) unless this would be incompatible with their own duties or otherwise have an adverse effect on the exercise of their functions.

5.7 When considering the recommendations above regard must be given to the public sector equalities duty to eliminate unlawful conduct under the Equality Act 2010 and the duty set out at Section 149 of the 2010 Act. This requires the Council, when exercising its functions, to have 'due regard' to the need to eliminate discrimination (both direct and indirect discrimination), harassment and victimization and other conduct prohibited under the Act, and to advance equality of opportunity and foster good relations between those who share a 'protected characteristic' and those who do not share that protected characteristics. Provision of an effective reablement service, particularly if additional consideration is given to how to address mental health as well as physical health needs, should ensure greater compliance with these duties.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. The core focus of this review is on the council's approach to delivering an effective Reablement Service as part of its statutory obligations under the Care Act 2014. Reablement is available for all residents, however the significant majority of service users are aged 65 and over. This review makes a number of recommendations to ensure all elderly people in the borough are supported to be as independent as possible and have easy access to reablement services through improved partnership working with the NHS and other key stakeholders, strengthening engagement with the third sector, and improving communication to effectively convey of the role of the reablement service.

7. BEST VALUE (BV) IMPLICATIONS

7.1. The recommendations in this report are made as part of the Overview & Scrutiny Committee's role in helping to secure continuous improvement for the council, as required under its Best Value duty

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1. There are no direct environmental implications arising from the report or recommendations.

9. RISK MANAGEMENT IMPLICATIONS

9.1. There are no direct risk management implications arising from the report or recommendations.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1. There are no direct crime and disorder reduction implications arising from the report or recommendations.

Linked Reports, Appendices and Background Documents

Linked Report

- NONE.

Appendices

- Appendix 1 – Health Scrutiny Sub-Committee Reablement Review Report
- Appendix 2 – Community Health Services in Tower Hamlets
- Appendix 3 – Healthwatch Tower Hamlets Reablement Report

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report
List any background documents not already in the public domain including officer contact information.

- NONE

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Tower Hamlets Health Scrutiny Sub-Committee

Reablement Service Scrutiny Review

April 2017

Chair's Foreword

I am pleased to present this report which explores the challenges facing the Reablement Service in Tower Hamlets. An effective Reablement Service is beneficial for residents, local authorities, and the NHS as it assists individuals to lead full and independent lives whilst reducing the overall cost of provision. Reablement can play a decisive role in helping people to regain their independence and maximising their health and wellbeing following hospitalisation or ill health. It can also reduce the amount of time a person needs to stay in hospital, therefore aiding faster recovery and preventing deconditioning.

It is also clear to me that a commitment to providing an effective Reablement Service is not only beneficial to clinical outcomes and residents' health and wellbeing, but also provides opportunity to make savings at a time of public sector funding cuts. Reablement can help to ease the financial and capacity pressures placed on both Local Authorities and the NHS through decreasing the need for hospital admission, decreasing the need for long term care packages, and appropriately reducing the level of ongoing home care support required. These financial pressures are driving services to identify opportunities to work in different and innovative ways. The Discharge to Assess pilot programme, for example, demonstrates that financial savings can be achieved through greater integration between health and social care. However as programmes like these drive savings in the NHS, I hope appropriate funding flows through to local authorities who will be picking up the extra work in the community.

Although there are a lot of things our Reablement Service does well, there is always room for improvement. We do not work with our third sector partners as productively as we could, and there are sometimes issues with the way the service communicates its aims with service users and their families. Whilst we work closely with the NHS on many parts of Reablement and related packages, there is still some work to be done to establish true partnership working. Too many patients are being discharged too late in the day, without proper preparation or medications. This is having an impact both on patient dignity and on the Reablement Service's ability to manage demand and use its resources effectively.

This report therefore makes a number of practical recommendations for the council and its partners for improving the service. The recommendations focus on improving communication and training to increase awareness of the service, improving the hospital discharge process, better utilisation of the third sector, the Reablement Service performing a social prescribing or commissioning role, and better performance monitoring during the first week after discharge.

I would like to thank all officers and external speakers that contributed to the review, especially Cath Scholefield (Lead for New Models of Care) and Paul Swindells (Reablement Team Manager) for providing their support and

knowledge to the review, and officers from Greenwich Council for providing us with their time and insight of good practice in the service. I am also grateful to my Health Scrutiny colleagues for their support, advice and insights.

Councillor Clare Harrisson
Chair of the Health Scrutiny Sub-Committee

Contents

1. Recommendations

Recommendation 1: That the Reablement Service delivers additional training to social care staff in strength based practice to ensure they are able to convey the aims of the service and the reablement approach positively to service users and their families/carers.

Recommendation 2: That the Reablement Service works with Real to review cases where concerns were raised, and use this information to improve service delivery for disabled service users via tailored training for specific teams or individuals in association with Real.

Recommendation 3: That the Reablement Service develops a communications plan linked into the launch of the new integrated single pathway to educate the community on the role and aims of the Reablement Service so they are better advocate for themselves, and identify and challenge poor practice.

Recommendation 4: That the Reablement Service explores options to provide emergency provision for supplies through pre-payment cards and food vouchers to assist those who are discharged from hospital into the service.

Recommendation 5: That Barts Health reviews its discharge procedures so that all patients are provided with dosette boxes when they leave hospital and medication is accompanied by a Medicine Administration Record (MAR) chart.

Recommendation 6: That Barts Health reviews its discharge planning process to ensure that the appropriate quantity of correctly fitted continence pads are provided to the at the point of discharge.

Recommendation 7: That Barts Health reviews its discharge planning process to ensure that discharge does not take place at the end of the week without advance communication to the Reablement Service, allowing for better planning that takes account of service users full range of needs and smoother handovers.

Recommendation 8: That the Reablement Service reviews service user data to identify which hospital wards require further training to educate staff members on the purpose of the Reablement Service, its referral pathways and how it aligns with other rehabilitation provision.

Recommendation 9: That the Reablement Service examines the procedures for liaison with environmental health so that response times to address issues faced by some patients upon discharge, such as bed bugs, are improved

Recommendation 10: That the Reablement Service improves its engagement with service users by working with the Third Sector to help strengthen the transparency of its performance monitoring process, including closer involvement of the OPRG.

Recommendation 11: That the Reablement Service establishes procedures for contacting service users by phone or in person within 24hrs of discharge to ensure they are safe and have no immediate issues about their care and support.

Recommendation 12: That the Reablement Service learns from observed good practice in Greenwich and introduces a questionnaire for all Reablement service users within the first 5-10 days after discharge from hospital.

Recommendation 13: That the Reablement Service learns from observed good practice in Greenwich and explores how they could use ICT systems to improve the coordination and efficiency of staff planning and rostering

Recommendation 14: That the Reablement Service explores options to link the Reablement Service into existing mental health provision to provide more integrated physical and mental health support as part of the six week reablement intervention.

Recommendation 15: That the Reablement Service explores the possibility of performing a social prescribing or commissioning function to refer people on to appropriate community support/activities at the end of its formal intervention.

Recommendation 16: That the Reablement Service develops a forum to share information on ongoing projects, available services, and opportunities for partnership working between the third sector and statutory services, perhaps building on the multi-agency meetings of each of the GP localities

Recommendation 17: That the Reablement Service explores options to train formal and informal carers and volunteers to support the reablement process and promote the principles of recovery and independence.

Recommendation 18: That the Reablement Service reviews how social care staff introduce reablement positively to residents and their families and examines how the annual re-assessment procedure for people with long term care packages to establish how reablement may assist service users.

2. Introduction

2.1. Over the course of 2016-17 the Health Scrutiny Sub-Committee has taken a thematic approach to its work programme and focussed on issues relating to the access of health and social care services in Tower Hamlets. As part of this, the Sub-Committee identified the performance of the council's Reablement' Service as the subject for a Scrutiny Review, as it is a key gateway into the social care system from both acute and community health services. The ever increasing pressure on the NHS and adult social care arising from the needs of a growing, older population and continued public spending restraint, means the performance of the Reablement Service is an issue of major importance to the sustainability and effectiveness of the boroughs social care services.

2.2. The Reablement Service offers a short-term, six week Occupational Therapy-led intervention that supports people to regain their abilities to manage everyday tasks following an accident, ill health, disability or a stay in hospital, enabling them to live as independently as possible in the community. This has significant benefits for a person's health and wellbeing and allows the council to concentrate its limited resources on those who have eligible needs for care and support.

2.3. National evidence suggests that supporting early and safe discharge from hospital into a reablement-type service delivers better outcomes for individuals when compared to longer periods of hospitalisation or immediate transfer into domiciliary care. It is also cost effective for health and adult social care services, both reducing pressure on bed-capacity in the acute sector and the need for large packages of ongoing community or institutional care.

2.4. The Sub-Committee wanted to review the performance of the Reablement Service in Tower Hamlets to understand whether the current service offers accessible and effective care, and determine whether this is delivered to the right people, in the right place and at the right time. Moreover the Sub-Committee wanted to review the service user experience to ensure it was supportive, safe and compassionate. The review is underpinned by four core questions:

- How is the Reablement Service delivered and how does it perform in Tower Hamlets?
- What is the patient experience for residents of Tower Hamlets being supported by the Reablement Service?
- How do partner organisations view the Reablement Service in Tower Hamlets and what level of integration exists across services?

- How does the Reablement Service in Tower Hamlets compare to London and national benchmarks, and what can be learnt from areas of good practice in London?

2.5. There are a number of reablement and rehabilitation pathways delivered in the borough, including the Admission Avoidance & Discharge Services, Community Health Teams (including Physiotherapy and Occupational Therapy led rehabilitation), Elderly Care Rehabilitation Services, and Specialist Rehabilitation Services such as stroke rehab for patients after an acute stroke and cardiac rehab and heart failure services. There are many issues identified in this report which are applicable across all of these services, including the experience after the first week of discharge, housing adaptations and environmental health issues such as bed bugs. Whilst the scope of this review explicitly covers the LBTH Reablement Service, the Health Scrutiny Sub-Committee wish to use this review as a proxy for the other services and hope to apply the learning and recommendations from this review to other services where applicable. *See appendix 1 for a detailed breakdown of the services provided by each of these services.*

2a) Review Approach

2.6. The review was chaired by Councillor Clare Harrisson, Chair of the Health Scrutiny Sub-Committee and supported by Daniel Kerr, Strategy, Policy and Performance Officer; LBTH.

2.7. To inform the Sub-Committee's work a range of meetings and evidence gathering activities were undertaken between January 2017 and February 2017. These included:

- **26th January 2017**

  The first evidence session set out the context to the review, including an overview of local needs and demand for the Reablement Service. Service managers from Reablement met with the Sub-Committee to detail the role and aims of the service, how it is delivered in Tower Hamlets, and how it performs compared to London and national benchmarks.

- **6th February 2017**

  The second evidence session invited key local health partners to share their views on the Reablement Service, including both commissioners and health providers. Colleagues from the Tower Hamlets Clinical Commissioning Group, Bart's Health Trust, Tower Hamlets GP Care Group, East London Foundation Trust, LBTH Occupational Therapy, and LBTH Housing all offered their perspectives on the service and participated in a discussion that focused on the level of integration across partner organisations,

highlighted gaps in the current provision, and identified possible actions for service improvement.

- **16th February 2017**

  The third evidence session invited service user groups to share the experiences and views of people who have been through the Reablement Service. Real, a local disability advocacy organisation, provided insight on the experience of disabled people who are often referred to the service as part of the process to reassess their care package. AgeUK East London, which offers support to elderly people in both the hospital and the community, shared their views on the care and support needs of the 65 and over group. The Carers Centre and the Older People's Reference Group both provided written submissions of evidence detailing the views of their clients and, in addition, the Sub-Committee worked with Healthwatch Tower Hamlets to contact and interview 14 service users who had left the Reablement Service in the last three months.

- **23rd February 2017**

  A site visit to meet with officers from the London Borough of Greenwich Reablement Service was conducted. The Greenwich Reablement Service has been identified as an example of good practice and the Sub-Committee visited with them to learn how they achieve successful outcomes for residents, minimise demand for ongoing care and support, and how their residents feel about the service they receive.

  A site visit to meet LBTH reablement officers. Reablement officers discussed their experiences of working with services users, key partners in the hospital and in the community, and detailed the challenges they face in their role.

  A final meeting of the Sub-Committee and key partners to review the evidence collected as part of the review and discuss the findings and recommendations.

2.8. Health Scrutiny Sub Committee Members;

Councillor Clare Harrisson	Health Scrutiny Sub-Committee Chair
Councillor David Burbidge	Health Scrutiny Sub-Committee Member
Councillor Sabina Aktar	Health Scrutiny Sub-Committee Member
Councillor Peter Golds	Health Scrutiny Sub-Committee Member
Councillor Muhammad Ansar Mustaquim	Health Scrutiny Sub-Committee Member
Councillor Abdul Asad	Health Scrutiny Sub-Committee Member
David Burbidge	Health Scrutiny Co-Opted Member

The panel received evidence from a range of officers including;

London Borough of Tower Hamlets

Cath Scholefield	Lead for New Models of Care
Brian Turnbull	Interim Service Manager – Community & Hospital Integrated Services
Gill Beadle-Phelps	Service Manager – Community & Hospital Integrated Services
Paul Swindells	Team Manager - Reablement
Alex Hadayah	Head of Integrated Occupational Therapy Services
Martin Ling	Housing Strategy Manager
Helen Sims	Senior Occupational Therapist
Siobhan Davey	Occupational Therapist
Julie Archer	Occupational Therapist
Saleh Abed	Independence Planner
Ann Marie Bacchus	Independence Planner
Leyla Maxamed	Reablement Officer
Masum Bhuiya	Reablement Officer
Laura Ayles	Reablement Officer
Gulam Hossain	Reablement Officer
Bibi Mohabeer	Reablement Officer
Masad Miah	Reablement Officer

London Borough of Greenwich

Claire Northover	Service Manager for Hospital Discharge Team
Steve Martin	Team Manager Hospital Discharge Team
Elaine Maunsell	Scheduling and Support Officer
Janet Bennett	ICAH Reablement Manager

External Partners

Rahima Miah	Integrated Commissioning, Tower Hamlets CCG
Richard Fradgley	Director of Integration, East London Foundation Trust
Phillip Bennett-Richards	Chair of Tower Hamlets GP Care Group
Claire Hogg	Director of Community Health Services and Mile End Hospital

Service User Groups

Karen Linnane	Delivery and Development Manager, Real
Chris Tymkow	Project Coordinator, The Royal London Home & Settle service, AgeUK East London
Neil Hardy	Director, Carers Centre
Diane Hackney	User Involvement Coordinator, Older Peoples Reference Group
Dianne Barham	Chief Officer, Healthwatch Tower Hamlets

3. National context

3.1. Reablement was first set out as a concept in 2006 in the Department of Health's '*Our Health; Our Care; Our Say'* strategy, which aimed to deliver the then Labour Government's vision of more effective community health services. This vision was based on five priority areas: more personalised care, services closer to home, integration between health & social care services, increased patient choice and a focus on prevention rather than cure. This was followed by the 'Putting People First' White Paper in 2008 which promoted a shared vision for the transformation of Health and Social Care based around the aims that people stay healthy (prevention), receive rapid and timely support (early intervention) and are helped to get back on their feet after an illness and to do as much as possible for themselves (reablement). In 2010, 'Think Local; Act Personal' was introduced and established a national partnership of more than 50 organisations committed to transforming health and care through personalisation and community-based support. The partnership includes central and local government, NHS, the provider sector, and people with care and support needs, carers and family members.

3.2. The Care Act 2014 introduced by the Coalition Government replaced much of the preceding social care legislation and underpins the council's reablement practice. It promotes wellbeing for individuals and their families, promotes personal resilience, and places a duty on local authorities to prevent and delay ongoing need for formal care. Furthermore, it formalises the integration agenda as it ensures that care and support services work together with health colleagues. Specifically the Care Act mandates local authorities to provide reablement for free, for a period of up to six weeks.

3.3. Reablement is an area which is seen as critical to a sustainable adult social care system as it helps people to get back on their feet and regain their independence, reducing social care costs and the burden placed on hospitals. Performance statistics from across the UK support this, for example, in Kent, 90 per cent of clients required no further long term support packages following a reablement intervention, whilst equivalent figures in Tyneside were 68 per cent, and in Greenwich 60 per cent. In 2013, Southwark reported that their social care costs reduced by 40 per cent as a result of Reablement Service intervention.

3.4. Reablement services are a significant part of the health and social care integration agenda. The Better Care Fund (BCF) is the Government's primary funding mechanism for the integration of health and social care, and it is intended to shift resources out of hospital into community services. Nationally the effectiveness of integrating health and social care, and the importance of the reablement service, can be seen through the impact of the BCF, which in its first year of operation saw the proportion of older people who were still at home 91 days after discharge from hospital

into reablement or rehabilitation services increase to 82.7 per cent, exceeding the target of 81.9 per cent.

3.5. Improving support for older people at home, either to prevent hospital admission (or readmission) or to facilitate discharge when they are ready to leave hospital is key to patient flow and ultimately to delivering the four hour A&E waiting times target. Delayed transfers of care (DTOC) have increased substantially over the past three years and have contributed to a shortage of hospital beds in a number of NHS Trusts. This is a significant issue which is costly to the NHS and impacts on hospitals capacity to admit emergency A&E patients and treat patients effectively. A DTOC occurs when a patient is ready to depart from their current care setting but is still occupying a bed. In 2016 there were 2.16 million 'delayed days' due to delayed transfers of care – an average of just under 6,000 each day. This was 23 per cent higher than in 2015 and 56 per cent higher than in 2011. Delayed transfers of care involving patients with both health and social care needs are occurring with increasing frequency. Between December 2013 and December 2016, the number of delayed discharges from hospital attributable to local authorities (or jointly to local authorities and to the NHS) rose from 36,000 (32 per cent of all delayed transfers of care) to 86,000 (44 per cent). The majority of delayed discharges in 2016 were as a result of people awaiting a care package in their own home, or awaiting nursing home placements. Delays in both of these categories have risen by over 40% in the last year alone.

4. Local context; background to LBTH Reablement Service

4.1. Tower Hamlets has seen the largest population growth of any area in the country over the last 10 years, increasing by 27 per cent and this trend is projected to continue over the next decade with the borough's population expected to grow by a quarter to 2024, the largest increase in England. There is likely to be an increased demand for adult social care from all sections of the population as it continues to expand. Evidence shows that people aged 65 and over are the highest users of the Reablement Service in the borough and, significantly, in 2014-2015 there was a higher rate of hospital episodes per 100 people (91.76) in Tower Hamlets residents aged 65 and over than in London (84.10) and England (80.30). In 2015, there were 16,700 older people in Tower Hamlets, which represents 5.8 per cent of the Tower Hamlets population and this is projected to increase over the next 15 years to reach 7 per cent by 2030. However, the increase in healthy life expectancy in Tower Hamlets has not kept pace with improvements in total life expectancy. This means that if the extra years of increased longevity are mostly spent in poor health and disability, there will be an increase in demand on services across all client groups.

4.2. Within Tower Hamlets the work of the Reablement Service is linked to a number of strategies. The Reablement Service is crucial for helping the council to deliver its strategic priority of 'supporting more people living

healthily and independently for longer'. The council's Strategic Plan sets out a series of actions to improve care and support for vulnerable adults and their carers, integrate with health services, promote independence, and keep people safe from all forms of abuse. Additionally, the work of the service is linked to the ambition set out in the refreshed Health and Wellbeing Strategy to 'develop an integrated system'. The service will also link into the LBTH Aging Well strategy which is currently being developed. The Aging Well strategy aims to enhance the health, wellbeing and quality of life of people growing older in Tower Hamlets to ensure they are able to retain their independence and dignity with the assistance of family, friends and community services.

4.3. The Reablement Service will perform a critical role in the delivery of the NHS Transforming Services Together programme (TST). TST is a joint partnership programme between Newham, Tower Hamlets and Waltham Forest CCGs and Barts Health NHS Trust, which responds to the challenges posed by the changing healthcare needs of the population. It aims to improve and modernise healthcare services across the three boroughs by addressing inequalities, helping patients take control of their own health, and tackling the problems faced by health services across the area. As part of TST there is an aim to reduce the number of inpatients and shorten the length of stay for vulnerable people. In order to respond to these changes and ensure they are successful, community care and social services need to be able to safely and effectively support patients back into community settings.

4.4. The role of the Reablement Service is currently under operational review and is being redesigned as part of the Tower Hamlets Together (THT) Vanguard program. The Vanguard brings together commissioners and providers of acute, community, mental health, social care and primary health services to create a joined up approach that combines the resources of different local organisations. This will improve patient experience by allowing for a more personalised approach to health and social care, and help reduce pressure on the system through better coordination of services. In regard to Reablement, the driving aspiration of Tower Hamlets Together is to reshape the separate reablement and rehabilitation services into an integrated pathway which is easier for everybody to understand and that better utilises resources.

4.5. The LBTH Reablement Service is a large service with 66 members of staff (58.65 FTE) and a budget of £2.4 million in 2016/17, which is funded through the BCF. Reablement officers are trained up to NVQ diploma Level 2 and NVQ diploma Level 3 in Health and Social Care. A number of staff members are contracted to Barts Health but are embedded in the Reablement Service. If all staff members have full rosters the service is able to ensure it is supplemented through the domiciliary care contract. Support is also provided to service users out of hours through a dedicated support service.

4.6. A CQC inspection of LBTH Reablement Service in September 2016 rated the service as 'Good' overall. The service was rated as good in four out of five CQC lines of enquiry; safe, effective, caring, and responsive. In the final category which inspected whether the 'service is well led' the service was rated as 'requires improvement,' however this was because of a failure to formally notify the CQC of administrative and regulatory incidents and is not reflective of problems in leadership or performance. The inspection recognised that there were good support structures in place and the service worked well together as a team.

4.7. The majority of service users are aged 65 and over. From April 2016 to December 2016 508 out 640 (79 per cent) service users were aged 65 and over. Those with new disabilities tend to be younger and they often experience traumatic injuries or neurological conditions and are more likely to go through a rehabilitation pathway. There were 368 female service users, and 265 male service users (7 service users gender were unknown). The majority of users were white British (305), with Bangladeshi users representing the next highest client group (154).

4.8. A key performance indicator for the service is the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement or rehabilitation services. In 2015-2016, 79 per cent of older people were still at home 91 days after discharge from hospital into reablement or rehabilitation. This was below the London (85 per cent) and national (83 per cent) averages; however this has increased to 89 per cent for Q1 2016-2017. The other key measure for performance is the proportion of older people discharged from hospital offered reablement services. At 3 per cent Tower Hamlets is in line with the national average; however it is marginally below the London average (4 per cent). Furthermore, in 2015-2016, 262 out of 372 (70 per cent) new service users (new to social care and without any established support plans in place) had no long-term support needs following their time with the reablement service, demonstrating the effectiveness of the service's interventions.

4.9. Demand for the service is increasing. Currently there are 800-900 referrals per year (averaging 71 per month) and this has been increasing since October 2016. The service is forecasting almost 600 independence plans in 2016/-2017 (when a completed assessment is performed) and this will represent an increase of 10-15 per cent on the previous year. There has been a 50 per cent increase in referrals from Hospital Social Work Teams since July 2016, although this can be explained to some extent by a new pilot project from health called 'Discharge to Assess.'

4.10. 'Discharge to Assess' aims to enable patients who have been deconditioned as a result of their admission to the Royal London Hospital to return home and receive a period of up to six weeks integrated Rehabilitation and Reablement. This supports NHS partners to reduce delayed discharges, therefore freeing up bed capacity, and enables people to return to independence at home rather than in hospital. This was a pilot project and it aimed to provide a much more accurate assessment of the

service users' needs, taking into account the fact they have been deconditioned by their hospital stay and that their starting point is not a true reflection of their long term care and support needs.

4.11. This scheme involves a team of nurses, physiotherapists, and occupational therapist (run by Barts Health) and reablement officers. The pilot scheme achieved a number of positive outcomes, with reductions to the cost of commissioning, reduction in the readmission rate (none of whom were readmitted for the original reason they were in hospital), and positive service user feedback. Barts Health is looking to extend this pilot.

4.12. Housing and Planning services have expertise in developing adaptable new housing stock and Occupational Therapists and surveyors work with residents to adapt existing housing stock wherever possible. Further developments of these services are included in the Ageing Well strategy. Therapists try to install quick fixes as soon as the person goes home such as disability equipment, assistive technology and ramps so that the person can begin their reablement immediately. Longer term adaptations can then be considered once the person has completed their period of Reablement and their level of ongoing support can be assessed.

4a). How is the LBTH Reablement Service currently delivered

4.13. The current pathway into Reablement is via the two social care access points; the Royal London Hospital and the community based access service (Assessment and Intervention Team). Often, when people are referred from hospital there is a need for reablement at the point of discharge and when this is the case, the service aims to ensure that reablement support is in place within 24 hours.

4.14. There are significant differences in the referral criteria across the country. In Tower Hamlets the referral criteria is relatively open, with the only people excluded from the service being people who are at end-of-life, people who need rehabilitation before reablement can take place, and people with no potential to be re-abled. As there is a flexible eligibility criteria it means the service works with people with complex disabilities.

4.15. Once a referral to the service has been made, a robust functional assessment is performed by Occupational Therapists, Independence Planners, or Trusted Assessors in order to understand and accurately assess the needs of service users. This is an objective assessment of what the person is able to do through providing them with tasks and tests to perform. The assessments identify the support and treatment required for people to become independent.

4.16. Based on the results of the assessment an independence plan is developed in consultation with the service user which identifies the areas that people need support with. A goal setting document is used to identify SMART goals that people will work towards to regain their independence.

4.17. The average case lasts for six weeks but this can vary and be shorter or longer depending on the user's needs. After each case closes there is a review process which includes service user feedback and if required a referral is made for long term support.

5. Findings

5.1. The Sub-Committee examined various sources of service user experience and performance information. As detailed above, members of the Sub-Committee met with patients and service user groups, officers from the London Borough of Tower Hamlets' Reablement Service, their counterparts at the Royal London Borough of Greenwich and other key partners who are integral to the health and social care integration agenda in the borough.

5.2. In presenting and summarising the findings of this review it is important to stress that the Sub-Committee heard a range of views about the Reablement Service, some positive and some not so positive. The Sub-Committee was able to access this feedback as the service offers every user a service user questionnaire at the end of their intervention.

5.3. In general, users tended to agree that the service fulfilled its primary function, with 91% agreeing with the statement 'the support I get helps me to stay as independent as possible' in Quarter 2 of 2016-17 and 75% in Quarter 3.

"They worked with me... encouraged me where it was needed. They were able to see when they felt I could do a little bit more and supported me to do that, to gain that confidence…"
(Service user feedback)

"Now I can manage on my own"
(Service user with Multiple sclerosis – referred after knee replacement)

"The Reablement team help you get back on your feet, they're not there to do it for you…..slowly but surely each day you're supported do a little bit more for yourself… they're there to help me to do it for myself."
(Service user feedback)

"Two or three weeks down the line, I was actually getting up and washing myself…"
(Service user feedback)

"Staff were always friendly, helpful, and enabled me to get better. They were a great source of support through a difficult period."
(Service user feedback)

"The service was great they helped keep her independent and when she was not comfortable about doing some things they understood."
(Service user feedback from HWTH report)

"My last carer was fantastic. She helped me regain my independence slowly and encouraged me to eat even though I suffer from an eating disorder and really only like to drink shakes."
(Service user feedback from HWTH report)

"They knew where she required some extra equipment and made her feel a little more comfortable about doing things on her own with that acquired equipment"
(Service user feedback from HWTH report)

5.4. The key ingredients to the delivery of a successful reablement intervention seem to include:

- Service users being clearly informed of what the Reablement Service is so that expectations are properly managed;
- Service users being discharged at a reasonable time of day to ensure there is a coordinated and effective transition into the service and to allow for an immediate needs assessment and independence planning;
- Advanced discharge planning must take place to ensure that any housing adaptation needs or environmental health issues such as bed bugs are addressed, and so that service users leave hospital with the correct medicines.

5.5. During the course of the review some key themes came through very strongly, including: issues around hospital discharge, quality assurance checks, social commissioning, understanding of the service, clear communication, the role of the third sector, social worker training, reassessment of people with long term support needs, navigation of different pathways and the cultural approach to social care services in Tower Hamlets.

5.6. The Sub-Committee identified a number of areas for improvement that would further enhance service effectiveness and outcomes for service users:

- Navigation of reablement and understanding of provision;
- The hospital discharge process;
- Service design and improvement;
- Social commissioning and the role of the third sector;
- The approach to social services in Tower Hamlets.

5a) Navigation of reablement and understanding of provision

5.7. There are currently a number of reablement and rehabilitation pathways in Tower Hamlets which caused the Sub-Committee to raise concerns about how people are expected to be empowered and involved in making choices

about the care they receive if there is no easy comprehension of the system or accessible information about it.

Currently service users can be referred to the following:

- Reablement
- Community Health Service, which provides a combination of both nurses and therapists who deliver nursing interventions which are not specifically related to rehabilitation but have a strong emphasis on self-management.
- Admission Avoidance and Discharge Service, which provides help and support for people with intensive nursing and therapy needs who would traditionally have been admitted to, or have remained in, a hospital bed or rehabilitation bed at Mile End Hospital.
- Specialist pathways: if patients have a specific health issue which has caused them to be in hospital they will be referred to a more specific rehabilitation pathway e.g. Stroke Rehab Team, Specialist Community Neuro Team, and Cardiac Rehab Team.

5.8. Within these services, the Sub-Committee heard that teams are sometimes performing similar tasks and the Director of the Community Health Team explained that whilst there is a good relationship between the Reablement Service and the Community Health Team there is a sense of confusion among staff and patients around what service is most appropriate. Streamlining provision would help make the pathways more navigable to clients and staff, and avoid duplication within the system.

5.9. The Sub-Committee was informed that some of this work was already underway, with a review of the reablement and rehabilitation pathways currently being undertaken as part of the Tower Hamlets Together Vanguard programme. The aspiration of Tower Hamlets Together is to move the separate services into an integrated service with a single point of access, which would provide one route into community health and social services for Tower Hamlets residents. This will be easier for both professionals and service users to understand and improve resource utilisation. Work is currently being undertaken to scope out the detail of an integrated service and it is anticipated that the new integrated service will commence in April 2018.

5.10. The Sub-Committee heard a number of examples to suggest that amongst some service users there is a misunderstanding of the role of the Reablement Service. This creates unrealistic expectations about the service people will receive and therefore negatively impacts on people's outcomes and satisfaction. From their interviews with service users Healthwatch Tower Hamlets concluded that the more extensive a service

users knowledge of reablement is, the more likely they were to provide positive feedback and satisfaction.

5.11. However, despite 83 per cent of respondents to the Healthwatch Tower Hamlets interviews confirming that they were aware of the purpose of the Reablement Service, comments made when asked about whether the service h**e**lped them to regain their independence (64 per cent felt it did not) suggests many do not fully comprehend the philosophy behind the service.

"They are good. But this isn't what I need. I need to move where there are people who can take care of me. They have adapted my doors, so that's been good."
(Service user feedback from HWTH report)

"My mother in-law isn't independent I have to do everything for her. She isn't interested in being shown how to make snacks and drinks. She can do those things, she needs other support. I don't see the point of this service"
(Service user feedback from HWTH report)

"Like I said my mother in-law needs a carer and someone to take her out. I am her main carer and we asked for some type of respite care. I'm not sure what the point of this service is. When I asked the helper to do it for her she said no and said she is only here to show her. She is old and she isn't in need of becoming independent. I asked to be given a carer. I have my own ailments that need to be managed. When you ask for help they don't want to help you"
(Service user feedback from HWTH report)

5.12. As these comments suggest, some clients have a view that the service does not provide the level of intervention they think is required. This indicates that either users/carers are unaware that the service is designed to foster independence rather than provide 'Homecare' style interventions, or that they understand the reablement approach and consider it inappropriate for their needs.

5.13. The Sub-Committee concluded that further work needs to be undertaken within the community and acute settings to explain the role of the Reablement Service to patients and staff. This would help promote a more widespread understanding of reablement philosophy, but also help to explain where it fits into the wider social/community healthcare offer (e.g. it may be that a referral to Homecare is required in future).

5.14. More specific user feedback was provided by Real, which evidenced a lack of understanding of the service amongst disabled service users and how it can support their needs. There is a widespread perception amongst their users that referral to the Reablement Service is the council's way of cutting support packages and that it is not appropriately designed to support a person with limited reablement potential. For example, some disabled service users felt that that Reablement Service is ineffective for certain groups and that it is not the right setting to assess people with long term conditions/degenerative disabilities, especially where there are limits to how much they can benefit from Occupational Therapy support, adaptions, and reablement equipment.

5.15. The service reported that these issues were likely the result of a lack of confidence amongst social workers about how to perform an assessment of changing needs if there is a request for an increase in a person's care package, which is something that has historically caused some issues. In recognition of this, the service has invested a lot of time empowering social workers to feel more assured when identifying whether the reablement service is appropriate as a default pre-cursor to increases in care package, as it is clearly not a suitable pathway for all clients. In addition, there is currently a training programme underway to improve conversational technique and the language used amongst social care staff to help better communicate the empowering objectives of the service.

5.16. However there clearly remains some challenges and the Sub-Committee felt that more work was required to convey the purpose of the service and dispel negative perceptions amongst disabled service users. There is a significant programme of change for social care staff planed, which builds on the introduction of the practice framework and is moving towards a more empowering and enabling approach through the conversations that staff have with service users, with a specific focus on the language used.

5.17. Service user groups also expressed their confusion over how the system works. The Tower Hamlets Older Peoples Reference Group informed the Sub-Committee that it was not aware that the service was available for older people who are already in their homes and struggling to maintain their independence, or how to get a referral to the service. Furthermore, the Carers Centre stated that they were unclear about whether people are able to refer directly to the Reablement Service or if they have to go through the Assessment and Intervention Team.

5.18. The difficulty in navigating the reablement and rehabilitation system is also experienced by GPs. The GP Care Group informed the Sub-Committee that it is not always clear which pathway a patient is on if they've been discharged from an acute setting, or which reablement/rehabilitation service is appropriate for a community referral. Improving the flow of information about patients at the point of discharge would be useful for GPs, and better communication about the role of the Reablement Service would help GP decision making when considering a referral.

5.19. Feedback from the Healthwatch Tower Hamlets interviews with service users supports the view that there is a lack of clarity amongst GPs around referral pathways and patient's suitability for the service. The majority of respondents to Healthwatch Tower Hamlets interview were referred by the GP and Healthwatch discovered that many of these patients were elderly and felt that they needed long-term care rather than reablement. As such, many did not benefit from the service because they were too ill to regain independence or had not been appropriately advised about the remit and expectations of the service. Healthwatch concluded that with the GP referrals it was less clear that people would benefit from reablement (three

referrals were for people with mental health issues) and they were generally more negative about the benefits of the programme.

"I'm not sure why they sent them because my mother in law has mental health issues so her opportunity to be independent is very limited. They told us they will be coming for about six weeks but when they weren't any help we asked them not to come again."
(Service user feedback from HWTH report)

"The GP referred us because he has mental health issues."
(Service users feedback from HWTH report)

5.20. The Sub-Committee expressed its particular apprehension over the ability of new GPs and locum doctors to understand how the Reablement Service works and fits onto the reablement/rehabilitation pathway. The GP Care Group accepted this as a legitimate concern given the severity of GP shortages and recognised that it is easier to navigate the system and respond to patient needs if you are a regular GP with familiarity of the medical history and needs of your patient. However, the Care Group also stated that GP surgeries are moving away from this mode of working and that regardless of the duration a GP has spent in a General Practice they still have a professional responsibility to liaise with other colleagues. In practice it should not be a significant issue; especially given the integrated care programme assigns a named GP as part of a patients care package.

5.21. In light of this, the Sub-Committee feels that communication to stakeholders and key partners needs to be improved so that GPs, and colleagues at the Carers Centre and Older Peoples Reference Group, amongst others, know how the system works and how to access it.

Recommendation 1: That the Reablement Service delivers additional training to social care staff in strength based practice to ensure they are able to convey the aims of the service and the reablement approach positively to service users and their families/carers

Recommendation 2: That the Reablement Service works with Real to review cases where concerns were raised, and use this information to improve service delivery for disabled service users via tailored training for specific teams or individuals (in association with Real).

Recommendation 3: That the Reablement Service develops a communications plan linked into the launch of the new integrated single pathway to educate the community on the role and aims of the Reablement Service so they are better advocate for themselves, and identify and challenge poor practice.

5b) Hospital discharge process

5.22. Discharge from hospital is an important part of the patient pathway. Evidence heard as part of this review highlighted that effective hospital discharges can only be achieved when there is good joint working between the hospital, local authorities, housing organisations, primary care and the voluntary sector, with each having a clear understanding of their respective roles and responsibilities. Whilst the Sub-Committee heard a number of examples of this joint working happening effectively, there remains a clear need for improvement, specifically in the relationship between the Barts Health Trust and the Reablement Service.

5.23. The Sub-Committee is alarmed by a number of issues in the hospital which appear to be having a significant impact on the performance of the Reablement Service and outcomes for service users. Reablement officers reported that there is a pattern of increased risk-taking with discharges as a result of the current pressures on the hospital, which is resulting in less notice being provided to the Reablement Service of discharge, and less involvement of adult social care in the discharge decisions making process.

5.24. The chief concern of the Sub-Committee relates to the time and day that patients are discharged. The Sub-Committee heard from a number of partners, officers, and service user groups that discharge into reablement too often occurs at the end of the week, without adequate notice given to the Reablement Service. This impacts on the capacity of the service to sufficiently prepare their support package for the client, which in-turn undermines the service user experience, outcomes, and physical and mental wellbeing. There are no longer home visits by therapy staff from the hospital wards which leads to people being discharged without the hospital or relevant adult social care teams having any knowledge of the situation a person will be placed in. Consequently, reablement officers will visit a person for the first time and it will often transpire that there are no basic supplies in the house such as food or electricity, leaving the person at risk. Reablement officers informed the Sub-Committee that this often requires them to respond to emergency situations in the first 24-48 hours. AgeUK East London try to pick this up and support people being discharged from hospital but there is no formal procedure in place for this and relies on them being in the right place at the right time as somebody is being released from the hospital ward. The danger this poses to a person's wellbeing, and the challenge it places on the capacity of the Reablement Service is exacerbated when the person is released at the end of the week at a time when all essential services and shops are closing and it is far harder for the Reablement officer to get the essential provisions in place.

5.25. Department of Health and NHS guidance recognises that assessments for NHS Continuing Care and Community Care need to take place as soon as possible and well before a person is discharged. However the Sub-Committee feel that this is not happening in Tower Hamlets, or if it is it is, is not being communicated effectively to the Reablement Service. The Sub-Committee would like to see Barts Health review its discharge planning

process so that a person's full range of needs, including their physical and mental health, housing, and financial situation, are taken into consideration and communicated to the Reablement Service in advance of discharge. Where possible, the Sub-Committee would like the hospital to undertake discharge planning early and not leave it until Thursday or Friday when the Reablement Service is less able to respond effectively.

5.26. The Sub-Committee identified that some service users are being discharged without access to money, which is having a significant impact on resources. Withdrawing money from a client's account requires two Reablement officers to receive signed consent from the service user and, where somebody does not have a bank card, Reablement officers have reported needing to visit food banks to obtain groceries. Both of these are extremely time-consuming and an ineffective use of staff time.

5.27. The Sub-Committee identified the process for the provision of medication for hospital discharge as ineffective, potentially dangerous, and wasteful. The likelihood that an elderly medical patient will be discharged on the same medicines that they were admitted on appears to be less than 10%. Currently patients are discharged with a bag of medication, which is very challenging for patients who are unable to read the medication boxes and administer the correct dosage (especially for older patients or those suffering with dementia). This presents a challenge as Reablement officers are not permitted to administer medication from individual boxes without a Medication Administration Record (MAR) chart or unless it is transferred into a dosette box first. At present, it appears the pharmacy in the hospital does not issue MAR charts and there is inconsistent use of dosette boxes.

5.28. A MAR chart should accompany the medication as part of the discharge process and the Reablement Service has raised this point at discharge meetings however it is yet to receive the appropriate action or response. If a MAR chart is not provided at the point of discharge then the alternative option to allow officers to handle medication is for people to be discharged with a dosette box however this is not happening and is just as problematic to solve. The Sub-Committee feel that this is an unnecessary misuse of resources as the old medication is often taken away to be incinerated and new medication is filled into the dosette box by the pharmacy. One Reablement officer stated that the NHS procedures do not permit the hospital pharmacy to prescribe medication in dosette boxes and this was illustrated to her when she recently visited the hospital rehabilitation unit. This also very time consuming and ineffective use of a reablement officer's capacity. One reablement officer commented that in the evening when they undertake a half an hour visit it can sometimes take the duration of that visit just to support the service user to arrange their medication. In cases where the service user is released with a dosette box it makes the process far more efficient. The Sub-Committee questioned whether hospital volunteers could be utilised to assist hospital pharmacies to fill the dosette box.

5.29. Reablement officers informed the Sub-Committee that there was insufficient provision of incontinence support from the hospital, which often

leaves the people they support in a compromising and an undignified position. As it takes time to provide people with correctly fitted pads via community nursing services they are provided with temporary pads at the point of discharge, however there are not enough pads to cover the patients' needs and it takes too long for the correctly sized pads to be provided. Reablement officers who were spoken to as part of this review voiced their frustration that the fitting of continence pads is not undertaken whilst the patient is in hospital as the patient will be wearing them during their stay and the hospital will have knowledge of whether the patient will need to wear the pads when they return home. Moreover Reablement officers reported that it was particularly difficult to communicate with the District Nurse to rectify this issue as the central telephone number they are provided with does not work.

5.30. AgeUK East London reported that the main problem their service users encounter is when their reablement needs are not identified in the hospital. Many service users are not referred to reablement and only realise they require the service once they are back home. The Sub-Committee found that knowledge and understanding of the reablement and rehabilitation services available does not translate across all wards within the hospital. If patients are not on the main wards where there is a greater level of dialogue and knowledge about rehabilitation and reablement services then it can lead to patients being discharged without the appropriate discharge planning taking place. Moreover, therapy input is not available on every ward which means that they do not benefit from early discharge planning and this can lead to instances where the patients' reablement needs are not identified. AgeUK also reported that another way a patient's needs are missed is if they are moved between wards and discharged from a different ward to the one they were originally in.

5.31. There is a significant programme of ICT updates as part of the Tower Hamlets Together Vanguard programme and TST, and the ambition is for Tower Hamlets to move into greater sharing with Health during the 2017-2018. The London Borough of Newham has already begun to share data with GPs and wider health colleagues. The Sub-Committee feels that this is an opportune time to ask for the new system to incorporate a method to manipulate service user data in order to identify which wards have discharged people without the appropriate reablement package in place. This will then allow the service to track the wards in the hospital which required further awareness and tailor a training package and promotional campaign at them.

Recommendation 4: That the Reablement Service explores options to provide emergency provision for supplies through pre-payment cards and food vouchers to assist those who are discharged from hospital back home without sufficient notice.

Recommendation 5: That Barts Health reviews its discharge procedures so that all patients are provided with dosette boxes when they leave hospital and medication is accompanied by a Medicine Administration Record (MAR) chart.

Recommendation 6: That Barts Health reviews its discharge planning process to ensure that the appropriate quantity of correctly fitted continence pads are provided to the patient at the point of discharge.

Recommendation 7: That Barts Health reviews its discharge planning process to ensure that discharge does not take place at the end of the week without advance communication to the Reablement Service, allowing for better planning that takes account of service users full range of needs and smoother handovers.

Recommendation 8: That the Reablement Service reviews service user data to identify which hospital wards require further training to educate staff on the purpose of the Reablement Service, its referral pathways and how aligns with other rehabilitation provision.

Recommendation 9: That the Reablement Service examines the procedures for liaison with environmental health so that response times to address issues such as bed bugs are improved.

5c) Service design and improvement

5.32. The Sub-Committee was informed that performance is monitored in a number of ways including service user questionnaires, case audits, and regular staff supervision meetings, spot checking cases, and attending site visits with junior staff to check performance. The Sub-Committee welcomes this clear commitment of the Reablement Service to improving the service user experience and outcomes for clients, but believes that more could still be done.

5.33. All informal and formal complaints are recorded and reported to senior management and where patterns of poor performance are identified the service aims to implement changes to address this. The Sub-Committee identified public involvement in the monitoring process is a significant gap, and believe the third sector (particularly the Older People's Reference Group) should be involved with case audits to encourage greater transparency. The Reablement Service acknowledged that there is very limited engagement with service users, particularly in improving and auditing the service, and there is an opportunity to develop this for the future.

5.34. Healthwatch Tower Hamlets reported a number of experiences where patients felt as though their goals were not taken into consideration by the Reablement Service. This could mean that the service is not personalised enough, or that people's goals are not aligned with the philosophy of

independence. The Sub-Committee feel that these issues should be identified and reviewed as part of ongoing performance monitoring and case audits.

5.35. The Sub-Committee identified the first week after discharge as a crucial stage in the reablement process. It is clear to the Sub-Committee that the majority of issues, such as those arising as a consequence of the hospital discharge process, bed-bugs in the home, housing adaptions or mobility assisting equipment not being ready in time, occur during this first week and it is therefore critical to ensure that this stage of the process is delivered effectively. The Sub-Committee feels that the performance monitoring of this stage of the reablement process needs to be strengthened. The Sub-Committee suggested an additional questionnaire be introduced into the performance monitoring process which could take place one or two weeks after the service has started as the experience after the first week and the experience after three months are significantly different. A questionnaire after one week would capture the acute problems which arise at the point of discharge and the issues which arise coordinating service provision. In Mental Health there is a national requirement to follow people up within seven days with a telephone calls or a visit. As part of the integrated care programme there could be a role to follow up with all patients discharged from hospital.

5.36. The London Borough of Greenwich Reablement Service provided a number of useful areas of learning to demonstrate how the performance monitoring of patient experiences immediately following hospital discharge can be undertaken. In Greenwich they have a quality assurance officer undertake a site visit to clients within the first week to two weeks to make sure that they are happy with the service, that all provision is in place, that there has been therapist input and a quality assurance form is completed. It also allows the Reablement Service to check that the client is on the correct pathway. This does not always have to be undertaken face to face, it can also be performed over the phone. Moreover they have a diary check within the first 48 hours which involves a senior officer visiting the client to explain service and find out what the users experience is.

5.37. The Sub-Committee was informed that a Discharge Forum has been set up and the issue of people not knowing who to contact if they had a problem within he first week to two weeks in their reablement and rehabilitation was highlighted. There are some teams which have a good system in place such as the Stroke Rehab Team and Barts Health are now trying to look at replicating this for General Discharges.

5.38. The Sub-Committee also identified the ICT system in place at Greenwich as another area of good practice to be adapted in Tower Hamlets. Greenwich has the IConnect Staff Plan ICT System in place which allows them to increase operational efficiency and improve care delivery. Referrals which are made to the service are digitised and all information about service users is sent directly to officers phones. This removes the need to communicate with staff as often as was required when paper rotas were in

place and can speed up the process of relaying information from hospital to officers. It helps the service to manage capacity as they can use the system to determine workloads and it is easier to view this on a screen then on paper rotas. Moreover they are able to send reablement officers to visit service users based on their proximity which helps to reduce travel time. They have split the service into three areas, Greenwich, Eltham and Woolwich and colour coded the areas to help manage and coordinate officer's workload. This could help in Tower Hamlets as the service reported that some members of their staff are traveling for up to 2-3 hours over the course of the day.

5.39. The Sub-Committee questioned whether there is any mental health provision included in the service given the elderly composition of service users, and that many are referred to the service following a prolonged hospital stay which may have impacted on their mental wellbeing. The Sub-Committee was informed that there is currently no recognised mental health support within the Reablement Service. There are a range of officers who have both physical health and mental health training however the service is very much focused on physical health. If mental health needs are identified officers try to refer people to the appropriate mental health teams. The Sub-Committee are concerned that this is a gap in the service which could significantly impact on outcomes. Healthwatch Tower Hamlets identified this as an issue and concluded that in some cases the service did not seem to be personalised as it could have been. Unless the service is able to deal with the issue that is most important to that person at the time their experience of the service overall is going to be negative. With referral to a mental health service often requiring a waiting period before treatment the Sub-Committee feel the Reablement Service will perform more effectively if the treatment of both physical health and mental health is aligned.

5.40. Service users felt that if people with mental health issues are going to continue to be part of the reablement programme staff may need more mental health awareness training. Healthwatch Tower Hamlets found that people with mental health issues were generally more negative about the benefits of the programme.

"I'm not sure why they sent them because my mother in law has mental health issues so her opportunity to be independent is very limited. They told us they will be coming for about six weeks but when they weren't any help we asked them not to come again."
(Service user feedback from HWTH report)

"They should educate the carers on mental health issues"
(Service user feedback from HWTH report)

Recommendation 10: That the Reablement Service improves its engagement with service users by working with the Third Sector to help strengthen the transparency of its performance monitoring process, including closer involvement of the OPRG.

Recommendation 11: That the Reablement Service establishes procedures for contacting service users by phone or in person within 24hrs of discharge to ensure they are safe and have no immediate issues about their care and support.

Recommendation 12: That the Reablement Service learns from observed good practice in Greenwich and introduces a questionnaire for all Reablement service users within the first 5-10 days after discharge from hospital.

Recommendation 13: That the Reablement Service learns from observed good practice in Greenwich and explores how they could use ICT systems to improve the coordination of staff planning and improve the efficiency of staff planning.

Recommendation 14: That the Reablement Service explores options to link the Reablement Service into existing mental health provision to provide more integrated physical and mental health support as part of a six week reablement period.

5d) Social commissioning and the role of the third sector

5.41. The CCG are currently pioneering work around social prescribing is in Tower Hamlets at a primary care level, allowing GP's to prescribe non-medical things for people that need additional support. However, the Sub-Committee feel that Reablement officers are also perfectly placed to perform a similar function as they have more frequent interaction with service users and can identify issues such as social isolation and refer people to the appropriate social activities or clubs, such as lunch clubs or befriending services, especially as part of exit planning from the service. The Sub-Committee was informed that there is an acknowledgement across the council and the Tower Hamlets Partnership that there are opportunities within the voluntary and third sector which need to be explored further. There is a programme within the Vanguard which focuses on greater community engagement and is working to strengthen the relationship with the voluntary sector and the linkages need to be made.

5.42. AgeUK East London informed the Sub-Committee that they have recently been working with a GP and both were unaware of the role each other performed. There are a number of care navigators in the community that do not appear to be linked into mainstream services. The Sub-Committee feel it would be valuable to link the care navigators with the social prescribing pilot, Reablement officers, voluntary sector, and advocacy sector as an information sharing forum. There are currently four locality community boards that are led by GPs who are looking to refresh their membership. This could be expanded to become a wider care team to include everybody who is in the local area, including both the statutory and the voluntary sectors. One of the drivers for health and social care change is to work in localities more, for example the new domiciliary care contract is spread across the four sectors which also tie in with the GP primary localities, and an information sharing forum could work to a similar framework.

5.43. As the pressures placed on adult social care budgets increase, the Sub-Committee wanted to understand the implications for this on the service. The Sub-Committee were informed that the move towards self-care and community based care can support the council to be more flexible with their resources. The Sub-Committee suggested that a possible course of action is to train formal and informal carers and volunteers to support the reablement process. This may also lead to improved service user outcomes, as in many cases the success of reablement depends on the attitude of the family, not just that of the service user. It will also help to increase the service's reach and help support service users in the transition beyond the 6 week reablement period. The Carers Centre expressed their view that there needs to be better communication with the 'cared for', their carers and their advocates.

Recommendation 15: That the Reablement Service explores the possibility of performing a social prescribing or commissioning function to refer people on to appropriate community support/activities at the end of its formal intervention.

Recommendation 16: That the Reablement Service develops a forum to share information on ongoing projects, available services, and opportunities for partnership working between the third sector and statutory services, perhaps building on the multi-agency meetings of each of the GP localities

Recommendation 17: That the Reablement Service explores options to train formal and informal carers and volunteers to support the reablement process and promote the principles of recovery and independence.

5e) Tower Hamlets approach to social care services

5.44. The Sub-Committee was informed of the view that, historically, types of adult social care in Tower Hamlets were about providing a certain type of interventionist care that sometimes encouraged dependence rather than independence. The work of the Reablement Service is premised on an alternative approach, which offers service users the chance to regain their independence without ongoing, long term support.

5.45. This is indicative of the trend across the health and social care sector in the UK, although embedding this ethos is a challenge in terms of service user expectations and professional practice. The Sub-Committee was informed that there is recognition within adult social care, the council, and also across the wider Tower Hamlets Together partnership that the philosophy does need to change and that this is a key component part of the Vanguard program.

5.46. The Sub-Committee found that there is a need to encourage a culture of reablement across the local system (not just within the Reablement Service), particularly in the hospital and amongst social care providers. A

handover to a more traditional home care service might undo the progress made following a period of reablement. Reablement officers provided examples of where people who were discharged were allocated care workers who provide a high level of intervention and then shortly afterwards the reablement staff turn up with the aim to reduce dependency, however by this time the service user is accustomed to the care service. This is likely to happen when somebody who has an existing package of care goes into hospital and then is referred through the reablement pathway at discharge. It also occurs where there is not the capacity in the service on discharge to provide the Reablement officers so the next step is to set up what the hospital wants through brokerage service. The aim is to move these care packages back into the service as quickly as possible but it may be too late. This then creates the perception that reablement service's role is to cut services.

5.47. The Sub-Committee heard from reablement officers that the annual review of those on long term support is not being enforced as robustly as it should be. This leaves the council in a position where it is paying for high levels of support for somebody who is no longer in need of it. Moreover it can cause resentment in the community and create a negative attitude towards reablement as people are unable to understand why they are being supported to regain independence and not being provided with the same level of support as people who are no longer as immobile or in ill health.

Recommendation 18: That the Reablement Service reviews how social care staff introduce reablement positively to residents and their families and examines how the annual re-assessment procedure for people with long term care packages to establish how reablement may assist service users.

The Admission Avoidance & Discharge Services (AADS)

The AADS is an integrated service which combines the following functions:-

- Admission avoidance in ED with follow up in AAU and/or the community (7 days per week in ED from 8am to 7pm)
- Hospital at home for medically optimised patients who need increased nursing / therapy support (e.g. for 2 weeks) to support prompt discharge from hospital (7 days per week from 8am to 6pm)
- In-reach nursing team who work between wards and community health teams to facilitate discharge for patients with complex needs (7 days per week from 8am to 6pm)
- Home support pathway or discharge assess, which enables patients to be discharged home for assessment of care needs with additional health & social care packages in place. This pathway includes providing CHC assessment in a person's home where appropriate. (7 days per week from 8am to 6pm)

The AADS team includes nurses, occupational therapists, physiotherapists and social workers. The team is made up of both permanent and temporary employees due to the nature of the funding arrangements currently in place with the CCG.

The AADS aims to:

- Avoid unnecessary admissions for patients who attend the Emergency Department
- Improve the transfer of care from the Royal London Hospital to community services
- Facilitate discharge for patients who are expected to become clinically stable in the next 1-2 days and can be safely managed by community nurses with advanced clinical skills
- Support patients who require further health/therapy assessments to go home as soon as they are medically stable
- Support patients who require short term rehabilitation to return to their previous level of function

Identifying patients for the AADS starts in the Emergency Department with patients identified by the admission avoidance team who can be safely discharged home and followed up in the community by therapies or other members of multi-disciplinary team (MDT). It will not always be possible to discharge all patients home and where this is the case, the AADS team follow the patient into the hospital ensuring that there discharge back home is planned from point of admission.

Patients are identified from the wards by the in-patient therapy teams, who make direct referrals to AADS as well as by the nurse screeners who form part of the AADS team. The nurse screeners as well as the in-reach team work directly with wards to case find and identify patients suitable for the home support pathway. The nurse screeners & in-reach teams will also refer cases to CHC assessors where appropriate. The in-reach team attend daily board rounds on RLH, with their main focus being on the 11th, 13th & 14th floor, to enable them to work with ward teams to support the prompt discharge of patients home and identify additional cases for AADS. Clinical dialogue will take place if patients are already known to the CHTS/ specialist teams to ensure the right person sees the patient to support discharge.

A member of the AADS team also attends the RLH daily safety huddle and at least one of the thrice daily capacity meetings to ensure all patients who will benefits from the AADS service are identified and referred to the team.

Patient attends RLH Emergency Department between 8am-7pm and is identified for AAT input (by case finding or ED staff referral)

AAT assess patient and advise whether s/he is able to be discharged home

Patient discharged home

If community follow up is required:

-AAT alert CHT or

- if not known and requiring therapy input, contact patient to arrange AADS follow up visit within 24 hours

Patient assessed by AAT in ED/CDU and admitted to RLH

- Initial Assessment template completed and AAT therapy staff hand over to AAU therapists the same day/following morning to assist with discharge planning
- If transferred to other ward, AAT call therapy staff to hand over
- In-reach nurses attend board rounds daily and track progress
- In-reach nurses inform AADS screener if patient still suitable for community input or not medically stable
- **OR** Ward staff call DEC phone 45898 to make new referral

Patient in hospital not previously known to AADS and:

- Is suitable for discharge to assess model or
- Needs intensive rehabilitation or
- Will become medically stable in 1-2 days and suitable for AADS nursing
- Needs short-term IV antibiotics

Ward staff call DEC phone 45898 to make referral
(or IV phone 07507894927 for community IV antibiotics)

AADS staff liaise with CHC staff.

If a patient has a positive checklist and is able to be supported at home then can be discharged home with AADs support.

Checklist will be re done by CHC at 4 weeks / DST as appropriate

- Screener takes information over phone/ goes to ward to review patient if required (all nursing patients) - within 2 hours if same day discharge, if not medically stable/ready for discharge then within 48 hours
- Patient is accepted for AADs or referral rejected and reasons provided
- Once accepted, screener follows up daily until medically stable/discharge date confirmed
- Screener/In-reach nurses take proactive approach to facilitating discharge as soon as medically stable/optimised
- Once discharge date is known, AADS visit offered same or next day (depending on time patient leaves hospital)
- AADS community staff (including social worker) meet every morning at 9am to allocate new patient visits
- Screener calls community staff member if need for urgent visit identified after allocation meeting

Community Health Teams (CHT)

Community Health Teams are multi-disciplinary teams of Nurses, Occupational Therapists, Physiotherapists, Care Navigators, Social workers, Psychologists and access to additional health care professionals. Services operate 24 hours a day, 7 days a week for nursing. The community nursing team focus on nursing interventions which are not specifically related to rehabilitation but have a strong emphasis on self-management.
Referral to the services is via the Single Point of Access.

CHT Therapy Physiotherapy and Occupational Therapy Rehabilitation Service:

The therapy service within CHT are mainly focused on rehabilitation and working towards a person's individual goals. A thorough home based assessment will be carried out by a fully trained health care professional and a treatment plan tailored from the assessment findings. Various strategies will be employed to assist a patient in attaining their goals which will include use of functional rehabilitation, home based exercises, provision of appropriate equipment etc. All interventions will be discussed with the patient in advance and aim to work towards their personal goals.

The therapy service provides short term intervention with a strong focus on self-management and continued improvement once therapy provision from CHT has stopped. The therapists within CHT will work with patients suffering from a variety of medical conditions and complaints. The following are examples of common reasons for referral to the therapy service:

- Falls
- Balance impairments
- Fractured Hips (traumatic)
- Pre-habilitation (preparation of patients for elective orthopaedic surgery)
- Musculo-skeletal complaints for those who are housebound
- Post admission rehabilitation
- BPPV
- Difficulty in managing activities of daily living e.g: difficulty with managing meal preparation
- Cognitive Rehabilitation

Referral Pathway and referral triage process:

Referral to the CHT therapy team is received from varying health care professionals. All new referrals are submitted to the Single Point of access. Here the referral is registered and placed in the correct locality in accordance to patient's GP and address demographics. All new referrals are screened and triaged by integrated locality team members daily. Each new referral is prioritised and placed into the correct therapy service.

CHT therapy team have a priority criterion as follows:

Rapid Response (2 hrs)

Immediate assessment and intervention (needs based contact within 2 hours) to keep the person at home if safe and possible to do so, or facilitate a safe discharge

- Sudden deterioration (within the past 24 hrs) in the community with immediate high risk of admission
- Facilitation of discharge from ED of hospital (i.e. non-admitted patients) whereby patient is at high risk of readmission (within 24 hours)
- Palliative care – to enable dying at home
- Urgent Response (24 hrs) Needs based contact within 24hrs for assessment and intervention as required to facilitate safe and timely discharge home from hospital or prevent an admission to hospital
- Breakdown of urgent equipment (if not covered by CES)

- Client / carer at high risk of injury due to manual handling
- Acute chest infection / aspiration. Client at risk of admission and requires assistance with secretion clearance (must have already been seen by medic within 24 hours and commenced on antibiotics)
- High falls risk e.g. recurrent (2 or more) within past 5 days. Not presented to other health services.
- Replacement walking aid for indoor mobility required (not known to CES)
- Non routine post-surgical e.g. Total Hip Replacement assessment / intervention to decrease risk of dislocation
- High risk of readmission of palliative care client

Routine Care (5 days)

- Facilitate safe and timely discharge home from hospital or prevent an admission to hospital / long term placement
- Palliative care at risk of readmission or to facilitate discharge / carer advice
- Assessment of client who has not received an assessment from another CHT clinician / HSW / Lead Care Navigator within 5 days of referral
- Falls risk
- Post-op intervention for orthopaedic surgery with risk of deterioration or readmission
- Significant high level of risk in carrying out essential care and daily living tasks
- Manual Handling issues for carers
- High risk of pressure area breakdown & needing MDT input

Non urgent Rehabilitation (3weeks) (which may include long-term rehab client with on-going potential)

- Post-op intervention for progression of function with no risk of readmission or deterioration
- Progression of mobility aid with no risk of readmission or deterioration
- Outdoor mobility and community access
- Patients who are reprioritised following, for example, psych input and are therefore ready for treatment
- Client has on-going rehab needs but is able to maintain function
- Long-term chronic pain
- Vocational rehabilitation

Hours of service:

The therapy team operates from 08.30hrs – 17.00hrs Monday- Friday and 09.00hrs - 17.00hrs Saturday and Sunday.

Elderly Care Rehabilitation Services

Elderly care rehabilitation services are based at Mile End Hospital. There is one elderly care rehabilitation ward (24 beds) which is supported by a multi-disciplinary team of nurses, doctors and therapists.

Criteria for admission to the ward is over 65, accepted under the care of the elderly care consultants at the Royal London.

Patients will have on going rehabilitation needs or complex discharge needs eg anxiety or 3 to transfer. Patients can stay for up to 42 days but average length of stay is much shorter- last year average length of stay was 11.2 days.

Specialist Rehabilitation Services

Barts Health runs some specialist rehabilitation services that support patients who have been discharged from hospital following a specific condition related episode. These teams are:-

- Stroke Rehab for patients after an acute stroke.
- Cardiac rehab and heart failure services.
- Adult Community Neuro Team for patients with acute, chronic and progressive neurological conditions.
- Adult Community Respiratory Team (ArCare) for patients with chronic lung disease and patients with heart failure.

These specialist services: aim to provide timely high quality care for patients and their families/ carers who have been diagnosed with a long term condition or had an acute episode of care. The focus is on early intervention and assessment in the community, involving a range of health care professionals with specialist knowledge. The services provide a multi-disciplinary holistic assessment. They work as an integrated part of the team with secondary care Consultants and ward staff to facilitate early supported discharge. They provide admission avoidance and anticipatory care in the community by case management and care co-ordination, aiming to minimize risk, complications and to manage changing conditions. They provide on-going goal orientated rehabilitation within community settings

The teams include occupational therapists, physiotherapists, specialist nurses, speech and language therapists, psychologists, support workers, care navigators, dietician's physiologists and administration staff. The services aim to meet the physical and psychological needs of the individuals and their support network.

The services run with varying hours for each team but across 7 days. Referrals are taken directly from the ward, from AADs , from the CHTs or via SPA.

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healthwatch Tower Hamlets

Supporting independence

Report on service user views of the reablement programme in Tower Hamlets 2017

Contents

Healthwatch Tower Hamlets is an independent organisation led by local volunteers. It is part of a national network of Healthwatch organisations that involve people of all ages and all sections of the community.

Healthwatch Tower Hamlets gathers local people's views on the health and social care services that they use. We make sure those views are taken into account when decisions are made on how services will be delivered, and how they can be improved.

www.healthwatchtowerhamlets.co.uk

Introduction

Healthwatch Tower Hamlets interviewed 14 local users of the local authority reablement service. The aim was to get an understanding of their experience of the service: what had worked well; what had not worked so well; and how the service could be improved.

The purpose was to provide this information to the Local Authority Health Scrutiny Committee to support their review of the reablement service and to improve the service for local residents.

What is reablement?

Following an accident, ill health, or a stay in hospital people may have lost confidence or ability to do everyday tasks for themselves. Reablement is a short-term support service that can help them to regain their skills or ability to cope with everyday tasks, and helps them to live as independently as possible. The service lasts for up to six weeks.

A range of both personal care and household support is provided as part of an Independence Plan. This can include:

- Getting washed and dressed
- Using the toilet
- Taking care of their health or managing their medication
- Preparing snacks and meals
- Completing laundry and housework
- Doing the shopping
- Getting out and about
- Accessing social activities

Method

The Health Scrutiny Committee provided us with a list of 34 service users who had gone through the reablement service in the past two to three months. They also provided an interview question guide (attached Appendix 1).

A member of staff and two Healthwatch volunteers contacted all of the individuals on the list by phone and 14 agreed to take part in a phone interview.

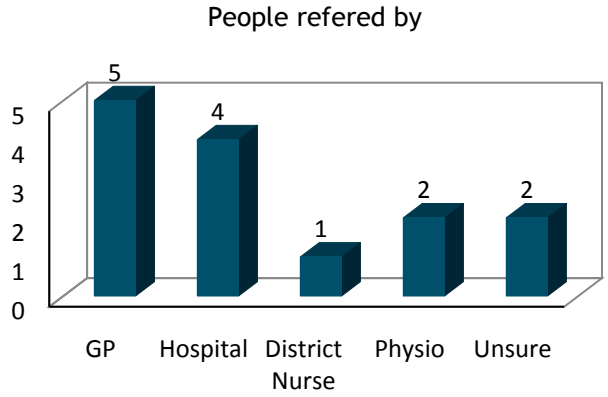
Participants

We spoke to 14 people, 5 men, 9 women, five of whom were both Bangladeshi and Sylheti speakers.

Key Findings

1. Referral

People were generally referred to the programme by their GP or the hospital.



The hospital and physio referrals seem to be appropriate to the aims of the service.

I had spinal surgery done and they set me up with the service when I was discharged.

My mum broke her leg and is incontinent. The physio referred her to this service.

However with the GP referrals it was less clear that they would benefit from reablement (three referrals were for people with mental health issues) and they were generally more negative about the benefits of the programme.

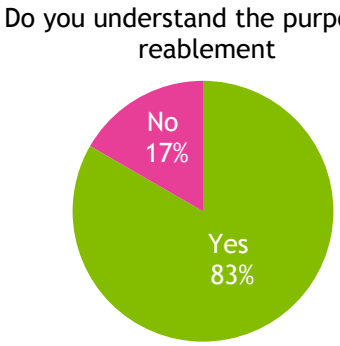
I'm not sure why they sent them because my mother in law has mental health issues so her opportunity to be independent is very limited. They told us they will be coming for about six weeks but when they weren't any help we asked them not to come again.

The GP referred us because he has mental health issues.

Some patients were confused as to why they had been referred and a number were under the impression that they were being assigned a carer rather than an individual who would aid them in achieving personal goals and become more independent.

2 Understanding the service

The majority of people did know what the Reablement service was and were pleased with the idea of becoming more independent after their injury or illness.



Yes they explained what the service was clearly. That it's about increasing the independence and not doing it for my sister. They would be with her for approximately 6 weeks

When asked follow up questions regarding their knowledge, their feedback was more positive based on their awareness of exactly the type of care they were going to receive. Patients who were not aware of the specific aims of the service were caught off guard and rather confused. Some people needed full time carers and were unhappy when "told what to do" without much consultation.

Yes they did explain what the service is, but we thought they were going to help us and not just give advice. They explained everything.

All in all, people were generally pleased with the service when regaining independence was what they desired. When people did not know exactly what the service aimed to provide, they were dissatisfied due to a misunderstanding of the carer's intentions.

It is the biggest waste of money Tower Hamlets could ever have. They did not tell me anything they just went ahead and bossed me around. I need a carer forever. This was not what I needed.

The patient's extensive knowledge of the service was more likely to result in positive feedback and satisfaction.

3 Views of the service

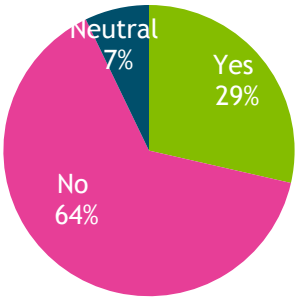
If the Reablement workers helped patients become independent doing tasks they asked for help with and wanted, patients were very satisfied with the service. For those who wanted it, the service helped them cook and prepare food in the kitchen, clean, take medications, wash clothes, bathe safely, and get out of bed safely.

The service was great they helped keep her independent and when she was not comfortable about doing some things they understood.

My last carer was fantastic. She helped me regain my independence slowly and encouraged me to eat even though I suffer from an eating disorder and really only like to drink shakes.

However, a significant number of patients felt as though their goals were not taken into consideration. These patients tended to become frustrated with the care they received with tasks they did not need or could not perform. Many of these patients were elderly and felt that they needed long-term care rather than independence. Thus, they did not benefit because they were too ill to be independent.

Did reablement help you to regain independence



Many patients felt as though the service was beneficial in theory, but not relevant to them. It did not seem to match up with their needs or what was really important to them at that point

We didn't benefit from the service at all. They tried to show my mother in-law how to use the bathroom taps. She wasn't interested and in fact it made her more annoyed. My mother in-law isn't independent I have to do everything for her. She isn't interested in being shown how to make snacks and drinks. She can do those things, she needs other support. I don't see the point of this service

I know how to make myself a cup of tea and food. I live alone and am very scared. They are good. But this isn't what I need. I need to move where there are people who can take care of me. They have adapted my doors, so that's been good.

They did not do what I asked, which was to install hand rails for my bath. They put in an electric seat with a remote control that moves me in and out, but I still need a hand rail.

They just bossed me around without asking me how I feel.

4 Suggested improvements

Patients reported that the staff were competent to meet their needs for the most part. At the same time, some felt unsure because the Reablement workers did not spend enough time with them or assumed what they needed without asking them.

They knew where she required some extra equipment and made her feel a little more comfortable about doing things on her own with that acquired equipment

Hard to tell because they did not spend much time with me

Even though some patients did not feel as though they were involved in identifying their goals or aims whatsoever, some did; responses varied greatly.

Patients were almost always encouraged to prepare their own light snacks and drinks, but some were unable to do this because of their medical condition. Again, this was very frustrating for them.

I was encouraged to make my own shakes.

I cannot cook - only microwave. They did not ask me about any of this, they only installed the bath seat

After their experience with the service came to an end, some patients were aware of how to report any concerns or complaints in relation to any aspect of the care they received from the Reablement, whereas others were not. Some patients suggested a standardized protocol for providing them with information about contacting Reablement after the service ends.

Some people felt that what they really needed was a permanent care package and that reablement was a waste of time and money.

My sister got annoyed with the service. They would show her how to bathe, but if she got any water on the floor because she needs assistance, then she was expected to wipe up the water herself. She is elderly and could easily slip and fall. But they said they cannot help her. She got annoyed and she told them not to come back after four weeks. She knows how to make food and drinks alone. She needs assistance and not showing how to become independent. She isn't any more better off from this service

Like I said my mother in-law needs a carer and someone to take her out. I am her main carer and we asked for some type of respite care. I'm not sure what the point of this service is. When I asked the helper to do it for her she said no and said she is only here to show her. She is old and she isn't in need of becoming independent. I asked to be given a carer. I have my own ailments that need to be managed. When you ask for help they don't want to help you

It did not do anything. And yeah I need 24 hour care not this reablement stuff

If people with mental health issues are going to continue to be part of the reablement programme staff may need more mental health awareness training.

They should educate the carers on mental health issues and explain that they are just there to help not to judge or say anything about people's lifestyles. There was also an issue with logging their hours. They needed to go to a certain amount of people and if they did not have time they just would not come which also set me back

Summary

Although people appreciated what it was that the reablement service was trying to achieve and the staff it was concerning how few of them felt that it had actually helped them to regain their independence. Those for whom it did work were people who had had a single incidence of need e.g. operation or fall and there wasn't a preexisting deterioration.

There appears to be a mismatch between what service users think the programme will do and what staff are there to do. A clear assessment needs to be made of whether regaining independence is what the person wants and that realistic steps can be made towards that goal within the six week period. There seems to be a delicate balance between supporting and pushing someone to achieve their goals and being seen as being bossy and not listening.

A number of users and carers felt that what they really needed was longer term social care support and the objective of regaining independence was unrealistic. For this reason they became very frustrated and sometimes annoyed by the programme. There was a sense that from some that they saw reablement as a hurdle you have to go through in order to establish that you need an ongoing care package.

In some cases the service did not seem to be personalised as it could have been. Unless you are able to deal with the issue that is most important to that person at the time their experience of the service overall is going to be negative.

They did not do what I asked, which was to install hand rails for my bath. They put in an electric seat with a remote control that moves me in and out, but I still need a hand rail.

I know how to make myself a cup of tea and food. I live alone and am very scared. They are good. But this isn't what I need. I need to move where there are people who can take care of me.

It is unclear how reablement links to wider integrated care and integrated personal commissioning programmes in the Borough. It seems that some of the users could benefit more from links to longer term support through social prescribing, home adaption and carers support services.

Interview Question Guide

1) **How did you come into contact with Reablement?**

2) **Do you understand what the purpose of the reablement service is?**

   - **(Prompt)** Did you feel you had enough information about the Reablement Service prior to you being seen by them?

   - **(follow up)** Were the aims of Reablement made clear to you when you entered the service?

   - **(Prompt)** When you were admitted to the service did the staff talk to you about how long you would be expected to remain in the service?

3) **What are your views on the performance of the service? What went well?**

   - **(Prompt)** Can you tell me what went well about your time with the reablement service?

   - **(Prompt)** Did the service help you to regain your independence? Did you need a home care service after the team stopped working with you?

   - **(Prompt)** Do you feel the staff were competent to meet your needs?

   - **(Prompt)** Did you feel you were involved in identifying your goals or aims?

   - **(Prompt)** Did you feel you were encouraged to prepare your own light snacks and drinks?

   - **(Prompt)** Were you aware of how to report any concerns/complaints in relation to any aspect of the care you received from the Reablement Service?

4) **What are your views on the performance of the service? What could be improved**

   - **(Prompt)** Can you tell me what issues you had with the reablement service? What do you feel could be improved?

   - **(Prompt)** Did you feel you were encouraged to wash and dress yourself?

   - **(Prompt – if discharged from hospital)** When you were discharged from hospital was a reablement package already in place or did you have to wait? Did you have any issues getting the right support in place?

   - **(Prompt)** Did you require any equipment or home adaptions from the reablement service? How long did this take to arrive?

5) **Do you have any other comments about any aspects of the reablement service?**

Close

Thank you for answering my questions.

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Non-Executive Report of the: **Health Scrutiny Subcommittee** 29/06/2017	
Report of: Graham White, Acting Corporate Director Governance	**Classification:** Unrestricted
Access to health and social care services in Tower Hamlets	

Originating Officer(s)	Sharon Godman, Divisional Director strategy, policy and partnership Daniel Kerr, Strategy, Policy and Partnership Officer
Wards affected	All Wards

Summary

In 2016/17 the Tower Hamlets Health Scrutiny Sub-Committee's (HSSC) identified the area of ***'Access to Health and Social Care Services'*** as a thematic focus for its work programme. The Sub-Committee wanted to review the accessibility of specific health and social care services in the borough and develop recommendations to improve provision.

This report provides a brief overview of the key issues raised over the course of these meetings, the response of services to meeting the identified challenges, and the recommendations put forward by the committee for consideration.

Recommendations:

The Health Scrutiny Sub- Committee is recommended to:

1. Note the report and recommendations.

1. REASONS FOR THE DECISIONS

1.1 By reviewing access to health and social care services in Tower Hamlets the Health Scrutiny Sub-Committee had the opportunity to explore what significant challenges face residents in accessing health and social care services in Tower Hamlets, and consider cutting edge solutions for improving access to the appropriate care.

2. ALTERNATIVE OPTIONS

2.1 To take no action. This is not recommended as the scrutiny review provides an evidence base for improving access to health and social care services in the borough

2.2 To agree some, but not all recommendations.

3. DETAILS OF REPORT

3.1 The Health Scrutiny Sub-Committee (HSSC) took a thematic approach to its work programme during the 2016/17 municipal year, agreeing to focus its scrutiny on the issue of resident access to local health and social care services - something that has become of increasing concern in recent years due to a number of social, economic and policy factors.

3.2 The Sub-Committee identified four areas of interest for review across the year:

- Community Pharmacy,
- Primary Care, Planning and Health Infrastructure,
- Early Years
- Adult Mental Health Services

3.3. The Sub-Committee wanted to review the accessibility of specific health and social care services in the borough and develop recommendations to improve provision

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 This is a noting report and there are no financial implications arising from the contents of this report.

5. LEGAL COMMENTS

5.1 This is a noting report asking the Sub-Committee to note the 'Access to Health & Social Care in Tower Hamlets - Annual Report of the Municipal Year 2016-17' and its three recommendations contained therein. There are no legal implications arising from the contents of this report.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 This review provided recommendations which will ensure that people from different ethnic groups, age groups, and genders are provided with the same quality of service, and level of access to health and social care provision in the borough.

7. BEST VALUE (BV) IMPLICATIONS

7.1 There are no direct best value implications arising from this report or its 'Action Plan'.

8. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

8.1 There are no direct environmental implications arising from the report or recommendations.

9. RISK MANAGEMENT IMPLICATIONS

9.1 There are no direct risk management implications arising from the report or recommendations.

10. CRIME AND DISORDER REDUCTION IMPLICATIONS

10.1 There are no direct crime and disorder implications arising from the report or recommendations.

Linked Reports, Appendices and Background Documents

Linked Report

- NONE

Appendices

- Appendix 1: Access to health and social care in Tower Hamlets Report.

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report
List any background documents not already in the public domain including officer contact information.

NONE

Officer contact details for documents:

- Daniel Kerr
  ext 6310
  Daniel.kerr@towerhamlets.gov.uk

Health Scrutiny Sub Committee

Access to Health & Social Care in Tower Hamlets

Annual Report of the Municipal Year 2016-17

BACKGROUND

Health scrutiny is the fundamental way by which democratically elected local councillors are able to voice the views of their constituents, and hold relevant NHS bodies and relevant health service providers to account. To this end, the primary aim of health scrutiny is to act as a lever to improve the health and wellbeing of local residents by ensuring that:

- The needs of local people are properly considered in the commissioning, development and delivery of health services,
- Health inequalities are addressed by safeguarding and promoting equal access to services and supporting more equal outcomes across different communities,
- Proposals for substantial service changes put forward by the NHS are reasonable and appropriately consulted on,
- Service commissioning and delivery partners' work together to provide more integrated services.

In 2016/17 the Tower Hamlets Health Scrutiny Sub-Committee's (HSSC) identified the area of ***'Access to Health and Social Care Services'*** as a thematic focus for its work programme. The Sub-Committee wanted to review the accessibility of specific health and social care services in the borough and develop recommendations to improve provision. The Sub-Committee identified four areas of interest for review across the year.:

1. Community Pharmacy,
2. Primary Care, Planning and Health Infrastructure,
3. Early Years
4. Adult Mental Health Services

Each of these areas was given a time slot across the four ordinary meetings of the committee, with representatives and professionals from the relevant services invited to provide an overview of the main challenges in their areas of work. Committee members then asked questions and discussed the implications for residents, offered their own perspectives, and agreed a set of recommendations for action.

This report provides a brief overview of the key issues raised over the course of these meetings, the response of services to meeting the identified challenges, and the recommendations put forward by the committee for consideration. The report does not provide a verbatim record of the discussions, but these can be found in the formal minutes of the relevant meetings.

Table of Contents

1. Introduction

1.1. The Health Scrutiny Sub-Committee (HSSC) took a thematic approach to its work programme during the 2016/17 municipal year, agreeing to focus its scrutiny on the issue of resident access to local health and social care services - something that has become of increasing concern in recent years due to a number of social, economic and policy factors

1.2. Tower Hamlets has seen the largest population growth of any area in the country over the last 10 years, an increase of 27%, and this trend is projected to continue over the next decade with the borough expected to grow by a quarter to 2024 (the largest increase in England). Moreover, the diversity of Tower Hamlets population and its high level of deprivation pose some additional challenges to resident access to health and social services. Many residents suffer from chronic conditions linked to poverty, and certain cultural issues amongst our communities restrict local understanding about how to access the appropriate provision.

1.3. However, this growing demand for services has not been fully matched by increased resources. Challenging efficiency targets for the NHS and persistent reductions to local authority budgets have impacted on the capacity of the health and social care system to respond – for example, locally Barts Health has the largest deficit of any hospital trust in England, and Tower Hamlets Council has to make £63 million of savings though to 2018/19. Innovation in prevention, early intervention and demand management will be crucial for ensuring that services are able to meet local needs and provide effective care.

1.4. By reviewing this theme the Health Scrutiny Sub-Committee has the opportunity to explore what significant challenges face residents in accessing health and social care services in Tower Hamlets, and consider cutting edge solutions for improving access to the appropriate care.

2. Community Pharmacy

Attendees

Name	Organisation
Bhavin Patel	North East London Local Pharmaceutical Committee
Dr Somen Banerjee	Director of Public Health
Simon Hall	Acting Chief Officer, NHS Tower Hamlets Clinical Commissioning Group
Dr Sam Everington	Chair, Tower Hamlets Clinical Commissioning Group
Jenny Cooke	Deputy Director for Primary and Urgent Care, NHS Clinical Commissioning Group

2.1. The Sub-Committee considered the significant but often overlooked role of community pharmacies in the delivery of primary health services to local residents. The Sub-Committee wanted to develop a clearer understanding of:

- The current role of community pharmacies in Tower Hamlets and their place in the local healthcare system;
- Barriers to access for local residents and the potential impact of the proposed £300 million Government cuts to the community pharmacy budget from 2017/18*;*
- Possible opportunities for improving access, for example through better integration between community pharmacies and other local health services.

2.2. Community pharmacies are a key touch point for the public with the health system due to their significant presence in local communities. They offer a wide range of service, including prescriptions, support for people with lifelong conditions and advice on ‘over the counter’ medication/minor ailments.

2.3. Nationally, there are 1.6 million visits a day to community pharmacies, of which 1.2 million are for health reasons. Community pharmacies dispense around 1 billion medicines every year with prescriptions growing at a yearly rate of 2.5%.

2.4. Pharmacies represent the most accessible primary care location for local residents and 96% of people can reach a pharmacy within 20 minutes on foot or by public transport (increasing to 99% by car). According to NHS England, nationally there has been a 20% increase in the use of pharmacies in recent years, with the average person visiting a pharmacy 14 times each year.

2.5. Most community pharmacies have extended hours and weekend opening that GPs are unlikely to offer at scale any time soon. All of this helps to relieve pressure on hard-pressed GPs and A&E departments, freeing them to focus on patients with greater, more complex needs. It is reported that as many as 20% of all GP appointments could be dealt with just as effectively, and far more rapidly, through community pharmacy[1].

2.6. The Sub-Committee heard that the 48 pharmacies in Tower Hamlets play an important role in supporting the delivery of health services to local residents, as well as offering social and economic benefits to many of the borough's high streets by supporting foot-fall.

2.7. In addition to more traditional services, community pharmacies in Tower Hamlets also play an important role in supporting the prevention agenda by offering easily accessible and low level interventions, such as sexual health services and smoking cessation support. The Sexual Health programme (delivering chlamydia screening and contraception advice) was reported as being particularly popular with patients, especially young people, who preferred the anonymity offered by avoiding more formal settings such as the sexual health clinic.

2.8. However, it was felt that community pharmacies could play an even greater role as a high street clinic and form a more integral part of the new model of care that is emerging locally. By offering a wider range of services, such as medicines usage optimisation, enhanced support for people with long term conditions and treatment for minor illness and injuries, community pharmacies could help to relieve growing pressure on other elements of the healthcare system, such as general practice and urgent care.

2.9. The Sub-Committee were informed that the Tower Hamlets Clinical Commissioning Group (CCG) and the Local Pharmaceutical Committee (LPC) are working together to deliver an enhanced offer, with an initial focus on:

- Improving the availability of 24 hour pharmacy access locally and consideration of how this could assist with night time hospital discharge;

[1] http://www.lgiu.org.uk/2016/06/06/viewpoint-a-bitter-pill-to-swallow/

- Developing more comprehensive use of pharmacy ‘dashboards’ in order to help drive up quality and provide a sound evidence base for future decision making;

- Increasing the number of pharmacies with access to GP notes and shared records to help pharmacies provide a better, more bespoke service for residents.

2.10. The LPC also informed the Sub-Committee that they had the aim of establishing pharmacy federations on a hub model in order to offer more holistic support that is better integrated with local GP surgeries, care homes, those with long-term conditions in the community and mental health teams.

Recommendations

The Sub-Committee recommended that following issues be considered by the CCG and LPC:

1) That the lack of 24 hr pharmacy access locally is addressed, especially in terms of how this can support night-time hospital discharges;

2) That better and more comprehensive pharmacy performance dashboards are developed to help drive up quality and provide sound evidence base for future decision making around provision;

3) That the number of pharmacies with access to GP notes/shared medical records are increased.

3. Primary Care, Planning and Health Infrastructure

Attendees

Name	Organisation
Chris Banks CEO	GP Care Group
Tracey Connell	GP Care Group
Jenny Cooke	Deputy Director for Primary and Urgent Care, NHS Clinical Commissioning Group
Josh Potter	Deputy Director Of Commissioning And Transformation, NHS Tower Hamlets Clinical Commissioning Group
Tim Madelin	Senior Public Health Strategist, Adults'

3.1. The Sub-Committee considered the issues facing the commissioning, planning and delivery of primary care services in the borough. The Sub-Committee wanted to develop a clearer understanding of:

- The barriers facing local residents in accessing quality, safe and compassionate primary care services;
- The role of spatial planning in maximizing improved access to primary health services, especially in the context of a growing population and restricted public spending;
- The relationship between infrastructure and service investment and the delivery of improved patient care in the primary setting.

3.2. The NHS England 'General Practice Forward View' was published in April 2016 and aims to stabilise and transform General Practice by redesigning the way care is delivered, as well as setting out plans to tackle the issues of declining GP numbers, high workloads and out-dated infrastructure.

3.3. The Sub-Committee was informed that in Tower Hamlets General Practice is currently facing unprecedented levels of demand due to the rapidly growing population and high levels of need resulting from deprivation. In addition, the transient nature of the local population means that Tower Hamlets has high numbers of un-registered patients who access healthcare through expensive urgent care and A&E, meaning they

often don't receive preventative and proactive care. Moreover, changes in GP contracts and patterns of GP employment are significantly impacting on funding, meaning there remains a major recruitment and retention challenge for primary care staff.

3.4. These pressures are impacting on the accessibility of primary care in the borough. In the latest Tower Hamlets GP patient survey, 78% of respondents said they were able to see or speak with a health professional the last time they needed to, and 88% said this was at a time convenient to them, however feedback still suggests that whilst patients are satisfied with the standard of clinical care too many are frustrated with the process of getting an appointment. Healthwatch Tower Hamlets informed the Sub-Committee that of the 224 comments collected since 1 April 2016, 87 related to GP services, and of those comments 10 were positive and 51 were negative. Negative feedback focused clearly on two key areas; surgery telephone systems that prevented people from accessing appointments (41 comments), and the unavailability or long waits for appointments, particularly non-urgent appointments (46 comments).

3.5. The Sub-Committee was informed that in response to these challenges the CCG and GP Care Group have undertaking the following to date:

- Constituted the GP Care Group as a Community Interest Company (CIC) in order to consolidate the local primary care offer;

- Obtained additional resources from the GP Access Fund to set up four primary care hubs in the borough where residents can access 350 appointments per week out of core hours;

- Developed a 'Physician Associate' scheme to help with staff shortages and offer greater support to GP practices.

3.6. Going forward the CCG is prioritising the development of improved digital access so that patients can book appointments online, access their own medical notes, receive on-line consultations and obtain remote support for long-term conditions. The CCG is also developing a centralised registration process and streamlining urgent care and extended access.

3.7. In terms of physical infrastructure, the Sub-Committee was informed that the Public Health Team worked closely with planning professionals to develop the 'Local Plan' which sets out the 15-year planning policy framework (including the design, scale and location) for all developments in the borough. Through this process the 'Local Plan' has identified and safeguarded potential sites for infrastructure development and considered how key infrastructure, including health facilities, could be funded. It was reported that the planning department, public health and NHS partners felt confident that this process had been comprehensive and sufficiently robust.

3.8. A component of the required funding will be drawn from the new Community Infrastructure Levy (CIL), which replaced Section 106 funding as the main form of developer contribution to local infrastructure costs in April 2015, however CIL funds are only likely to meet up to 20% of the full cost of the identified infrastructure requirements. In addition, whereas s106 agreements could earmark funding for specific projects, CIL is a collective tax and the allocation of CIL monies is made by the Mayor and Cabinet. The Sub-Committee were informed that, to date, allocations had been adequate to meet the physical infrastructure needs of primary care.

Recommendations

The Sub-Committee recommended that following issues be considered by the CCG, GP Care Group and LBTH Public Health/Planning:

1) That consideration be given to the quality/access to non-GP primary care services in the borough, e.g. dental care;

2) That a strong local offer to attract and retain GPs in Tower Hamlets is developed collaboratively.

3) That the planning of healthcare infrastructure take account of the geographic dimension of population growth e.g. physical space constraints in certain localities, such as on the Island;

4) That the Community Infrastructure Levy (CIL) continues to be spent on addressing the borough's health priorities (e.g. is there scope for using it to improve housing conditions?)

4. Early Years

Attendees

Name	Organisation
Christine McInnes	Divisional Director, Education and Partnership, Children's
Esther Trenchard-Mabere	Associate Director of Public Health,

4.1. The Sub-Committee considered the main challenges facing 0 to 5 year olds in the borough in accessing the appropriate health and social care services. The Sub-Committee wanted to develop a clearer understanding of:

- The main challenges facing service provision for 0 to 5 year olds and their parents/carers;
- The response of local services to addressing these.

4.2. Tower Hamlets is a "young" borough, with a quarter of the whole population aged 0 to 19 years old and an estimated 21,843 0 to 5 year olds (7.7% of the population). The borough has the highest rate of child poverty in the UK, with 49% living below the poverty line. In 2015, 61.6% of children in Tower Hamlets achieved a good level of development at the end of reception compared to 68.1% in London (the worst in London) and 66.3% in England. Moreover, Tower Hamlets has low birth weights, above average infant mortality rates, excess weight and obesity, dental decay, and lower levels of vaccination and immunisation coverage than the national average.

4.3. The formative years from 0 to 5 are critical to the future health and wellbeing of infants in Tower Hamlets, and will depend on the extent to which the social, economic and family environment in Tower Hamlets supports the emotional, social and cognitive development through their first years of life. Early intervention by services in a child's life can help ensure that incipient issues are addressed quickly, thereby preventing further escalation or crises, and ensuring resources are put to the best possible use.

4.4. Officers from Children's Services and Public Health set out what is being done to improve access to health and social care for 0-5 year olds in the borough, including:

- Ensuring that early intervention services are outcomes focussed;

- Developing the Tower Hamlets Together (THT) model to integrate early-years services with universal health services, including re-designing the Children Centres offer to ensure they better meet the needs of children and families. In some parts of the borough universal health services, community maternity services and health visiting services, are already delivered from Children's Centres. Developing a model that makes this the norm across the whole borough will bring more families into children's centres.

- Improving the registration at Children's Centres by working with health visitors to simplify the process and by enabling Children's Centres to access to live birth data so that they can target hard to reach families/access data on the number of eligible children in their catchment area;

4.5. Going forward work will focus on developing the relationships between the Children's Centres, Child and Family Hubs and wider services including primary care, specialist children's health services, child and adolescent mental health services (CAMHS), children's social care and services for school age children. This should help reduce the over reliance on A&E by families of 0 to 5 year olds, who do not know who to turn to in the event of illness, by offering more active and holistic services.

Recommendations

The Sub-Committee recommended that the following issue be considered by LBTH Children's Services and Public Health going forward:

1) That links between hospitals and children's centres be strengthened to ensure birth data is shared and children automatically registered at Children's Centres and A&E usage for minor ailments is reduced;

2) That more be done to understand whether vulnerable families are missing out on Children's Centres provision through data collection/analytics;

3) That Children's Centres work to strike a sensitive balance between free and charged services they offer so as not to create a 'two-tiered' system;

4) That Children's Centres work to provide an adult offer to support new mothers, especially those from BME communities, who risk being isolated to language barriers etc.

5. Access to care for people with mental health problems

Attendees

Name	Organisation
Edwin Ndlovu	Borough Director for Tower Hamlets East London Foundation Trust
Craig Chalmers	Interim Operational Service Manager Mental Health
Michelle Kabia	MIND in Tower Hamlets and Newham
Carrie Kilpatrick	Deputy Director for Mental Health and Joint Commissioning

5.1. The Sub-Committee considered the main barriers people with mental health problems have in accessing the services they need in Tower Hamlets. The Sub-Committee wanted to understand:

- The progress in establishing parity of esteem between mental and physical health as set out in the Health and Social Care Act 2012;
- Whether crisis services are responsive and high quality, and if people admitted to general hospital have access to good mental health care;
- Whether mental health community based services are localised, integrated and promoting choice, independence and wellbeing, and if talking therapies are accessible to children and people from BME communities.

5.2. Tower Hamlets has amongst the highest level of mental health need in the country, and there has been significant growth in need over the last 5 years. This level of need is set to continue with population growth and demographic change over the next 5 years. Tower Hamlets has a high prevalence of risk factors that can contribute to the development of mental health issues such as child poverty, long term unemployment, pensioner poverty, overcrowded households, population density, homelessness, crime (including hate crime against specific communities), carers working over 50 hours per week, and harmful alcohol use. As a result, there is significant demand for mental health services in the borough for people of all ages, across both primary and secondary services.

5.3. The CCG and East London Foundation Trust (ELFT) outlined the main barriers people face in accessing services and the plans in place to improve mental health provision from both a commissioning and delivery perspective. The Sub-Committee was informed that the most significant barrier was a lack of awareness about mental health within the population, where there is a significant stigma attached to mental health, especially amongst BAME communities.

5.4. In addition, access is restricted by ongoing workforce and resource issues, as finding and retaining mental health practitioners is very challenging in the current environment and there is not always adequate capacity in the right place to meet demand or support new models of care. Furthermore, provision has become fragmented in recent years which means there has been more duplication, often causing confusion about what services are the right ones to use. It was recognised early intervention was required for the student population, in particular the 18 – 35 age group, as mental health problems within this age group were increasing and there is a particular issue around effective transition pathways at 18 from Children to Adult services.

5.5. Additional challenges that were highlighted include variability in the quality and outcomes between different services, with some areas of excellence but others that require improvement, and the continuing challenge of bringing services together - too many patients are still being treated in silos, which presents risks to delivering the ambition to deliver parity of esteem between mental and physical health.

5.6. To address these barriers and improve provision for people with mental health problems, the Tower Hamlets Mental Health Partnership is working within the North East London Substantiality and Transformation Plan to develop a population based approach and tackle the wider determinants of mental health. This work includes:

- Launching the ‘Time to Change’ programme to raise awareness and combat stigma, and the development of a new local suicide strategy;

- Developing a new model of primary mental health care to achieve better integration of physical and mental health, deliver services in a ‘normalised’ environment, and provide continuity of care with GP services (this will help with early interventions as GPs are well placed to identify problems early);

- The development of the Children and Young People’s Transformation Plan 2016-2021 which sets out how early intervention services will be strengthened;

5.7. The partnership intends to build on these over the course of 2017 by redesigning dementia care pathways, establishing clear pathways for adults in crisis to ensure acute bed availability, developing a high quality

supported accommodation offer within the borough, further improving urgent and community care pathways, and prompting whole person care commissioning.

Recommendations

The Sub-Committee recommended that following issues be considered by the CCG, ELFT and other local mental health care providers:

1) That work continue to achieve the 5 Year Forward View objective of reducing suicides by 10% - this is significant in a borough where there is an increasing student population;

2) That councillors be given more information about where they can signpost residents with mental health needs that they come into contact with via casework;

3) That the choice of mental health interventions offered in primary care is reviewed to ensure that people have a range of talking therapy options;

4) That the interface between local mental health services and the Criminal Justice System (including YOT) be considered to ensure pathways for support/interventions are clear.

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