HEALTH AND WELLBEING BOARD

Minutes of the meeting held at 1.30 pm on 1 December 2016

Present:

Councillor David Jefferys (Chairman)
Councillor Diane Smith (Vice-Chairman)
Councillors Ruth Bennett, Stephen Carr, Ian Dunn, Robert Evans, Colin Smith and Pauline Tunnicliffe

Stephen John, Director: Adult Social Care
Dr Nada Lemic, Director of Public Health

Dr Andrew Parson, Clinical Chairman CCG
Annie Callanan, Independent Chair - Bromley Safeguarding Children Board
Linda Gabriel, Healthwatch Bromley
Colin Maclean, Community Links Bromley
Mark Cheung, Chief Financial Officer, CCG

Also Present:

Ade Adetosoye, OBE (Education, Care & Health Services), Lorna Blackwood (Education, Care & Health Services), Jackie Goad (Environment & Community Services) and Dr Agnes Marossy (Bromley Health Authority)

90 APOLOGIES FOR ABSENCE

Apologies were received from Dr Bhan, and Mark Cheung acted as substitute.

Apologies were also received from Harvey Guntrip.

The new Deputy Chief Executive and Executive Director of Education, Care and Health, Ade Adetosoye OBE, attended the meeting, and was welcomed by Board members.

91 DECLARATIONS OF INTEREST

Colin Maclean declared an interest in agenda item 7 which was the BCF update.

92 MINUTES OF THE MEETING HELD ON 6TH OCTOBER 2016

The minutes of the previous meeting were agreed as a correct record.

93 QUESTIONS FROM COUNCILLORS OR MEMBERS OF THE PUBLIC

Questions were received from Sue Sulis, representing the Community Care Protection Group.

The questions were for written response, and will be appended to the minutes with the answers as Appendix A.

94 INTEGRATED CARE NETWORK AND FRAILTY UNIT UPDATE

The Integrated Care Network update was provided jointly by Mark Cheung and Dr Andrew Parson.

Dr Parson commenced by providing a brief summary of the key points of work undertaken to date, and by explaining that the aim of the Integrated Care Network (ICN) was to reduce hospital admissions. A summary was provided of the significant engagement that had already taken place with a variety of stakeholders. This was broken down into 4 main areas:

- Involvement of GP Members
- Involvement of GPs as Providers
- Involvement with other Partners
- Work in progress

The other partners involved included the GP Alliance, patients, Kings College Hospital, PRUH, Bromley Healthcare, Oxleas, St Christopher's, and Bromley Third Sector Enterprise. The initial stages in the ICN process would commence with all health care professionals case finding and identifying individuals deemed as high risk, and providing their details to the MDT Liaison Coordinator (MDT is Multi-Disciplinary Team).

It was noted that the next step in the process would be for the MDT Liaison Coordinator to support GPs with updating EMIS—the GP information system. Verification would be provided by consulting the patient to see if they were happy to be put on the Proactive Care Pathway.

Dr Parson informed the HWB that a number of GPs were already engaged in the process, and were involved in the mechanism of case finding deteriorating or difficult to manage patients. These details had been forwarded to the relevant MDT. The plan was to bring together a team around the patient to enhance patient care and experience. In most cases, initial holistic assessments would be undertaken by Community Matrons—this could be face to face or in a virtual environment. Information would be available to everyone involved to facilitate joint working.

The next stage in the Proactive Care Pathway would be the formulation of an Integrated Care and Support Plan—this would be developed by the Community Matron in conjunction with the patient, and supported as required by the Care Navigator. After this, there would be an initial MDT meeting, where the Care Plan would be ratified, and the Clinical Lead would be assigned.

The Board heard that in terms of governance, a nominated GP Chair would Chair the MDT meetings to ensure that the patient's needs were considered and actioned. A re-assessment would be undertaken when required, as would reviews of the Care and Support Plan. If the Integrated Care and Support Plan was updated, this would be shared with the patient and the most relevant person. Throughout the process, the patient's main point of contact for Primary Care would be the Clinical Lead, and the main point of contact for all other issues would be the MDT Liaison Coordinator. Dr Parson highlighted the key role that Geriatricians would play in implementing the Care Plan for the elderly. It was anticipated that input would also be provided from the voluntary sector, and that social prescribing would also be used where appropriate.

The Board heard that the recruitment process for recruiting into key MDT roles was nearly complete. The new key roles were outlined as follows:

- GP Chair
- MDT Liaison Coordinator
- Care Navigators
- Interface Geriatrician
- Mental Health Professional
- Social Prescribing Administrator

The Board heard that it was planned to roll out the new MDT system in three locations simultaneously. The Chairman asked if there was going to be a communications plan. Dr Parson responded that initially there would be no noticeable difference to patients, and so a direct marketing initiative was not required.

Cllr Evans asked for clarification of the role of Social Care in the process. He asked if Social Care would be consulted and officers involved. Dr Parson responded that the support of Social Care was required, and that plans were being developed with Lorna Blackwood (LBB Head of Adult and Community Services). The LBB Director for Adult Social Care assured that the appropriate Social Care systems would be in place.

The Board were referred to page 11 of the ICN report, and were given a brief overview of the Frailty Pathways for Step Up and Step Down services. The idea was to try and limit the admission of the elderly to A&E and to acute medical units. The gatekeeper for beds in the Integrated Unit would be a geriatrician who would be working to agreed criteria, and monitored by governance groups. Further objectives were to link more urgent out patients to the MDT, and to avoid the stress of unsuccessful discharges.

Cllr Carr expressed concern around the efficiency of other boroughs in discharging patients that had been treated in Bromley. Dr Parson replied that, it would be important to ensure that other boroughs were working efficiently. Work was being undertaken with Kings and Community GPs to ensure that the relevant protocols had been put in place. Cllr Carr was concerned that social care funding could be used to fund the acute sector, and was worried that the proposed model could

result in Bromley having to pay for the inefficiency of other boroughs. It was noted in this regard that other boroughs would be liable for excess charges. Cllr Carr was uneasy that the current model did not seem to provide any real incentives for other CCGs to be efficient, and Cllr Colin Smith expressed similar concerns.

Cllr Dunn referred to the section on the report regarding a level of frailty of 6-7 on the Rockwood Frailty Scale, and asked what this was. Dr Parson explained that this was a frailty score that was not based on age, but was based on function. Cllr Ruth Bennett asked if spare capacity in step up facilities could be sold to other CCGs. Mr Cheung responded that this had not been looked into, but in theory the answer was yes, subject to capacity allowing. A charging mechanism would need to be evaluated.

Cllr Colin Smith expressed concern around the potential waiting time for those awaiting transfers late at night, or in the early hours of the morning. Dr Parson gave assurances that this would not happen, and that any transfer required would be a deferred decision by a Geriatrician.

The Chairman concluded by welcoming the work undertaken to date to establish the ICN. He stated that much good and innovative work had been done and was encouraged to hear of the involvement of the third sector. He asked that an update report be brought to the Board in March 2017, with an emphasis on cross border flows.

RESOLVED that an ICN update report be brought back to the HWB in March 2017.

95 PRIMARY CARE CO-COMMISSIONING UPDATE

This was an update report drafted by Jessica Arnold, Head of Primary and Community Care at Bromley CCG.

The report had been presented to the HWB to explain the preparations being undertaken to move to delegated primary care commissioning in Bromley during 2017, together with the implications of such a move. The HWB were asked to note the report.

Dr Parson outlined the three levels of primary care commissioning:

- NHS Commissioning
- Joint Commissioning between the NHS and the CCG
- Fully delegated CCG commissioning

All six of the CCGs in South London had decided to apply for level 3 delegation, and the applications had to be submitted by December 5th 2016. Following submission of the applications, each CCG would be assessed for their readiness to assume fully delegated responsibility. This would include assessments of how the CCGs were preparing for changes to governance, conflicts of interest, and risk management. A specific new appointment had been made to deal with any potential conflict of interests. Dr Parson stated that primary care co-commissioning

needed to be transparent and provide good local commissioning.

Cllr Carr felt that providers may be beyond proper control and enquired how they could be influenced. Dr Parson responded that providers would need to consistently provide value for money, and that it would need to be ensured that GPs delivered the services needed as required. The workforce would need to be committed and well supported. It was noted that currently there was a shortage of GPs, and so the use of GP Federations may be required. The GP contract may need modifying to focus on local priorities.

Cllr Robert Evans asked if under the new arrangements, the CCG would have more influence to enforce GPs to fulfil expected requirements. Dr Parson responded that what was required was better, intelligent commissioning. Some GPs would have to join collectives in order to expand working hours.

The Chairman noted the importance of fully delegated commissioning, and stated that he hoped for more intelligent commissioning going forward.

96 BETTER CARE FUND 2016/17 PERFORMANCE UPDATE

The report on the Better Care Fund 2016/17 Performance Update was provided by Jackie Goad. The report provided an overview of the first and second quarter performance of the Better Care Fund 2016/17, regarding expenditure and activity levels up to the end of September 2016.

The report was provided to the HWB to keep members informed regarding the position of the pooled fund and progress of the locally agreed Better Care Fund schemes.

The Board was asked to note the latest financial position and the performance and progress of the BCF schemes. Ms Goad reminded the Board that the BCF 2016/17 local plan had been formally agreed and endorsed by the HWB at its meeting on the 21st April 2016. The plan was submitted to NHS England for approval in May 2016. The Board were informed of the performance metrics as outlined on page 3 of the report, and were also directed to the BCF Financial Implications table that detailed a total BCF budget of £21.6m.

Cllr Colin Smith referred to section 4.5.5. of the report (Delayed Transfers of Care-DTOC) and enquired how the 2016/17 planned figures had been formulated. This was because the Director for Adult Social Care had stated that the figures he was aware of, differed from the NHS figures noted in the report. Cllr Colin Smith asked why there were two different sets of figures. It was noted that the figures in the report were the product of a national data churn, and were not local figures. Mark Cheung and the Director for Adult Social Care offered to look into the reporting anomaly, and to report back to the Board.

Cllr Colin Smith and Cllr Carr felt that it was imperative that the issue of the TOCB data be followed up and clarified, and requested an answer by December 15th 2016.

RESOLVED that Mark Cheung and the LBB Director for Adult Social Care report back to the HWB on the anomaly around the TOCB data.

97 JSNA UPDATE REPORT

The report title was 'Approval of the 2016 JSNA'. It was presented to the HWB by Dr Agnes Marossy, Consultant in Public Health. The report asked HWB members to approve the 2016 JSNA (Joint Strategic Needs Assessment) and to consider the proposed structure for the 2017 JSNA.

The Board heard that the structure of the 2017 JSNA would consist of the following sections:

- Demography
- Life Expectancy and the Burden of Disease
- In depth analysis of Learning Disability
- In depth analysis of 'Carers'
- Integrated Care Network Profiles
- Older people
- Mental Health
- Substance Misuse

The Board were informed that there would be a separate JSNA prepared for Children and Young people. This was to better inform the Children's Services Commissioner. The Board agreed that the Children's JSNA should also be presented to the HWB in addition to the Children's Safeguarding Board.

The 2016 JSNA looked at the issue of homelessness, and the associated negative health impacts. In most cases, homelessness also meant losing access to health services, with a detrimental impact on both mental and physical health. There was often a low level of access to preventative services. Another problematic area that needed addressing was the issue of discharging homeless people from hospital. There was no standard protocol for this, and it was important to try and remove homeless people from the negative cycle associated with homelessness and ill health.

Other in-depth areas in the 2016 JSNA were domestic violence, sexual health and alcohol.

Cllr Colin Smith expressed concern regarding the population projections, which seemed to predict a reduction in the number of young people in Bromley. Dr Marossy explained that population prediction was not an exact science, and the figures in the JSNA were based on GLA data, which was the best data available for London and was based on population figures from the Census, with adjustments for migration and developments. Dr Lemic confirmed that the GLA data was the best available.

RESOLVED that

1) The report be noted, and the proposed Children's JSNA be presented to the HWB in due course.

2) The 2016 JSNA be approved.

3) The proposed structure of the 2017 JSNA was endorsed with the addition of sections on Homelessness and on Domestic Violence.

98 QUESTIONS ON THE DRAFT JSNA 2016 INFORMATION BRIEFING

The following questions were submitted by Cllr Ian Dunn:

1- Do we know why Clock House is the lowest Ward in the borough for NHS checks?

2- Do we know why scarlet fever has increased sharply in recent years?

3- What are the consequences for the health and social care systems of the work which has been done on housing and homelessness?

The answers are as follows:

Question 1

There are 7 GP practices bordering Clock House Ward who over the 5 years the data refers to, have each had either intermittent or ongoing issues which have reduced their ability to provide NHS Health Checks.

None of the practices providing services for Clock House Ward have been able to achieve the target numbers set each year. Therefore the lower numbers have accumulated over each year.

These issues include:

Staffing
Other services given priority
Reliance on alternative providers--as no capacity in house.

Question 2

Public Health England issued information on this in March 2016.

In 2014, unusually high numbers of scarlet fever cases were noted, the highest since 1969, which persisted into the following year's season and then into the current season. The reasons behind this increase are unclear but may reflect the long-term natural cycles in disease incidence seen in many types of infection. Assessment of bacteria obtained from patients has excluded the possibility of a

newly emerging strain of group A streptococcus with increased ability to spread between patients causing the increase in disease incidence.

Question 3

Homeless people are high users of health services including A&E. In addition, poor housing is known to be detrimental to health.

In the Homeless Health Needs Audit of single homeless, we found that:

- 74% had physical health problems
- 77% had mental health problems
- 71% had seen a GP in the last 6 months
- 30% had seen a GP more than 3 times in the last year
- 43% had visited A&E
- 28% had been admitted to hospital

We found that there were low levels of access to preventative services.

There are (according to official statistics, so an underestimate) approximately 147 single homeless in Bromley.

Much bigger is the number of homeless families (in 2015/16, 438 homeless applications were accepted owing to dependent children), often these are placed in temporary accommodation outside the borough. Moving out of the borough means being cut off from support services and networks and often having to change doctor, making it more difficult to manage any health problems.

Implications/Consequences:

- There is considerable health need in the homeless population
- Low levels of access to preventative services will exacerbate the health problems.
- There is an issue about discharging people from hospital when they are homeless, there is no systematic approach in place.
- We will be investigating the health needs of families early next year.

99 BROMLEY WINTER PLAN

The Bromley Winter Plan had been added to the agenda for noting. It was anticipated that a report on performance would be provided at the next meeting.

The report contained subsets of the Bromley Winter Plan 2016/17 and incorporated information from the PRUH Urgent Care Improvement Plan. The report was separated into three sections for clarity and ease of reading. The three areas were:

- Section A: Performance
- Section B: Delivery against 5 national initiatives
- Section C: Winter Surges.

The report had highlighted that the main cause of breaches in A&E performance at the PRUH was bed management and waiting times to see a first clinician.

Mr Cheung mentioned that plans were being developed to limit A&E admissions when they were not really required. Patient Champions may be used to check that individuals really needed to be seen in A&E. Plans were also be drafted to commission more appointments in primary care hubs.

Section 4.3 noted four escalation stages. These ranged from OPEL 1 to OPEL 4, where 4 represented the highest risk, and the possibility of operational failure. 'OPEL' was an abbreviation for Operational Pressures Escalation Level. Cllr Dunn requested more information regarding how many times the PRUH had been in the various escalation levels, and Mr Cheung promised to investigate this.

RESOLVED that the Winter/Escalation Plan be noted, and that a report on performance against the Plan be provided at the next HWB meeting.

100 PHLEBOTOMY UPDATE

The Board heard that investigations were under way to try and find ways to improve access to phlebotomy services, and to improve pathology. The immediate question was what could be achieved quickly. Currently GPs were helping, but this was regarded as a short term solution. GP Federations could also be used to increase capacity. It was not clear what increased level of capacity GP Federations could supply.

The Chairman stated that this was a matter that had been going on for some time, and needed resolving.

101 ELECTIVE ORTHOPAEDIC CENTRES

It was noted that a decision had been taken to progress with plans to develop the Elective Orthopaedic Centres on the two approved sites.

102 HEALTHWATCH INEQUALITIES REPORT

The Healthwatch report was entitled 'Banking on a Meal' and was presented by Folake Segun and Stephanie Wood.

Healthwatch highlighted the 'Living Well Project' based at Holy Trinity Church in Penge. Individuals attending the project were able to access a foodbank and various community services. It was noted that at one session there were over 100 people in attendance. The project offered a hot meal, shower, food parcel, as well as art and music sessions. Bromley Drug and Alcohol Team were also present for those that needed advice. The Board were concerned to learn that many present suffered from mental health challenges, and lacked any form of clinical or familial support.

Healthwatch cited an example of an individual who had identified as homeless, and had previously been given a prescription for a course of treatment from a local

drop in clinic. He had been unable to access the treatment as he was not registered with a GP. He had been turned down for registration by a local GP service because he did not have a permanent address. This happened despite the fact that it was no longer a legal requirement to have a permanent address to register with a GP. Healthwatch had to escalate the matter with the CCG and with NHS England before the matter was resolved; it was agreed that the church address could function as a temporary address for the client.

There were 5 main points that had been highlighted by Healthwatch's research:

1- Those suffering from financial hardship were more likely to suffer from lower standards of physical and mental wellbeing.

2- Zero hour contracts and insecure employment often left people with insufficient resources to support themselves and their families. This caused a dependency on local support such as food banks.

3- Lack of communication between services meant that people were susceptible to falling through the gaps. This was most evident with benefit processing and a delay in payments.

4- GP registration and access to primary care was severely restricted by a lack of permanent address, despite legislation stating that it was not a statutory requirement.

5- Those who were already at risk were unable to support themselves in day to day life, and as a result remained liable to further health complications. This picked upon the discussion of the proposed sections for the 2017 JSNA.

Colin Maclean referred to the proposed development of a Homeless Strategy, and requested an update concerning this. It was agreed that an update on the development of the strategy should come back to the Board.

Cllr Evans asked for clarification concerning the definition of 'homeless' in relation to the Healthwatch report. He stated that LBB had provided accommodation for homeless people in line with statutory obligations, and that as far as he was aware, there were currently less than 12 homeless people on the street. The basic problem was that more houses were required. He referred to section 9.3 of the report that recommended '*additional council support and advocacy for those who are struggling to live independently to prevent people from entering the cycle of deprivation'.* He stated that Council support and advice was already provided, and wondered what more the Council could do. Folake Segun from Healthwatch agreed that Council support was provided, but felt that it would be helpful if the public could be made more aware of how they could access services.

The Chairman noted that many of the recommendations had been presented to the CCG for consideration.

RESOLVED that the report be noted, and that an update on the development of the Homelessness Strategy be brought back to a future Board meeting.

103 BROMLEY SAFEGUARDING ADULTS BOARD ANNUAL REPORT--2015-2016

It was intended that the report be provided for information and noting, with a more detailed discussion to take place at the next meeting in February 2017.

Annie Callanan (former Independent Chair) clarified that she had now finished her work as the Independent Chair of the Bromley Safeguarding Adult's Board, and that recruitment was under way for a new Independent Chairman. She highlighted the significant pressures that were now being manifest in all parts of the sector. She emphasised the ongoing commitment of the Board in ensuring the success of cross sector services working together.

Cllr Evans highlighted page 17 of the report, which was referred to as 'Case Study 3—Mr Jones'. The case study highlighted the successful partnership working within LBB between the Housing Department, Adult Safeguarding, Legal and Trading Standards. Cllr Evans in particular praised the work of Mr Rob Vale and the Trading Standards Team.

RESOLVED that the report be noted and that a more detailed discussion of the report take place in February 2017.

104 LETTER FROM HOME OFFICE AND DEPARTMENT OF HEALTH--COLLABORATION BETWEEN POLICING AND HEALTH PARTNERS

The Board noted the letter from the Home Office and the Department for Health. The letter asked HWBs and Police and Crime Commissioners (PCCs) to consider how they could better work together by ensuring appropriate representation from both sectors on HWBs.

The Board agreed that a response to the letter should be drafted by 15th December.

RESOLVED that a response to the letter should be drafted by 15th December.

105 WORK PROGRAMME AND MATTERS ARISING

CSD 16160

The Board noted its Work Programme and progress on Matters Arising, and the need for an agenda planning meeting before the Christmas break.

106 ANY OTHER BUSINESS

Lorna Blackwood informed the Board that she had recently attended an Adults Stakeholders Conference about 'Isolation'. The event was well attended, and an action plan was being developed to deal with issues around social isolation. She asked if the HWB would be prepared to sponsor the action plan.

Cllr Tunnicliffe stated that the conference was good, and felt that it would be good if the HWB supported the action plan. She felt that many local pubs would be glad to help, particularly between the hours of 2.00pm and 6.00pm when they were not busy. It would be low cost but worthwhile initiative.

Cllr Colin Smith suggested that a funding stream may be required. The Chairman thought that it would be good to raise awareness of the issue, and the Director of Adult Social Care was also supportive. It was mentioned that a cab firm called 'Daisy Cabs' would be prepared to offer reduced rates for community groups.

Annie Callanan stated that it was good that people wanted to help, and that it had been proven that reducing isolation had beneficial effects on mental health. This being the case, it should be possible to build a valid business case to help and support any relevant initiatives.

Dr Parson felt that the HWB should be leading on any initiatives relating to combating mental health issues, and that any schemes designed to combat isolation should be supported.

Cllr Carr highlighted that LBB had a large potential resource in the form of 16-18 year olds, and that it may be beneficial to work with schools and community services to see what help they could provide. The Vice Chairman suggested that use could be made of the 'My Life' portal to provide information and direction. The Director for Adult Social Care proposed that a handout be provided that would list current resources and organisations that exist to provide support to those suffering from isolationism.

RESOLVED that the issue of Isolationism be reviewed at a future meeting, and that consideration be given to inviting the leaders of the stakeholder conference to address the HWB.

107 DATE OF THE NEXT MEETING

The date of the next meeting was confirmed as February 2nd 2017.

APPENDIX A-QUESTIONS FROM THE COMMUNITY CARE PROTECTION GROUP

The Meeting ended at 3.30 pm

Chairman

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Questions to the Health and Wellbeing Board—December 1st 2016

HWB Copy

(All questions are from the Community Care Protection Group)

Question 1:

1. DRAFT BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2016: EXECUTIVE SUMMARY – CHILDREN & YOUNG PEOPLE (Agenda item 9, p.14).

The report identifies that:

"Children eligible for free school meals perform less well at every key stage than the rest of the population, and this gap increases as they move through the education system"…….

Q. *Since a significant deprivation factor is poor diet and malnutrition, what additional supportive action is proposed?*

Answer to Question 1:

Maternity and Health Visiting services provide advice to support families to feed babies and young children appropriate food. Families who are identified as vulnerable are followed up by Health Visiting services and may be referred to appropriate groups in Children and Family Centres. A specific group run jointly by Children's Social Care and Health Visitors provides a place where mothers can be supported in a community kitchen setting to provide cheap nutritious food for their children.

School age children and their families may be supported by the Children and Family Centres and also by some schools as part of the Healthy Schools initiative. Nearly 90% of Bromley Schools are registered as a "Healthy School".

If necessary, families may be referred by their Health Visitor, School Nurse or GP to dietetic services for expert assessment and advice.

Question 2:

2016 OFSTED REPORT ON BROMLEY'S CHILDREN'S SERVICES:- 21ST JULY 2016 REPORT TO BROMLEY CLINICAL COMMISSIONING GROUP BOARD.

At the Meeting, it was minuted that:-

"Both Cllr Evans and Jefferys expressed concern that they had not been sighted on the situation as it had developed, and had thus been unable to provide oversight".

Q. *Please explain clearly whose responsibility it was to ensure these Members had oversight of the situation?*

Answer to Question 2

There were regular reports provided to Members by the Quality Assurance and Improvement Team which unfortunately indicated a better level of performance than Ofsted found. All parts of the organisation are working with key partners to deliver the necessary improvements to service.

Question 3:

"They were members of the HWB, and felt that, due to the size of their portfolio, they had been unable to give due consideration to Children's Services."

Q. *Children's Services is a complex and challenging responsibility. Does Cllr. Evans consider that Statutory Guidance recommending not enlarging this portfolio should be followed?*

Answer to Question 3

This is a matter for the Leader. However the statutory guidance does not preclude the portfolio including other functions.