# HEALTH AND WELLBEING BOARD
# COUNCIL CHAMBER - TOWN HALL, MAIDENHEAD AT 3.00 PM

## 25 April 2017

PRESENT**:** Councillors David Coppinger (Chairman), Dr Adrian Hayter (Vice-Chairman) and Natasha Airey

Also Present: Mark Sanders, Dr William Tong, Judith Wright Jeanette Bailey, Teresa Salami-Oru Karen Stevens

Officers: Wendy Binmore, Angela Morris, Hilary Hall and Nick Davies

## PART I

### 89/15 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Stuart Carroll, Alison Alexander and Dr Lise Llewellyn.

### 90/15 DECLARATIONS OF INTEREST

None received.

### 91/15 MINUTES

**RESOLVED UNANIMOUSLY: That the minutes of the meeting held on 15 February 2017 were signed as a true and accurate record.**

Mark Sanders, Healthwatch wanted to reassure the Board and the public that Healthwatch had been commissioned as a service and therefore, nothing would change. All email addresses and phone numbers had not changed; it was just a more efficient way of doing things.

### 92/15 STP UPDATE ON THE SOCIAL CARE WORK STREAM

Hilary Turner, Dr Adrian Hater and Angela Morris gave the Board a presentation on the latest update on the Sustainability and Transformation Plan. The main points of the presentation included the following key points:

Priorities for the next five years:

- Priority one: making a substantial step change to improve wellbeing. Increase prevention, self-care and early detection.
- Priority two: Action to improved long term condition outcomes including greater self management and proactive management across all providers for people with single long term conditions.
- Priority three: frailty management – proactive management of frail patients with multiple complex physical and mental health long term conditions, reducing crises and prolonged hospital stays.
- Priority four: redesigning urgent and emergency care, including integrated working and

primary care models providing timely care in the most appropriate place.

- Priority five: reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence.
- Many residents had the skills, confidence and support to take responsibility for their own health and wellbeing.
- The Frimley Health & Care STP could do more to assist them and were committed to developing integrated decision making hubs with phased implementation across the area by 2018.
- Integrated hubs provided a foundation for a new model of general practice provided at scale.
- An underpinning programme of transformational enablers included:
    - Becoming a system with a collective focus on the whole population.
    - Developing communities and social networks so that people had the skills and confidence to take responsibility for their own health and care in their communities.
    - Developing the workforce across the system so that is is able to deliver new models of care.
    - Using technology to enable patients and the workforce to improve wellbeing, care, outcomes and efficiency.
    - Developing the estate.

Next steps for the NHS Five Year Forward View:

- The Five Year Forward View (5YFV) set out why the NHS needed to change; the 5YFV next steps set out what changes the public would see in the next two years.
- The STP now stood for 'Sustainability and transformation Partnerships', better reflecting the purpose.
- The plan addressed the top five issues citizens wanted to see improved:
    - Mental Health services
    - Convenient access to GPs
    - Easier hospital discharge
    - Better social care
    - Reduced cancer waits
- The plan recognised access and the way GP services were run needed to change.
- The STP enabled the NHS to work more closely with local authorities.
- There would be more investment in primary care which would also look at extra places for talking therapies.

Mental Health and what would be different:

- 60,000 extra places for talking therapies meaning more residents could benefit from the service
- Better care for expectant and new mothers
- Improved CAMHS and increase in patient in-beds meaning residents could receive specialist care closer to home
- Specialist mental health care in A&E with a four hour target so residents received the same standards of care for mental and physical health emergencies.

How it would happen:

- Local investment standards
- 800 extra mental health specialists embedded in Primary Care
- Commissioning reform to expand local services and reduced out of area placements.
- Support from local authorities to reduce DTOC for mental health patients
- Greater transparency through new mental health dashboard.

Primary Care – What would be different:

- Increased convenient access to GPs, meaning more residents can get a same day appointment
- Streaming emergency appointment to alternative professionals (pharmacists, therapists, physicians assistants) so that GP time is freed up to see only those residents who need to see a GP
- 100% access to out of hours bookable appointments by 2019 – WAM CCG already met that standard
- 5000 extra GPs; 1,300 extra clinical pharmacists; 1,00 extra mental health practitioners; 3000 extra physicians assistants.

How it would happen:

- Increased investment in GP services, including workforce and premises
- Encourage practices to work in 'hubs' for population size 30,000 to 50,000 at a joint location with improved access to diagnostics and clinical practice rooms
- Sharing community nursing, mental health and clinical pharmacy teams

Urgent and Emergency Care – what would be different:

- By September 2017, all trusts must achieve:
    - 90% on the four hour target – Wexham Park regularly achieving between 86-91%
    - Front door clinical streaming so residents presenting at A&E who need a GP appointment could be redirected to a GP within A&E
    - Appropriate patient flow including D2A, Trusted Assessors and seven day discharges – Wexham Park already discharged seven days a wee.

How it would happen:

- Free up 2,000 to 3,000 acute beds across England by providing a discharge to assess service
- 85% of CHC assessments to happen in the community, either in community beds of people's homes
- Enhanced support to care homes to prevent admissions and speed up discharge by adopting a Trusted Assessor model
- Implementing the high impact change model for managing transfers of care.

Integrated Health Care – What would be different:

- New partnership models encouraged to reduce the growing demand on the emergency services
- Increased integration of health and social care based on the BCF
- Creation of integrated (or 'accountable') health systems through STPs so that all partners are working as an integrated health systems.

How it would happen:

- New STP boards incorporating GPs, local authority and non-executive partners
- STP programme supported by pooling skilled resources from CCGs, trusts and local authorities
- NHSE will allow CCGs to realign their governance and management teams to the STP Geography
- Consider proposed changes to geographical boundaries to support patient flows
- NHSE will produce a policy framework under which STPs will operate and be judge by success.

Cancer – What will be different:

- Better survival rates – an additional 5,000 survivors by 2020
- Expanded screening for prevention and early diagnosis for bowel and cervical cancer
- Faster test results
- New standard of definitive diagnosis within 28 weeks from 2020

How it will happen:

- £130m targeted investment
- Workforce expansion for endoscopy and radiology
- Clearer accountability through a new cancer dashboard.

Nick Davies, Service Lead Adult Commissioning provided the board with an update stating there had been a lot of work carried out on care home quality and there was a need for investing and understanding relationships. Care homes in the Borough required a huge amount of work to be done to reduce falls. There had been better hydration rates in care homes due to support from the Hydration Project. Work had also been done around medication management with medication reviews being carried out and making sure medication management was robust and reducing anti-psychotic medication. There had also been investment in the workforce.

Councillor Airey stated the work done had been fantastic and asked if views of the under 18 year olds had been incorporated in developing services, particularly mental health services. Dr Hayter responded that there had been a lot of work done over an extended period of time including consultation work which was used to develop services such as CAMHS. Dr Tong highlighted the issue that the NHS required money to deliver projects. Connections could be improved and the steering groups did include young people too. The Chairman said that the planning application for the new Heatherwood Hospital had been submitted and would be heard at the Borough-Wide Planning Panel.

## 93/15 THE CHANGING FACE OF GP SURGERIES

Dr Hayter gave Members a brief presentation on the changing face of General Practice. Members noted the following key points:

- Things were changing while services continued to be provided, the situation was fluid and ever changing.
- The GP Forward View came after the Five Year Forward View.
- GPs were part of the community looking after patients.
- GPs recognised the historical model was not fit for the future so they were talking about joining up services to provide wraparound care.
- GPs needed to think about how care was redesigned.
- GPs were less well funded and more investment had gone into hospitals instead of GP practices. GP investment would now be increased.
- GPs were starting to think as providers and were coming up with solutions such as having Clinical pharmacists being resident in GP surgeries; that would help patients manage conditions such as diabetes.
- Federation WAM was helping smaller practices to survive as they were doing things more to scale.
- GP practices were also working more collaboratively with staff being shared across surgeries.
- In Dr Hayter's Practice, Runnymede Medical Practice, the CQC said some things could be done differently, the practice saw triple the number of people with sever frailty compared with other practices in other areas.
- The Runnymede Medical Practice began to think about doing things differently and put a bid in for funding to help support carers.

- Support for carers included things such as providing training or information to keep them well, offering annual health checks for carers and informing them on how to receive practical support as a carer.
- A carers event was held in March with the Runnymede Medical Centre working hard to identify young carers; they carried out their own young carers week, worked with local schools and held a coffee morning. The work went well and 10 young carers were identified and now receiving support.
- Overall, there were 320 carers identified across all groups which was up from 40.

## 94/15 DEMENTIA CARE ADVISORS UPDATE

Jeanette Bailey, Team Manager for the Short Term Support and Rehabilitation Service gave a brief presentation on Dementia Care Advisers. Members note the following key points:

- The role was originally established in 2014 to provide supportive advice and signposting for all newly diagnosed residents. This was linked to Memory Clinics and third sector dementia support services.
- The role was well established and valued by all stakeholders over two years.
- 2014-2016 saw a period of growth and change such as:
    - As dementia diagnosis rates increased, there was an increased demand for services.
    - The profile of dementia raised as a specific condition and as part of complex needs with other long term needs.
    - Care Act implementation – there was more focus on carers needs.
    - Additional network of supportive services and liaison – through older person as Mental Health Sub-Group.
    - Launch of Each Step Together programme.
- Maternity leave offered an opportunity to take stock, review and absorb learning from other models of DCA support – nationally and across Berkshire.
- Activities from September 2016 – to date have included:
    - Increased staffing to 1.2 WTE – two DCAs with complementary and different skills and experience to widen scope of the role.
    - One nurse and one specialist in Cognitive Stimulation therapy
    - 136 new referrals in seven months with a wide spectrum of neurological conditions.
    - Refresh all promotional information and proactive engagement with all contact points across wider H&SC systems i.e. practice nurses, public Daily Living Made Easy event in October 2016.
    - Speedy response and onward referral to targeted community support – EST approach.
    - Proactive relationship with the Memory Clinic – DCAs involved in last week of introductory course for better client/carer face to face contact.
    - Holistic and sustained support to dementia patient and family – better carer identification and support.
    - Targeted advice on acquisition of relevant equipment and use of assistive technology (with demonstrable impact on falls related NEL admissions), telephone triaging to identify those near crisis and offer immediate pre-emptive support with immediate access to other health and social care specialist advice.
- Impact – Resident stories:
    - More joined up information sharing – reinforces the ‘tell your story once’ objectives for residents and targeted support without repeating historical information.
    - More timely and creative interventions to promote independence and reduce risk of crisis.
    - Tailored support for different types of dementia diagnosis – and links to other long term conditions.
    - Shorter waiting times for referral implementation e.g. reduced six week waiting

time for Day Centre referrals to one week – EST
    - Whole person – lifelong support – not just at initial diagnosis – gateway to ongoing advice and support throughout patient journey.
    - Patient and carer – supported individually and together – multigenerational households.
    - Better/increased use of other dementia related services.
- Dementia Care Advisors tried to personalise the service based on need
- DCAs acted as key workers; they tried to avoid unnecessary hospital admissions and establish any longer term support requirements.

## 95/15 TRANSFORMING CARE PARTNERSHIPS UPDATE

The Berkshire Transforming Care Partnership Board held a shared vision and commitment to support the implementation of the national service model to ensure that children, young people and adults with learning disabilities, behaviour that challenges and those with mental health and autism receive services to lead meaningful lives through tailored care plans and subsequent bespoke services to meet individuals needs.

The Berkshire Transforming Care Plan had four big aims:

1. Making sure less people were in hospitals by having better services in the community.
2. Making sure people did not stay in hospital longer than they needed to.
3. Making sure people got good quality care and the right support in hospital and the community.
4. To avoid admissions to and support discharge from hospital, people would receive and be involved in a Care Treatment review (CTR).

There were the following work streams and project groups:

- Works Streams (Themes)
    - Demand and Capacity
    - Market Shaping – Housing and care Providers
    - Inpatients
    - Intensive Support Team
    - Communities and engagement
    - Communications and engagement
    - Children and Young people
    - Workforce Development and Culture
    - Co-production
    - Joint Commissioning and Integration
    - Risk Management
    - Programme Management
    - High Impact Actions.
- Project Groups
    - Finance and Activity
    - Housing and Accommodation
    - Autism
    - Intensive Intervention service
    - Occupation and Employment
    - Berks East Capital ‘Home’ Project
    - Co-productions (People’s Voice Service)
    - Experts by experience Steering Group
    - Communications and Engagement.
- 2016 TCP Achievements
    - Regular TCP briefings to all partners and communication teams to keep them up to date with national and local news
    - Secured:
        - 2016-2017 funding from NHS England for Shared Housing Provision in RBWM for up to three individuals from across Berkshire with complex

LD and challenging behaviours
    - 2016-2018from the DfH for 10 x Hold Ownership Schemes for people with long term disability
    - 2017-2018 national funding for interim intensive support service and respite
  - Co-opted carer and family experts by experience into the programme on voluntary appointment contracts, as members of the finance and activity project group, capital 'home' project group, and TCP Board, with further appointments planned in 2017
  - Commenced experience based co-design project with Point of Care Foundation – weekly BHFT led group with service users
  - Undertaken a desk top gap analysis of local authority LD and ASD strategies and, reviewed capacity and demand projections until 2019, to inform prioritising of the work plan for 2017/18
  - Started to map local authority and CCG work streams already in place for Children and Young People, to avoid duplication in work
  - Developed a repatriation timetable for NHS England specialist commissioned patients and Clinical Commissioning Group out of area placements.
  - Will be linked into STP funding
  - Autism was a key part with agencies working much more collaboratively
- Intensive Support Team:
  - All TCPs nationally were looking to commission a new service model in the community called an Intensive Support Team (IST) or Intensive Intervention Service
  - An IST would provide proactive community based support for people with a learning disability and/or autism who have associated mental health needs and/or present with behaviour that can challenge. Offering support to people in their own homes and preventing in-patient admissions where possible, the IST would provide access to specialist health and social care support.
  - There was a stream of work that was centred around primary care and that linked in with services for health checks and accessing services. The work was ongoing.

96/15 <u>BCF UPDATE</u>

Hilary Hall, Head of Commissioning - Adult, Children and Health gave a brief presentation and Members noted the following key points:

- National context – Admissions and delayed transfers of care
  - A&E attendances in 2016 had been 5% higher than in 2015
  - The number of emergency admissions rose by 4.5%. the rate was currently 10% higher than raw population increase
  - In 2016, each month's total admissions had been higher than the same month in each previous year
- Build up of pressure in the national 'system'
  - 21% of patients spent more than four hours in major A&E departments in December 2016, compared with 13% in December 2015 and 6% in December 2011
  - Long waits for emergency admission were 58% higher in 2016 than in 2015, and five times higher than 2011
  - However, the Borough was not performing as badly nationally
- Emphasises the need for integrated approach to managing front and back door in acute rusts reflected in BCF targets
  - Delayed transfers of care had increased substantially over the past three years
  - There were 23% more delayed transfers of care in 2016 than in 2016
  - Compared with 2015, delays where NHS was at least partially responsible rose by 17% whereas social care delays rose by 37%

- There were lots of ongoing actions to try and keep on top of the figures and the situation was being reviewed weekly.

- Local actions to address Delayed Transfers of Care (DTC)
  - Integrated weekly meetings with Wexham, Royal Borough Hospital team, Short Term Support and Rehabilitation Team and Carewatch to review individual cases and agree packages of support
  - Support from GP practices to identify and support frail patients using new electronic frailty index
  - Pilot in Old Windsor with support of parish council to identify those who live alone or are vulnerable – and offer them proactive support and advice
  - Focus on choice – proactive support for carers via SIGNAL and Dementia Advisors to enable residents to continue to live at home where possible
  - Review of third sector support from Red Cross to ensure that Royal Borough residents had access to the home from hospital service, e.g. milk in the fridge, settling in, prescriptions etc.
  - Proactive engagement with wider East Berkshire programme, including:
    - Monitoring patient flow – daily telephone calls with Wexham and partners to identify patients 'fit for discharge' and use of Alamac data set
    - Pilot of Discharge to Assess model in new Windsor Care Home for East Berkshire residents
    - Review/mapping of service pathways between Optalis and Berkshire Healthcare Foundation Trust to meet resident needs – June 2017
- Non-elective admissions – average stay post non-elective admission was decreasing as lots of work was ongoing with partners.
- Proportion of adults (65+) who were home 91 days after discharge from hospital –
  - The data showed the proportion of people who were at home 91 days after discharge from hospital from April 2015 onwards. That excluded those residents who had passed away, the target for the year was 87.5% and performance was currently at 87.09%
  - Significant increase in referrals direct from acute rather than community discharges – those were often more frail residents that needed more support and recovery time
  - Increase in falls related referrals and service users with long term/complex conditions
  - Slight increase in older age groups 85-94
  - More remaining in need of continuing support for longer at home due to having more complex needs and longer recovery times.

## 97/15 PUBLIC QUESTIONS

The Chairman regretted that there was no time left to take questions from the public.

## 98/15 FUTURE MEETING DATES

Members noted the future meeting dates.

The meeting, which began at Time Not Specified, ended at Time Not Specified

CHAIRMAN…….

DATE…….....