

TITLE: BRENT HEALTH PARTNER FORUM
CLIENT: NHS BRENT CLINICAL COMMISSIONING GROUP
RE: NOTE OF FORUM MEETING HELD ON WEDNESDAY, 12th FEBRUARY 2014 AT SATTAVIS PATIDAR CENTRE, FORTY LANE, LONDON HA9 9PE
DATE: 22ND FEBRUARY 2014

1. Introduction and overview

- 1.1 This report has been prepared by the independent facilitator commissioned by Brent Clinical Commissioning Group (the CCG) to chair a meeting of the Brent Health Partner Forum hosted on the 12th February 2014.
- 1.2 The event brought together members of the local community with representatives from the NHS, the local authority and voluntary sector. A total of 120 individuals attended the session with the diversity of public members slightly widening at this event, however the largest group continuing to be over 65s.
- 1.3 Following consultation with Brent CCG officers, local authority representatives and Patient Participation Group Chairs, the aims of the session were set out as follows:
 - To provide local people with an overview of the proposed integration of health and social care in Brent focusing on what it will mean for borough residents; and,
 - To invite advice and recommendations on how to make this work on the ground including how best to engage more widely with local people.
- 1.4 The event began with a welcome from **Dr Ethie Kong (Chair of Brent CCG)** and a short presentation by **Phil Porter (Director of Adult Social Services at London Borough of Brent)**. Participants were then given the opportunity to ask questions of a panel including **Ethie, Phil** and **Jo Ohlson (Chief Operating Officer, Brent CCG)**. After a short break, attendees were invited to work in groups, focusing their conversations around a series of prompt questions including:
 - How can we avoid hospital admissions in a crisis?
 - How can we improve discharge from hospital?
 - How can we keep people healthy in the community?
 - How can we best engage with local people around integrated care?
- 1.5 Any queries regarding this report should be directed to Keritha.ollivierre@brent-harrowpcts.nhs.uk

2. Opening Remarks and Presentation by Phil Porter

- 2.1 Dr Ethie Kong welcomed the participants and explained that the Forum was about bringing together residents and service-providers to work with the CCG and the local authority to help think about what could - and should - be meant by “**integrated care**” in the borough. This was followed by a short video which explained what integrated care might mean for a patient – ‘**Sam’s story**’ [video](#) from the King’s Fund).
(Transcript: http://www.kingsfund.org.uk/sites/files/kf/field/field_document/integrated-care-aimation-script.pdf)
- 2.2 Phil Porter then gave a brief presentation which provided an overview of the background to “whole systems integrated care” and what this might mean for residents in Brent. He highlighted the following key points:
- **“Integrated care” is an initiative which is being promoted across the country.**
 - **It is a response to a changing landscape of demand for care which will see the number of over 65 year olds doubling in the next 25 years.**
 - **Many of these people will have more complex conditions – they will need a more “integrated” package of care to stay healthy and at home.**
 - **The aim of integrated care is to improve the quality of care for patients, carers and their families by helping them to maintain independence in their community. This will mean: keeping people healthy at home; avoiding unnecessary hospital admissions; and, ensuring that there is a better integration of discharge from hospital.**
 - **Integrated care is about joining up services and service providers – so that there is more connection between adult social care and health care. It is also about joining up more effectively with the voluntary sector.**
 - **Practically it will mean that patients have “a care plan” i.e. a vision and plan of what support they need; a named “care coordinator” to help them to navigate the various care providers / systems; professionals from different organisations working in teams around the patient; and patients in control of what is happening to them!**
 - **It will involve pooling budgets between health and social care.**
 - **It will also involve the voluntary sector more directly in service provision.**
 - **Many individuals and organisations in Brent are involved in taking this forward: Brent CCG; the local authority; Brent Integration Board; GPs; hospitals; HealthWatch; and the voluntary sector more generally.**
 - **It is important that local people engage in developing and implementing plans.**
- 2.3 A copy of the slides from the presentation are provided separately in Appendix A.

2.4 After the presentation, delegates were invited to ask questions and make comments to a panel. This session is summarised in Table 2.1 below. Attendees were also encouraged to write down any additional questions and remarks. These have been collated and are attached in Appendix C.

Table 2.1 A Summary of the Questions and Comments to the Panel		
THEME	QUESTION / COMMENT	RESPONSE FROM THE PANEL
FUNDS	Is there any new money to do all of this? There isn't enough money now to go around! What will happen to business as usual?	The funds are being used differently. We are pooling resources between health and social care so that we can use what we have more effectively. Hopefully by working in this way we can actually save money.
VOLUNTARY SECTOR	<p>How can the voluntary sector get more involved? How will the voluntary sector be funded to get involved? Advice for Renters is not "in the loop" because we are not providers of personalised care. How can we help?</p> <p>Will Fuel Poverty get an equivalent amount of support to that which it has had previously now that budgets are to be pooled across the council and CCG?</p>	<p>Today is a good opportunity to tell us that you want to be involved! The thinking is underway around how this may work in Brent but it is early days. Come to these kinds of sessions and others. Funding for voluntary sector provision will be via the CCG and the council. Make yourself known to us as potential providers.</p> <p>We can't make a commitment to this tonight. We definitely do want to commission you for winter 2014/15. We will be taking this forward with the CVS at a launch event scheduled for 25 February 2014.</p>
MECHANICS OF MAKING THIS WORK	<p>What will happen to our data? Who will be able to access what?</p> <p>How is the "care plan" going to work? Who is the care plan for? Will everyone have one? How will these plans be designed?</p> <p>Who is the care lead? How will they be trained? Are those skills out there? Is there sufficient clinical leadership to make this work? What about if that person is away? You could learn from what has been achieved in mental health.</p> <p>Where has this be done before? Who else is trying to do what we are doing?</p>	<p>You will be asked to give consent for your data to be shared across different providers.</p> <p>At the moment GPs lead on this but in the future it could be anyone e.g. Age UK / the council. Anyone over the age of 75 will have a right to have a care plan. In addition there will be care plans put in place for anyone with complex conditions. Plans will be designed with the full involvement of the patient</p> <p>We are at early stages in making this into a reality. It will need training to be put in place across different professional disciplines so that people learn skills together. There is commitment at all levels and across all organisations to make this work – including local hospitals. There will be back-up for when staff are away.</p> <p>Torbay is often put forward as a successful pilot. There are 14 "pioneers" of which Brent is one.</p>

THEME	QUESTION / COMMENT	RESPONSE FROM THE PANEL
OTHER	<p>A particular case of someone with HIV/Aids who may potentially lose their home care support. Where will this person go for support? Was the person who did the assessment qualified to do it? It would not seem so.</p> <p>What is STARRs?</p> <p>Doctors do not diagnose properly!</p> <p>How do I get access to adaptations at home? This is not working for me at the moment. It is difficult to get adaptations / alterations made to temporary housing.</p> <p>There is a really poor history of health and social care working together. Can you demonstrate that things have changed? There is a real need for a significant culture change!</p> <p>What is the priority for social care in all of this? Is it just the poor cousin?</p>	<p>There should not be – and will not be – blanket removal of any support packages. Each case will be assessed individually. Please contact us if you feel that this is not being done.</p> <p>Short Term Assessment Re-ablement and Rehabilitation Services.</p> <p>If you feel that you are not getting a good service from your doctor, complain to your practice manager, the CCG or to NHS England.</p> <p>There is a range of equipment and funding available for adaptations. Call Brent Council and you will be helped by customer services. The aim is to respond to housing demand on a “priority need” basis.</p> <p>We are required to do this together! We have no choice but to get it right. There are new structures in place which ensures that we work together. Our involvement this evening hopefully demonstrates our commitment.</p>

3. Discussion Groups

3.1 After a short break delegates returned to their tables to put forward recommendations under four main headings. The results of these discussions are summarised in Table 3.1 below.

Table 3.1 Table Discussions – A Summary of Ideas	
FOCUS	IDEAS
How can we avoid hospital admissions in a crisis?	<ul style="list-style-type: none"> • Longer appointments for “at risk” patients. 5 – 10 minutes is not enough to check if someone is going into crisis. There also needs to be more time after an appointment to allow the GP to follow up. Could a patient see another professional who could feed into the GP as necessary? • Get pharmacists more involved in preventing hospital admissions. “More spotters out there in the community!” • More health advice for teenagers in particular – stop them becoming a “crisis cohort”. • Run campaigns, set up directories etc. to make sure that people have better access to the full range of options outside of A&E. • Get information on key websites e.g. STARRS and make sure that all professionals explain the range of options to patients, carers and families. • Promote community network education with community based trainers. • Advertise and promote services in: post offices; housing association offices; schools; supermarkets; pharmacists; on the radio; in magazines – all in a range of languages. • A 24/7 helpline that actually DELIVERS....not 111. • Better coordination of out of hours GP services. • Ensure that people are able to heat their homes. • More holistic assessments of people’s conditions – we should be looking at wider determinants of health. • Use the voluntary sector more effectively to support people at home. • Improve access to the GP hubs. • Develop something equivalent to “neighbourhood watch” so that people look out for their neighbours. • Extend periods of personal care in the home – so that carers can raise the alarm if necessary. • Key role for STARRS. • More direct support for dementia patients / those with mental health problems who forget their medication. • Extend the idea of care plans. • GP surgeries should do more to target their most “at risk” patients.

<p>How can we improve discharge from hospital?</p>	<ul style="list-style-type: none"> • Share the after care plan between the hospital and the GP. At the moment GP is often in the dark! • Make sure that information is actually recorded accurately. The discharge form needs to be completed in full with full list of medication and follow-up appointments. It needs to specify the primary / community care link professionals. • Patients also need “practical advice” sheets to go home with – so that common questions are answered effectively and details of care providers are set out clearly. • Get patients and carers to complete a discharge questionnaire which allows them to identify (and address) their concerns. • Do everything electronically – go paperless in hospital. Use email and SMS more effectively to support patients. • Better coordination of services especially for people living on their own – they should be seen as a priority. • More thought needs to go into “point of discharge” – e.g. with regards to ensuring that patients have transportation; medication; and, food. People should only be discharged if the hospital has assurance that the home environment is adequate. • Rigorously follow protocol – what happens if procedures are not followed and people fall through the net? • Be clearer with people who have been admitted to hospital about the discharge procedure. Give people a card with the names of the professionals they have seen / will be seeing. • There needs to be immediate adaptations in the home. • Build on the STARRS model – staff should proactively contact individuals at point of admission and upon discharge. • The role of pharmacists in hospitals is absolutely critical.
<p>How can we keep people healthy in the community?</p>	<ul style="list-style-type: none"> • Make sure that people can access a full range of community and leisure services to keep them healthy and active – day care; respite care; libraries and leisure centres. Appropriate equipment and staff in each facility to support health! • Better and more appropriate support for vulnerable people – they should not be pushed out into unsupported environments. There needs to be prompt access to health and social care support and advice. • We need a better skilled and more competent workforce who are able to do good assessments and then DO something on the back of it! • Improve the quality of people’s housing and heat people’s homes – especially those most vulnerable to cold e.g. Sickle Cell. • Make sure that all patients have a personal care / self-care plan and/or special packs of advice for most vulnerable. • Do more to actually interpret what is happening with the use of “111” and re-design services accordingly. • Befriending services would help enormously in addressing isolation. • Advice services e.g. with regards to debt; healthy eating; heating your home etc. • An overarching fuel poverty strategy. • Access to alcohol services. • Cost effective exercise programmes. Reward good health decisions in some way. • People need to access their own friendship circles. • People need to know where they can access social provision using their own funds. • Consider the development of special packages of support for the most vulnerable groups.

<p>How can we best engage with local people around integrated care?</p>	<ul style="list-style-type: none">• Every single person here this evening should speak to 3 – 5 others. We each need to be champions for engagement.• There should be more direct support for carers to get involved.• Carers and patients need to be actively involved in developing care plans.• Put the questions from today on the side of a double decker bus! With a free number / email address to respond to.• Put these questions out into the local media.• Use Patient Participation Groups more effectively.• Use IT more effectively – social media, text.• Engage young people from different communities to act as translators – and to get their families and friends involved.• Get involved with other organisations – and their consultation events – e.g. housing associations; schools.• Professionals themselves have got to commit to this – e.g. GPs put up posters for this event in their surgeries!• Keep people update on the back of events such as this one.• Provide hand-outs beforehand so that people can come more prepared to participate.
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4. Conclusions and Next Steps

- 4.1 Dr Ethie Kong thanked all of the participants for making the meeting so worthwhile. She also thanked those who had managed the event and the exhibition teams. Miffa Salter invited the participants to complete evaluations of the event and make sure that their contact details had been registered if they wished to receive a copy of the meeting report. The report would be circulated shortly with the following appendices: Appendix A – Copy of Phil Porter’s Presentation Slides; Appendix B - Additional Written Questions and Comments