

## Minutes of a meeting of the Health and Social Care Overview and Scrutiny Committee held on Thursday, 21 March 2019 in Committee Room 1 - City Hall, Bradford

Commenced 4.35 pm  
Concluded 7.30 pm

### Present – Councillors

LABOUR	CONSERVATIVE	LIBERAL DEMOCRAT
A Ahmed Mir Shabbir Berry	Hargreaves Senior	N Pollard

Observers: Sarah Ferriby (Portfolio Holder, Healthy People and Places)

Apologies: Councillor Kamran Hussain and Councillor Khadim Hussain

### Councillor Greenwood in the Chair

#### 73. DISCLOSURES OF INTEREST

Co-opted Member Susan Crowe disclosed, in the interest of transparency, that she received funding from the Clinical Commissioning Groups and Bradford Metropolitan District Council to deliver service as part of The Big Conversation, (Minute 77).

Councillor A Ahmed disclosed, in the interest of transparency, that she was employed by the West Yorkshire Ambulance Service (Minute 78).

#### 74. MINUTES

Resolved –

**That the minutes of the meetings held on 24 January and 20 February 2019 be signed as a correct record.**

#### 75. INSPECTION OF REPORTS AND BACKGROUND PAPERS

There were no appeals submitted by the public to review decisions to restrict documents.

## 76. REFERRALS TO THE OVERVIEW AND SCRUTINY COMMITTEE

There were no referrals made to the Committee.

## 77. INDEPENDENT ADVOCACY SERVICES IN THE BRADFORD DISTRICT

The Strategic Director, Health and Wellbeing submitted **Document “AJ”** which outlined the recently commissioned Independent Advocacy that was jointly commissioned by the Council and the Bradford District’s Clinical Commissioning Groups (CCG).

The report also set out the wider context of advocacy and what other services were available across the District and how future services might be shaped.

The Contract and Quality Assurance Manager addressed the meeting and explained that the purpose of the re-commission of the service was to ensure people had greater choice and control over how their health and social care services were delivered through a new joint approach to funding advocacy services.

Previously advocacy services had been provided by five Providers under 15 arrangements some of which were joint funding arrangements with the NHS and some of which were in the form of Council grants.

Document “AJ” revealed that the new two contracts had commenced in April 2018. Statutory and Non Statutory advocacy was provided by Voiceability. Self and Group Advocacy, Capacity Building and Volunteering was provided by Equality Together sub contracting to People First Keighley and Craven and Bradford People First.

A representative of Voiceability addressed the meeting to provide a flavour of the advocacy provided and how that was delivered. He explained that the majority of the work undertaken by his organisation was statutory and had evolved from the statutes and associated regulations and codes of practice from The Care Act 2014; The Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards (2009); the Mental Health Act 1983 (amended in 2007); The Equality Act 2010 and The Health and Social Care Act 2012. The report set out the various advocacy service roles that were required in relation to statutory advocacy services.

Members were advised that anyone who had been sectioned under the Mental Health Act, because they had been deemed to have had their capacity taken from them, had the right to have an advocate to support them through the section process or an appeal. The service acted as the voice of the person concerned and did not judge. Other services were required to assess what was in the best interest of the person and the advocate would act to voice that person’s opinion.

Examples of the work of Voiceability included situations when people lacking capacity had difficulty when assessing care needs were supported to make decisions about their care. The service was often involved in long term decisions about accommodation or if serious medical treatment was required and a person

lacked the capacity to accept or decline that treatment. People could be supported through safeguarding processes and were generally helped when there was no one else to support them. If it had been deemed that someone should be in residential care but they did not want to go the advocate would work to look at other options and may be able to engineer a plan to keep that person in their own home. Personal situations where the advocate had been able to get to the route of issues of which other services had been unaware were also discussed. It was reported that people often confided in advocates and that the service remained independent whilst supporting people through tough situations.

A representative of Equality Together discussed aspects of their work which included developing self-empowerment for people to take control of decisions and to tell others what they wanted. It was explained that whilst addressing issues other problems also came to light and they were able to help people to address those issues and prioritise plans. Work was carried out across non protected areas with vulnerable people with long term health issues.

A particular issue faced by the service had arisen following welfare reform with people suffering with ill health experiencing further anguish dealing with potential changes to their circumstances. Group advocacy sessions were particularly useful for people who were new to a situation and empowered them to address their issues through peer support.

It was explained that user voice and engagement was a big part of the contract; service users were listened to and regular meetings, focus groups and large events were held to allow people to gain information.

It was felt that the expectations of service users was increasing, however, through peer support and experts across the district people were empowered to take control of their own situations. It was explained that the service was under resourced and required more partnership working. As they moved to the second year of the contract it was hoped to create more clusters of organisations to self empower.

Following the representations a number of questions and issues were raised to which the following responses were provided:-

- People were referred by professionals involved with patients under the acts referred to in Document AJ. People also contacted the services directly to self refer.
- Voiceability had a presence on hospital wards where people had been placed under the Mental Health Act and that allowed them to make approaches for help directly.
- Telephone enquiries about non statutory issues often came from friends or family members.
- It was hoped to have more outreach work during the second year of the contract as the services had become more established and recording systems became better established.
- Since the contract had commenced Care Act Referrals had increased by up to 20 per week.
- People who experienced Deprivation of Liberty were visited every four to six weeks to ensure the sanctions were proportionate and realistic.

- The contracts had been awarded for three years with an option to extend by a further two.
- To deal with diversity and equality in Bradford additional interpreters and female advocates were required. At the last recruitment drive there had been no female Asian speaking applicants.
- Advocates utilised other skills other than talking to understand people's needs.
- Performance Indicators revealed that 85% of the time of advocates was spent with service users although different types of advocacy could take longer.
- Advocate skills were used to create action plans and to agree outcomes.

In response to the issues about recruitment a Member referred to the help that all Councillors could provide if details were forwarded to them.

A Co-opted Member referred to concerns which had been expressed to her by a previous advocacy provider. She explained their concerns that reductions in provision had resulted in people falling through the cracks in the system. They felt that because of the number of people with complex needs and with the changes to the welfare system needs were not being met. It was suggested that a review of provision should be undertaken and budgets increased to meet demand. It was acknowledged that the report confirmed that statutory duties were being met but it was believed that additional support to that defined as statutory was required. She questioned how many people used the advocacy services; how many approaches were made and the number of people who could not be assisted.

In response a representative of Voiceability acknowledged that there were areas of concern particularly around Personal Independence Payments. People often dreaded the assessments they were required to undertake and the service did not have the remit or capacity to support them. It was stressed that support at that level could make a big difference and prevent further distress and interventions. The number of people who could not be helped was reducing from two calls per day last year. It was considered that may be due to people knowing that they would not be supported so not making those initial requests.

A representative from Equality Together confirmed they had to turn down requests for help two to three times a day. Universal Credit was a major issue which some people did not have the capacity to understand. Approaches were made about welfare reform approximately 6 to 12 times per week. As the service was not funded to support people through the assessment process, and there were only three advice workers for the district, the advice team aimed to provide focused sessions. Members were assured that the service would not cast people adrift and that they could go back to the service if they felt they were not supported elsewhere.

In response to questions about future funding cuts it was explained that measures to reduce reliance on the public purse were being pursued.

Work with the Black Ethnic Minority (BME) communities was questioned and how discussions about individuals were handled. It was reported that data protection rules were explained so residents could understand the way in which the service

was operated. Checks were undertaken to ensure people had the authority to speak for other people or family members.

How a person's capacity or lack of capacity was determined was discussed and Members were assured that this was done by professionals before statutory advocacy services were requested. Once a lack of capacity had been established by a senior health professional the first question asked by the advocate was were they likely to regain capacity and could they be kept well until that time. It was reiterated that it was not the advocates' role to advise but to allow people to make their own informed decisions. The role of advocate was likened to that of a ventriloquist's dummy.

In response to questions about people who did not want the help of self and group advocacy it was explained that the situation would not arise as people self referred to that service. It was often found that once people requested help a number of underlying issues would come to light. The service would develop relationships and over time other problems could be addressed. Community Connectors worked with hard to reach people and their people- centred approach reduced barriers.

The way in which the effectiveness of the service was measured was questioned and it was explained that the Contract and Quality Assurance Team held regular meetings with the two providers separately. Regular email discussions occurred on day to day casework and performance information was provided. As the contracts entered their second year arrangements were in place to compare with previous providers and with the performance of the first year of the contract.

A Co-opted Member raised concerns that the value of the proposed new contracts had been significantly higher than the current contract costs and questioned if funds to deliver advocacy had been reduced. In response it was explained that funds had been retained for services for people out of the area who remained the responsibility of Adult Services. Increased expenditure had also been required for work around Deprivation of Liberty safeguards. Members were assured that only a small contingency had been retained and it was expected that half of that would be spent shortly.

In response to a question it was confirmed that the services did attend multi disciplinary team meetings with regard to patients with long term health conditions. Decisions such as when a patient would return home from care or future medical needs often required discussions with several agencies.

It was questioned how the services were benefitting people in the criminal justice system who, with acute and high level needs, were suddenly told they must be work ready but may have impaired capacity. It was maintained that better initial decision making would be less costly in the future and it was stressed that information on outcomes; achievements and lack of achievements was required to assess the performance of the new services. More evidential reports including connections to other services were requested and the potential to invest to save was discussed.

The Assistant Director, Commissioning and Integration, confirmed that the data could be gathered and quality of outcome measured in future reports. The need

for wider connectivity was acknowledged and would fit well with the strength based empowering work in Adult Services.

#### **Resolved –**

**That Independent Advocacy Services in the Bradford District be added to the work programme for 2019/20 and to include the presentation of performance information and outcomes; and consideration of demand for services, cultural competency and diversity.**

#### ***ACTION; Overview and Scrutiny Lead***

### **78. DIGITAL HEALTH AND CARE IN BRADFORD DISTRICT**

The Digital 2020 Board was formed in 2016 by health and local authority partners across Bradford District and Craven with a vision that appropriate technology could be used across an integrated system to assist in the delivery of health and care services.

The Digital 2020 Board submitted a report, **Document “AK”** which presented, in Appendix A, information on the Local Digital Roadmap: People First – Digital First. The Roadmap is a 5 year plan and is governed by the Digital 2020 Board.

Cindy Feddell, the Co-Chair, Digital 2020 and Chief Digital and Information Officer, Bradford Teaching Hospitals NHS Foundation Trust and Dr Justin Tuggey, Co-Chair, Digital 2020 and Chief Clinical Information Officer, Airedale Hospital Foundation Trust addressed the meeting.

Dr Tuggey provided examples of patient stories where people were accessing various care services at differing locations and the issues they faced with clinicians lacking all their information and patients having to repeat their medical history several times. The examples demonstrated the inefficiency and inaccuracy which could occur.

Appended to Document “AK” was a Roadmap of an ambitious five year plan through 2020/21 that was aimed primarily at seeing the completion of the strategy to have a fully interoperable electronic health record based on two electronic records – SystmOne from TPP and Millenium from Cerner. The Roadmap was being executed through each of the local partners and was governed by the Digital 2020 (D2020) Board. D2020 was comprised of all local partners including Bradford Metropolitan District Council.

In addition to the Roadmap all partners had plans in place to ensure that all organisations had digital patient records that were accessible anytime and anywhere.

The Roadmap also called for progress in the following areas:-

- Remote care to allow clinicians to care for patients from anywhere, which expedited clinical decisions and treatment.
- Transfer of care to ensure quick and safe transfer of patient’s care between different care settings, for example, once discharged from a

hospital to the care of a GP ensuring the GP had the right information in a timely way.

- Medicines management and optimisation that intelligently helped clinicians by, for example, alerting clinicians to allergies.
- Order and results management to expedite the diagnostic process as a critical step in diagnosing the patient and developing a treatment plan.
- Decision support to assist clinicians, enabled by digital clinical records.
- Asset and resource optimisation to ensure funding was used as efficiently as possible.
- Support for the programmes of work locally and for the West Yorkshire & Harrogate Partnership (the integrated care system), the Yorkshire & Humber Shared Care Record, and the National agenda.

In addition Document “AK” provided examples of several areas where progress had moved beyond the road map and included:-

- A transformational pathway re-design for diabetes that enabled patients to upload wellness and outcome focussed goals using mobile applications including video.
- Advancing the application of population health analytics via Connected Bradford for example using multiple pieces of data to enable the identification of people who could be frail to support self- management and avoiding harm.
- Bradford Teaching Hospital, in conjunction with local partners, housing of an Elderly Virtual Ward and Intermediate Care Hub, with over 200 beds, caring for people at home who would otherwise be admitted to hospital.
- A new Paediatric Ambulatory Care virtual ward (ACE) working with GPs to allow specialist following of paediatric asthmatic patients at home, improving outcomes and avoiding hospital admission.
- Analysis of population data to provide intelligence that local organisations could action through the Connected Bradford initiative at the Bradford Institute for Health Research. Findings have concluded, for example, that most deprived communities had the highest air pollution rates.
- The progression of digital initiatives to ensure solutions help clinicians to better care for patients, in particular for mobile staff, as part of a more efficient use of estate and accommodating flexible working for employees.
- Continuing to be a forerunner for telemedicine in care homes meaning care homes had video conferring access to clinicians to support treatment and care on site to enable quicker triage, clinical advice and treatment.

A Member who was also an employee of the emergency services acknowledged that fully shared records would prevent inefficiency and would improve patient experience and safety. The value of systems to enable the monitoring and intervention for patients with diabetes or asthma were also recognised. The ability to share radiology pictures and prevent repeated medical tests was also welcomed.

The benefits through patients having ownership of their health records and the empowerment that would provide was discussed and it was questioned when the systems could be linked to services for disabled people in the district. It was explained that work was on-going with a patients communication company based

in the district and pilot systems would be trialled shortly.

A view was expressed that working with a company employing people with a disability would enable a better understanding of a disabled persons needs and facilitate the production of more useful systems.

Members were reassured that D2020 were on the cusp of full integration locally. SystmOne from TPP used in primary care and Millenium from Cerner used in hospitals did talk to each other. There was a gap in Adult Social Care which had not yet been launched but the technology was available to do so. Bradford was in a fortunate position because all GPs were using the same system. The next phase would be to look at information sharing in Children's Services.

A Member questioned if there was anything in development to reflect the patient voice in their records and it was confirmed that engagement was on-going with patient groups to investigate that initiative and to consider how that could be supported and the benefits it could bring. Diabetic residents in the area already were able to input their health status into their records.

The Assistant Director, Transformation and Change, assured Members that there was an awareness to remain compassionate, empathetic and careful in how technology was deployed to free up clinicians and enhance the way they practised.

A Member referred to incidents where information sharing worked well and patients were moved efficiently through the system. Concerns were raised, however, that information about abusive patients or those with additional requirements, which other health services were aware of, had not been shared and, subsequently, ambulance crews had been assaulted or specialist equipment had not been provided.

Contrary to the views of most Members who believed the systems could save lives, one Member expressed his dislike of digital health. He believed that if patients suffering from mental health issues were asked similar questions at differing times they would not provide the same answers and that could provide a false assessment of their health. He felt that emotions could not be transmitted via technology and, whilst he acknowledged that information sharing could be beneficial, he questioned the situation if patients were out of the district.

In response it was explained that currently there was no national record sharing system. Systems across the district did talk and allowed for clinicians to hit the ground running without wasting time gathering background information.

A Member welcomed the interoperability of the systems and acknowledged the benefits of being able to monitor diabetic patients or alert residents to issues such as poor air quality or rises in air temperature which could be detrimental to health. He acknowledged that people often had a mistrust of technology and questioned and recognised the role that the Council could have in promoting those benefits. In response the Assistant Director, Transformation and Change, acknowledged the need to be transparent and articulate examples where the technology had been effective. The Co-Chair of D2020 confirmed that the systems had been discussed with young people and their preference to communicate via

technology.

A Member representing people with disabilities believed the technology had exciting possibilities and suggested that other applications including healthy eating and buddy systems could be added and could bring the world into people's homes. It was agreed that people should be aware of the benefits available through the communication of success stories.

A view recognising that once size does not fit all and the personal touch should be retained was expressed.

The possibility of record sharing to prevent people having to pay to retrieve medical records for assessment purposes was also suggested.

**Resolved –**

**That progress on Digital Health and Care in the Bradford District be added to the Committee's work programme for 2021/2022.**

***ACTION: Overview and Scrutiny Lead***

Chair

**Note: These minutes are subject to approval as a correct record at the next meeting of the Health and Social Care Overview and Scrutiny Committee.**

THESE MINUTES HAVE BEEN PRODUCED, WHEREVER POSSIBLE, ON RECYCLED PAPER