PUBLIC REFERENCE GROUP

Friday 5 April 2019

Africa Advocacy, 76 Elmer Road, Catford London SE6 2ER, 10.00 – 13.00

PRG MEETING SUMMARY

MEMBERS PRESENT:

Alex Camies	(AC)	PRG Member
Russell Cartwright	(RC)	Head of Communications and Engagement
Rachel Crampton	(RCr)	Speaker, Programme Manager, Lewisham Health and Care Partners, CCG
Neville Fernandes	(NF)	PRG Member
Husseina Hamza	(HH)	PRG Member
Adrian Ingram	(AI)	PRG Member
Rosie Jackson	(RJ)	PRG Member
Juliet McCollin	(JM)	PRG Member
Mabel Nwoko	(MNw)	PRG Member
Michelle Nembhard	(MN)	Interim Co-Chair, PRG
Tony Pilkington	(TP)	PRG Member
Teresa Rodriguez	(TR)	Engagement Officer
Keith Stewart	(KS)	Speaker, Senior Joint Commissioning Manager, Adult Mental Health – Joint Commissioning, CCG

APOLOGIES:

Anne Hooper	(AH)	Lay Member
Graham Carter	(GC)	PRG Member
James Campbell	(JC)	Interim Co-Chair, PRG
Jude Ibe	(JI)	PRG Member
Keith Walton	(KW)	PRG Member
Richie Morton	(RM)	PRG Member
Hayley Redmond	(HR)	PRG Member

1. Welcome, purpose and conflict of interest

1.1. MN welcomed everyone to the meeting.

1.2. Attendance and apologies were recorded. MN welcomed TP to the meeting and all were introduced around the table. Accessibility issues around interpreter availability meant TP could not attend the previous meeting.

1.3. No conflicts of interest were declared.

2. Previous meeting minutes

It was agreed that the minutes were an accurate record of the previous meeting and were approved by the group.

3. Frailty update

3.1. RCr introduced the Frailty project. The number of frail residents in Lewisham has been calculated using the eFI (electronic Frailty Index used by GPs) and poly-pharmacy data (medication taken). The Frail group can been classified in Mildly, Moderately and Severely frail. The Wirral have estimated that the average time for a resident to move to the next group (ie, mild to moderate) is around 18 months, though this needs to be verified. The project is under development and further conversations with clinical directors and PRG input will be considered.

3.2. Frailty was described as affecting many, including those with conditions which might not obviously be thought affected by frailty and including all age groups, such as children and young people. Frailty is a combination of conditions and therefore complex.

3.3. The three frailty brackets were explained and the necessity of equipping GPs at primary care level to know how to respond to a patient with a frailty score.

3.4. The project is also looking at reviewing patients on high numbers of drugs and as well as drugs that have a high anti cholinergic burden which impact cognitive ability and can increase frailty. It is hoped this will provide smaller patient cohorts to focus on. GP clinicians believe a pharmacist is the best person to review what medication changes should be made.

3.5. **Questions, answers & comments:**
Questions and suggestions by the group were:

- Age of residents in the study/project. RCr confirmed the project cover Lewisham population between 18-65+ (CYP not included) and mentioned Lewisham has a young population. There are some areas though with older population (for example, the South Lewisham GP practice has the highest proportion of over 65s in Lewisham).
- When and what factors influence whether drugs are reduced. RCr explained conversations with some patient could take place to investigate the possibility of reducing the number of drugs they are taking.
- Types of drugs considered in the project. The group raised and discussed issues on the complexity and consequences of prescribing, withdrawal symptoms and the importance of an explanation by the GP of some of the symptoms expected. Lack of information can have significant adverse effects on patient health, quality of life and outcomes. The withdrawal symptoms issue was noted by RCr in relation to coagulants and zopiclone.
- The group discussed anti-cholinergic burden (ACB) drugs, which may impair the cognitive ability to patients. This information can only be obtained from an EPACS pharmacy tool (high ACB count but not down to patient level).
- The group suggested In-house GP pharmacists, connected to a GP practice, can offer a good medicine review. RCr will see how this can be utilized.
- Drug awareness training for GPs is necessary. They need to be educated on specific withdrawal symptoms and long-term effects of some medications. Example of a repeated prescription of prednisone that caused frailty conditions was provided: the prescription aimed to alleviate immediate

symptoms, but worsening of the condition and long-term sustained ill health was not considered. Another case shared was the failure to advise from GP which led to gall stones and having to endure an operation and recovery

- RCr shared other ideas with the group:
  - the opportunity to prescribe/change dosage when patients in a ward setting because they are actively monitored so it is a safe environment to do this.
  - looking at practices UTIs data and looking at prevention and self-management to prevent mildly frail becoming moderately frail.
  - looking at those moderately frail – can a case management approach be taken?
    - Thresholds and triggers as a possible approach for managing large numbers of people?
    - However in the near future they want to finalise a characteristics table and potentially run a pilot on the medication element.

- Parkinson's and dementia patients to be taken into account
- Consider community enablement to prevent frailty. There are 3 ideas. 1) there are already things in place, we need to use them better; 2) enablement team; and 3) analyse high intensity users in Lewisham, such as identifying A&E users: allocating a mentor and counsellor and signposting other services. It's a multidisciplinary approach and needs to be applied proactively.
- Frail groups should be monitored for low vitamin D.
- RCr asked the group for input to better cover the BAME group needs.

RCr took note of the PRG comments. The group thanked RCr for attending.

Actions:

- **RCr suggested and it was agreed that the PRG would get involved in the pilot stage and then going forward. To meet at the end of May/June to work with the sub-group. TR to coordinate with sub-group.**
- **RC to arrange a visit from Caroline Hirst as CYP commissioner as only adult medicine being discussed.**

4. Mental health community services update

4.1. The Mental Health Commissioning team is a joint team between the CCG and LA.

4.2. KS said that a review in 2016 of the mental health voluntary sector contracts, identified that patients often came in and out of mental health services, and not getting their needs met. The review recommended that Lewisham should design an integrated approach to its service delivery. KS summarised the procurement process and gave an update on Lewisham Mental Health Community Services, which include:

- **Integrated Advocacy Service** (delivered by POWhER)
- **Integrated Dementia Service**, with Bromley, Greenwich and Lewisham (BGL) Mind working in partnership with Sydenham Garden and Carers Lewisham

- **Integrated Prevention and Recovery Service**, provided by BGL Mind in partnership with Sydenham Garden, Southside Partnership, Lewisham Refugee and Migrant Network and Metro. This service acts as a single point of access for people that require interventions for common to serious mental illness, who are in the community, providing short to medium term case management and other appropriate interventions to ensure that people with a mental health issue can establish and maintain their independence in the community.

4.3. The Mental Health Alliance; KS stated that there was a number of organisations that deliver a range of mental health services in Lewisham. The future is to develop a single mental health Alliance: the CCG, Local Authority, GPs, SLAM, community mental health organisations and Lewisham & Greenwich Trust (hospital) –will pool money and form a plan to address the mental health needs of Lewisham residents . However currently there's no service user involvement.

4.4. KS requested a volunteer to attend meetings and contribute a strategic voice to the alliance. RC explained currently meetings are held weekly.

4.5. **Questions, answers and comments:**

Questions from the group covered the following points:

- Availability of data on specific communities such as the deaf community and plans to include improving and creating an integrated service for those with specialist needs? KS explained that patients can use Personal Health Budgets to purchase specific mental health interventions to support their development and meet their specific needs

- Accessibility: how do you identify those who need it/how do they get the help? Referrals come from LA social care, hospitals, South London and Maudsley (SLAM), GPs, also direct referrals from individuals or family – the latter to happen once contact details are uploaded to the CCG website which will be soon. Contact information is already on the council website.

- On advocacy and carers (of those potential service users) who have mental health needs, are they eligible for the service and/or would they be signposted? KS explained this is complex because of GDPR. Only people who self-identify as a carer to the advocacy service will be signposted for further support.

- What about young people who might be vulnerable? This is a discussion for another day. The CYP commissioner can visit the group in a future meeting.

5. PRG development

5.1. RC went through the engagement report and suggested it should be done annually. Apologies were made for not circulating it in advance.
5.2. Currently it reflects the last 3 years.
5.3. RC and TR are hoping to move more actions further up the ladder.

Action: TR to send soon after the meeting to all.

6. Progress of actions

6.1. **You said we did:** revised draft from AB circulated and format explained. Sub-groups to have a similar template and this can be updated to the main group at meetings.
Red, Amber, Green – request to conditional format the status column.
6.2. **NHS England website link:** PRG members to look at the link circulated and let TR know so that tracker item can be completed.
6.3. **Discussed how the CCG talks today went and time for questions:** the group discussed the pros and cons of allocating one talk per meeting and how to use the time most efficiently. Discussion was very brief and for the time being it was suggested that receiving more information sooner ie two talks per meeting was preferable to delayed PRG involvement.
6.4. **Last session's minutes:** Pharmacy first, comment missed. RC: its' been logged.
6.5. **NHS email addresses:** TR to provide these when ready.
6.6. **Festivals:** TR updated us that there is no People's Day this year. Need members for 3 hours, not mandatory. TR to circulate a schedule to members.
6.7. **CCG report:** There will be a PRG Annual report. TR will include the PRG induction and training in it.
6.8. **Update on the NHS long term plan and CCG changes:** RC said there are six London Boroughs that will be collaborating and the governing body has agreed that it will go down this route. They are exploring what frameworks sit under that. From September 2019 there will be a shadow CCG. Some staff will move to South London-wide and some will move to place-based posts such as Las or an organisation where they do place-based operations.
RC/TR to keep us updated on the changes. RC said an infrastructure on Lewisham is needed and they need to keep the PRG as part of that voice.

7. AOB

Please can the commissioning structure and how statutory duties are met be explained if we are working on adult only medicine? How can we support the CCG to meets the duties in terms of CYP?
Action: RC to facilitate a CYP Commissioner visit to the group. RC suggested the CYP Sub-Group meeting before the CYP Commissioner attends so that desired outcomes can be agreed in advance of the meeting

REF.	ACTIONS	LEAD/S	DUE DATE	STATUS/COMMENT
1	Meetings suggested by previous cohort: CYP commissioner, CYP / Adult transition services, SAIL service	TR	JUNE	RC TO ARRANGE FOR THE CYP COMMISSIONER TO VISIT THE GROUP AND SUB-GROUP TO AGREE DESIRED OUTCOMES AT A PRE-MEETING
2	CCG Clinical Priorities document modifications	GC	MAY	ONGOING – TR TO CONFIRM IF THERE ARE ANY UPDATES?
3	'You said, we did' tracking spreadsheet	TR	MAY	VERSION AGREED. COLOUR TRACKING TO BE FINALISED AT NEXT MEETING.
4	PRG Information Governance training	TR/RC	MAY	ON AGENDA
5	Festivals	TR	MAY	TR TO CIRCULATE SCHEDULE TO ALL