MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD

Commitee Room 2 - Town Hall
8 May 2013 (1.30 - 3.22 pm)

Present

Cllr Steven Kelly (Chairman) Deputy Leader of the Council, LBH
Cllr Andrew Curtin, Cabinet Member, Town and Communities (Culture), LBH
Cllr Paul Rochford, Cabinet Member, Children & Learning, LBH
Conor Burke, Accountable Officer, Havering CCG
Dr Gurdev Saini, Board Member, Havering CCG
Dr Mary Black, Director of Public Health, LBH
Joy Hollister, Group Director, Social Care and Learning, LBH
John Atherton, NHS England
Anne-Marie Dean, Healthwatch
Alan Steward, Chief Operating Officer (non- voting) CCG

In Attendance

Julie Brown, HWB Business Manager, LBH
Louise Dibsdall, Senior Public Health Strategist, Public Health, LBH.
James Goodwin, Committee Officer, LBH (minutes)

Apologies were received for the absence of Councillors Lesley Kelly, Cheryl Coppell and Dr A Aggarwal.

All decisions were taken with no votes against.

The Chairman reminded Members of the action to be taken in an emergency.

10 **MINUTES**

The Board agreed the minutes of the meeting held on 10 April as a correct record.

11 **MATTERS ARISING**

Abdominal Aortic Aneurysm Screening Programme

The screening programme had been presented to local GPs. There was concern that with Centres of Excellence being located in Central London it became more difficult to develop specialist services locally. Healthwatch indicated that they could understand the benefits of centralising surgery but were of the opinion that a significant proportion of the surgery which could still be carried out locality. Consideration needed to be given to the needs of the patient, the cost of travelling

to and from Central London could be expensive and the travelling could be tiring and upsetting if it followed major surgery. These were issues which need to be considered by NHS England.

The three year plan for configuration had been signed off by the Secretary of State for Health. In support of these, local Trusts needed to produce Strategic Plans which would indicate which services they wished to provide locally. It was anticipated that the Strategic Plan for Barking, Havering and Redbridge University Hospital Trust (BHRUT) would be available in June. BHRUT might not wish to provide these services locally.

These specialist services would be commissioned directly by NHS England.

It had to be recognised that Queen's Hospital was a very expensive PFI hospital and an economic use of the premises needs to be found.

Once the screening was completed the patient would be referred back to the GP to arrange for the operation to be undertaken at the Centre of Excellence.

ACTION: The Director of Public Health would compose a set of notes for the NHS England representative on what should be discussed with the Board..

Substitute Members

Only the CCG members could send a substitute to the meeting.

Measles outbreak

The CCG and Director of Public Health had looked at the implications of the measles outbreak in Wales, for Havering. The Director of Public Health was able to give an assurance that all GP's in the area were ready to tackle any outbreak locally. Such was the effectiveness of arrangements locally the Director of Public Health was advising the Department of health on how to write up systems.

Locally nearly 90% of under 5's had been inoculated. The problem area was the 16/19 age group where only 30-50% were immunised. Plans are in place to tackle this gap.

12 PRIORITY 2: IMPROVED IDENTIFICATION AND SUPPORT FOR PEOPLE WITH DEMENTIA

Consideration of the report was deferred until the next meeting.

13 FURTURE DEVELOPMENT OF THE JOINT STRATEGIC NEEDS ASSESSMENT

Moving forward local authorities and Clinical Commissioning Groups share joint responsibility for preparing and demonstrating the use of the JSNA to inform commissioning decisions. The latest guidance recommended the establishment of

strong working partnerships with the local Healthwatch organisation to ensure that views were fed in through the community participation process.

The new requirements for the production and use of the JSNA were:

- Statutory duty on Local Authorities (including Public Health) and NHS Clinical Commissioning Groups, fulfilled through Health and Wellbeing Board
- Relatively high **organisational significance**
- Integral to new-decision making forums
- More involvement of the local community in development of the JSNA through the Health and Wellbeing board (Health Watch representative)
- Robust link to commissioning
- Resource mapping to complement integrated planning and commissioning agendas
- Focus on community 'assets' and ''deficits'
- A wide range of partner engagement
- Moving from 'snapshot' to 'trend' data, using both quantitative and qualitative data

Whilst the JSNA contained a lot of useful data, the discussion stressed that there needs to be a clearer statement of what needs to be done to address the issues highlighted. It was felt the JSNA should include examples of not just what is wrong but also areas of resilience in society.

The concept of 'deep dive' chapters was supported but to avoid a dilution of effort a smaller number of issues needed to be identified.

Reference was made to work being undertaken in Camden in the form of a Data 'Hack-a-thon', when the authorities' data would be made available to everyone. Everyone was facing the same problems of data overload and The Director of Public Health has submitted an abstract to be considered at the Public Health England conference later this year.

The JSNA needs to be linked to the Health and Wellbeing Strategy; therefore it needs to be reviewed one year before the Strategy is reviewed to help inform the strategy. A timetable needs to be drawn up to ensure deadlines are not missed. We also need to timeline 'deep dives' so they fit in with the reviews.

It was agreed that the Director of Public Health should chair the JSNA sub group.

ACTION: That a further report be brought to the next meeting addressing the issues raised with the current JSNA.

14 HEALTH AND WELLBEING BOARD SUB STRUCTURE GOVERNANCE AND TERMS OF REFERENCE

The report outlined the process and having considered the report it was agreed that it was not necessary to form an Integrated Care Group nor a Hospital Performance Group as the work proposed for these bodies was being picked up already. It was also highlighted that the proposed Health Protection Forum should not be a direct sub-committee of the Health and Wellbeing Board.

Given the tight turn around between Board Meetings it was important the Board had a clear Work Plan in place.

ACTION: It was agreed that Joy Hollister, Mary Black and Alan Steward should get together and develop a work plan. Similarly the key meeting between cycles was the clearance meeting when officers met the Chairman to clear reports. How officers reached this point was unimportant to the Board, what was needed was an assurance that a process was in place to ensure the Board received reports in a timely fashion.

15 DEMENTIA FRIENDLY ENVIRONMENTS: CAPITAL INVESTMENT AND PILOT SCHEME INITIATIVE

The Board noted progress with the Four Seasons Gardens project.

16 DISCHARGE PLANS FOR PEOPLE WITH LEARNING DISABILITIES

The Board was updated on progress on the Winterbourne Concordat. This involves identifying those patients with learning disabilities and highly complex needs who need to be discharged from long stay hospitals. 9 persons had been identified who required discharge and a person-centred plan must be in place for these people by the end of June 2012. However, there was some concern as to whether as partners we had sufficient capacity or the right services locally to meet their highly complex needs.

ACTION: A report would be submitted to a future meeting identifying the current progress of the plans, where we are now, and the cost which would be shared by the Council and the CCG in the form of Pooled budgets. A bigger piece of work was required to develop long-term plans for those with learning difficulties.

In addition we have a moral duty to develop plans for those diagnosed with dementia.

All plans would need to be underpinned by advocates for the clients. A briefing would be provided for the chairman on where we are and a paper would be submitted to the next meeting of the Board.

17 WELL MAN SCANS

The chairman mentioned that he had seen proposals for voluntary checking for dementia in all men between 50-75. Did the Board think this was right and if it was where was the funding to come from?

The CCG representative advised that this was in addition to the work of the memory clinics which were already oversubscribed. GS informed the Board that GP's were being required to undertake dementia screening for all patients between 50 and 75 who have a long term illness. This was part of the government's proposals to encourage Primary Care to do better. This had not started yet as GP's needed to be trained in how to do the memory tests.

If the screening revealed a patient was suffering from dementia who was responsible. The Director of Public health advised that this was in her remit. And she would present a paper to the next meeting of the Board.

18 HEALTHWATCH

AMD provided an update on the work of Healthwatch.

They had expressed concern around nursing homes and were to meet the CQC to discuss issues which had arisen

By the beginning of June they anticipated being in their own offices and would be looking for 13/15 senior volunteers.

19 DATE OF NEXT MEETING

The Board noted that the next meeting was due to take place on Wednesday 12th June 2013.

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Chairman