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Havering
LONDON BOROUGH

HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

7.00 pm	Thursday 20 March 2014	Havering Town Hall

Members 6: Quorum 3

COUNCILLORS:

Conservative (3)	Residents' (2)	UKIP (1)
Pam Light (Chairman) Wendy Brice-Thompson Peter Gardner	Nic Dodin (Vice-Chair) Ray Morgon	Ted Eden

Andrew Beesley
Committee Administration Manager

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AGENDA ITEMS

1 ANNOUNCEMENTS

Details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation will be announced.

2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

(if any) – receive.

3 DISCLOSURE OF PECUNIARY INTERESTS

Members are invited to disclose any interests in any of the items on the agenda at this point of the meeting. Members may still declare an interest in an item at any time prior to the consideration of the matter.

4 MINUTES (Pages 1 - 18)

To agree as a correct record the minutes of the meetings held on 23 January 2014 (joint meeting re Council budget) and 6 February 2014 and to authorise the Chairman to sign them (attached).

5 BARKING HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST (BHRUT)

To receive an update on issues facing the Trust from Stephen Burgess, Medical Director, BHRUT.

6 CHAIRMAN'S UPDATE

7 NORTH EAST LONDON NHS FOUNDATION TRUST (NELFT)

To receive an update from senior NELFT officers on plans for services in Havering.

8 HAVERING CLINICAL COMMISSIONING GROUP (CCG) FUTURE STRATEGIC PLANS

To receive a presentation from the Chief Operating Officer, Havering CCG on future strategic plans of the CCG.

9 COUNCIL CONTINUOUS IMPROVEMENT MODEL

To note that the following Cabinet decision is due for a review of progress under the Council Continuous Improvement Model and to decide whether to take an update at the Committee's next meeting:

Public Health Transition to Havering Council.

10 HEALTH AND WELLBEING BOARD MINUTES (Pages 19 - 26)

Minutes of meeting of Health and Wellbeing Board of 8 January 2014 attached for noting.

11 URGENT BUSINESS

To consider any items of which the Chairman is of the opinion, by means of special circumstances which shall be specified in the minutes, that the item should be considered as a matter of urgency.

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MINUTES OF A MEETING OF THE
JOINT (ALL) OVERVIEW & SCRUTINY COMMITTEE
Town Hall
23 January 2014 (7.30 - 9.05 pm)

Present:

COUNCILLORS

Conservative Group	Jeffrey Brace, Wendy Brice-Thompson, Pam Light, Robby Misir, Barry Oddy, Frederick Thompson, Melvin Wallace and Keith Wells
Residents' Group	June Alexander, Clarence Barrett, Gillian Ford, Linda Hawthorn, Ray Morgon, John Mylod, Linda Van den Hende and John Wood
Labour Group	Keith Darvill+, Pat Murray and Denis O'Flynn
Independent Residents Group	Michael Deon Burton
UK Independence Party Group	Lawrence Webb+, Ted Eden and Fred Osborne

+Substituting for Councillor Paul McGeary.
+Sunstituting for Councillor Sandra Binion.

Cabinet Members in attendance: Councillors Michael White (Leader of the Council) Steven Kelly (Deputy Leader) Roger Ramsey and Paul Rochford.

All decisions were taken with no votes against.

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

1 **MEMBERSHIP AND CHAIRMAN OF MEETING**

With the agreement of all Overview and Scrutiny Committee Members present, the Chair was taken at this special meeting by Councillor Pam Light.

2 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman advised all present of action to be taken in the event of emergency evacuation of the town hall becoming necessary.

3 **APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY)**

Apologies for absence were received from the following Members:

Children and Learning Overview and Scrutiny Committee:

Councillor Sandra Binion (substituted by Councillor Lawrence Webb)

Councillor Nic Dodin (Substituted by Councillor John Mylod)

Margaret Cameron (co-opted Member – non-voting)

Ian Rusha (co-opted Member – non-voting)

Crime & Disorder Committee:

Councillor Osman Dervish (substituted by Councillor Wendy Brice-Thompson)

Councillor Roger Evans (substituted by Councillor Frederick Thompson)

Councillor Georgina Galpin (substituted by Councillor Barry Oddy)

Councillor David Durant

Environment Overview and Scrutiny Committee:

Councillor Lynden Thorpe (substituted by Councillor Barry Oddy)

Councillor Barbara Matthews

Councillor David Durant

Health Overview and Scrutiny Committee:

Councillor Nic Dodin (substituted by Councillor John Mylod)

Councillor Peter Gardner (substituted by Councillor Frederick Thompson)

Towns & Communities Overview and Scrutiny Committee:

Councillor Osman Dervish (substituted by Councillor Frederick Thompson)

Councillor Garry Pain (substituted by Councillor Melvin Wallace)

Councillor Linda Trew (substituted by Councillor Jeffrey Brace)

Value Overview and Scrutiny Committee:

Councillor Rebecca Bennett (substituted by Councillor Barry Oddy)

Councillor Billy Taylor

Councillor Damian White (substituted by Councillor Jeffrey Brace)

Councillor Sandra Binion (substituted by Councillor Lawrence Webb)

4 DECLARATIONS OF INTEREST

There were no disclosures of interest.

5 THE COUNCIL'S FINANCIAL STRATEGY

The Leader of the Council, Councillor Michael White, explained that the Council had been required to find approximately £40 million of savings over the last four years. The Leader thanked officers for their hard work in delivering these savings. Front line services, for example weekly refuse collection, had been protected while the back office had been transformed through initiatives such as Shared Services. There had also been more than 80 restructures across the Council.

The latest financial settlement meant that further cuts would be required in the coming years although this was in line with projections for this period. Specifically, £6.5 million of funding would be lost in 2014/15 with a further £9.8 million lost in 2015/16. This would of course be challenging but the Council had been very robust in meeting savings targets. The Council should also be proud of there not having been a rise in Council Tax over the last five years.

It was felt that the funding cuts in 2014/15 could be covered in Havering without major service cuts or tax increases. Work was currently underway on the next financial strategy from 2015/16. This was estimating a potential budget gap of around £60 million which would be a challenge for the new Council.

The Government austerity programme would continue until at least 2017/18 and a further Comprehensive Spending Review was expected. Government policy to ensure an average 1% annual increase in public sector pay also impacted on the Council.

The introduction of local level business rates had not generated any additional income for the Council as the Council was only allowed to keep 30% of this revenue. A proposal to pool business rates with some neighbouring Councils would however allow the minimisation of risk. The leader also felt the use of the Council pension fund to invest in the local infrastructure could be explored further.

There was a 10% shortfall from the Government on Council Tax benefits although it was thought that a revision of the Council Tax base in Havering should deliver more money. A new homes bonus of £2.4 million for 2014/15 would allow some one-off investments such as that in Harrow Lodge Park.

There had been a rise in NHS funding to support social care but this was pooled with the Clinical Commissioning Groups (CCGs). New legislation affecting education and care for people under 25 years and the care of elderly people would also have a financial impact. This was also the case with the rise in numbers of properties and pupils in Havering and the rising numbers of very elderly people would lead to a heavy demand on social care services.

In conclusion, the Leader emphasised that the Council wished to protect front line services and this was in line with the Living Ambition strategy. Efficiencies had been made in all areas of the Council, for example the partnership with London Borough of Newham. Further savings would however be needed and it would be necessary to ask which Council services did not need to continue in their current form and which could be delivered in a better way in order to keep the budget under control.

Having received the presentation from the Leader of the Council, the Overview and Scrutiny Committees noted:

1. The financial position of the Council.
2. That the report was formally consulting them on the proposed Corporate budget adjustments and that this was the opportunity to scrutinise the budget proposals.

Answers to questions raised by Members on specific items of the budget are shown in the appendix to the minutes.

Chairman

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APPENDIX: JOINT MEETING OF OVERVIEW AND SCRUTINY COMMITTEES, 23 JANUARY 2014, ANSWERS TO MEMBER QUESTIONS ON THE COUNCIL'S FINANCIAL STRATEGY

Questions were asked by Members on the areas shown below and answers were given by officers or Cabinet Members as follows:

1. Amount of business rates levy able to be retained – The forecast for business rates did expect a growth in the pool from the Thurrock area although this did assume that the proposed port in Thurrock went ahead.

2. Details of the Council's response to the Business Rates appeal process – This could be made available to Group Leaders.

3. Robustness of estimate for rise in Council Tax base – For the first time a material rise in the Havering Council Tax base had been seen and officers were looking at the impact of this. This would lead to a rise in demand for Council services but it was difficult at this stage to forecast the precise impact.

4. Pooled Business Rates – This system allowed each Council in the pool to reduce what they paid into Central Government. Officers would produce a briefing note on this for Members.

5. Number of grant announcements still awaited – Most grant announcements had now been received and a full table would be included within the February Cabinet report. There were now fewer grants received than in previous years.

6. Increase in overall level of risk – There was a risk from changes to the means of funding e.g. the local collection of Business Rates. It was also difficult to manage in-year issues. Efforts were however ongoing to manage and mitigate risk within the budget. All Councils were struggling with the risk of grants potentially being replaced by funding that would have to be bid for. This was a challenge for Councils throughout the country. It was also noted that the risk referred to in paragraph 3.7 of the Cabinet report related only to the current programme of savings.

7. Overspend on the Special Educational Needs (SEN) budget – This was due to an overspend on transport costs but had been offset by other savings being delivered early. This would be a pressure again next year and the transport costs were currently undergoing a full review in order to ascertain if efficiency can be improved.

8. Customer Services budget variance – The on-line portal that would allow staff savings to be made had only gone live in December rather than August 2013 due to IT problems. Restructures had now started that would lead to savings in the longer term. It was recommended that Members should use the portal to report issues such as flytips in their ward.

9. Emergency Assistance Scheme – A proposal had been put to the Corporate Management Team to carry forward any underspend to the overall emergency funding budget for next year.

10. Proposed investment in the borough by the Council pension fund – It was intended to put a sum of additional money into the pension fund in order to avoid having to increase future annual contributions by the Council. This investment would allow the pension fund to invest in Havering by e.g. buying property. This was common practice in many other pension schemes and safeguards would be in place and professional advice taken. It was important to maximise the return from the pension fund and a similar model involving a number of local Councils had funded the successful Salford Quays development near Manchester.

11. Distribution of anticipated funding gap – It was expected that the majority of the funding pressures would take place in the first two years of the next four-year cycle. This included expected reductions in Government funding and local pressures.

12. Expected value of reserves – The Council's general reserve currently stood at £11.5 million. The figure for all earmarked reserves was £48 million.

13. Details of revised arrangements for social care funding – This was the first year of Better Care funding under the current arrangements. Governance arrangements were similar for 2014/15 but funding now had to be agreed by the Health and Wellbeing Board and by NHS England. Overall funding had risen as this now included the CCG budget but more services also now had to be provided. Arrangements would become more complicated in year two as issues such as delayed discharges and seven-day working in health and social care would have to be addressed. Negotiations would be needed with the CCG on these areas and a two-year plan had to be finalised by April 2013.

14. Impact of Children and Families Bill – Officers were continuing to work through the Bill and its implications. Financial modelling was in progress and it was wished for people to stay local although would be able to receive a personal budget that they could spend anywhere. An overview and scrutiny

topic group was currently looking at this area. It was not yet possible to say however what the demand for these services would be. The cost of potentially proving education for children with special educational needs up to the age of 25 was also being worked on.

15. Member allowances – A saving of two Cabinet posts had already been agreed in the budget although this depended on Members' views after the Council election.

16. Parking income – There was in the current year a projected shortfall of approximately £400,000 across all parking budgets. Central Government was currently consulting on Council parking policies and this and this could introduce measures such as the removal of CCTV cars and a grace period on tickets. Economic factors had meant there was now less use made of car parks and seasonal factors such as wintry weather also negatively affected income.

17. Building control – Officers felt there was not enough external work to bid for to meet the quite high income targets for building control. Some staff would however still be required to discharge the Council's statutory building control functions.

18. Remand framework – The costs of children on remand had now been passed from the criminal justice system to Councils with only a small grant to cover this. The Council had spent some £557,000 on this so far this year and the Council had no control over how quickly cases reached court.

19. Housing Benefit and Council Tax support grant – This grant had been reduced across London and this funding needed to be replaced by the Council.

20. Electoral Registration – More resources were needed to cover the required Individual Electoral Registration process that was due to start in June 2014.

21. Utilities price increase – This was mainly due to inflation in electricity prices.

22. Phase 2 primary expansion – The grant allocation covered both 2014/15 and 2015/16. Although there may be a need to spend some in advance of the grant receipt this would be managed as part of the Council's cash flow and would not impact on the wider Capital programme or delay delivery.

23. Estimated school maintenance grant – Details of schools grants had been compiled for the February Cabinet report but officers would confirm the exact grant figure by e-mail.

24. Transfer of public health – It was confirmed that this was now a function of the Council led by the Director of Public Health.

25. Production of budget - The Chairman and several other Members thanked Councillor Ramsey, the Chief Executive and Council officers for their hard work in producing the budget.

MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY COMMITTEE
Havering Town Hall
6 February 2014 (7.00 - 9.25 pm)

Present:

Councillors Pam Light (Chairman), Nic Dodin (Vice-Chair), Ray Morgon, Ted Eden, Wendy Brice-Thompson and Frederick Thompson (substituting for Councillor Peter Gardner).

Apologies for absence were received from Councillor Peter Gardner.

Councillors Paul McGeary and Lynden Thorpe were also present.

Ian Buckmaster, Healthwatch Havering was also present.

Officers present:
Joy Hollister – Group Director, Children, Adults and Housing
Mark Ansell – Acting Director of Public Health

NHS England – Rylla Baker, Deputy Head, Primary Care Commissioning and Lorna Hutchinson, Senior Commissioning Manager
Havering Clinical Commissioning Group – Alan Steward, Chief Operating Officer
Hurley Group/Harold Wood Walk-in Centre – Sue Shepherd, Centre Manager, Mabli Jones, Director of Operations and Organisational Development, Dr Eugene Lewis, Walk-in Centre GP

37 **MINUTES**

The minutes of the meeting of the Committee held on 12 December 2013 were agreed as a correct record and signed by the Chairman.

38 **CHAIRMAN'S UPDATE**

The Chairman confirmed that the Joint Committee had concluded that the proposed changes to cancer and cardiac services did not warrant formal consultation. The Committee's views had been given in a letter to the North East London Commissioning Support Unit which had been circulated to all Members.

The Children's Health topic group had recently met to scrutinise the introduction of personal health budgets and would be meeting again later in February to consider the provisioning work on the contract for Child and Adolescent Mental Health services.

Several Members were due to undertake a site visit with other Members of the Joint Committee to Moorfields to scrutinise the reasons for hospital's planned move of location.

The patient discharge topic group would be meeting next on 4 March.

39 UPDATE ON HEALTH AND WELLBEING STRATEGY 2012-14

Under the Council Continuous Improvement Model, the Council's Health and Wellbeing Strategy was due for review by the Committee at this point. The Group Director – Children, Adults and Housing explained that the Health and Wellbeing Board, chaired by the Leader of the Council, was quite a different model for Havering as it gave voting rights to officers as well as Members.

The strategy featured eight priority areas based on the Joint Strategic Needs Assessment and overall themes included prevention, integration of care via pooled budgets etc and improving the quality of the patient or service user experience. The Health and Wellbeing Board received an update on a different theme at each meeting.

A lot of work under the strategy was undertaken with NHS bodies such as the Clinical Commissioning Group (CCG) and North East London NHS Foundation Trust (NELFT). Work was also undertaken with the Council's Housing Services and with the third sector such as the 'Help not Hospital' project.

There had been a number of successes under the strategy such as the development of Community Treatment Teams which were multi-disciplinary teams supported by assistive technology such as telehealth which for example allowed a GP to monitor a patient's oxygen levels remotely.

Another success had been the introduction of the Integrated Case Management Team which was also multi-disciplinary and dealt with people with the highest risk of hospital admission. A Joint Assessment and Discharge Team was also about to be launched in Queen's Hospital that would apply across Barking & Dagenham and Redbridge as well as Havering.

There had been considerable success with dementia services but officers accepted that a lot more needed to be done. Waiting times at memory clinics had reduced and work was ongoing with clinicians to ensure innovative treatments etc were employed for dementia. A Health and Wellbeing Board sub-group was taking forward work on dementia with providers and commissioners. A lot of work was also taking place on obesity which was an increasingly important issue both locally and nationally. More work was also being carried out to increase the early detection of cancer.

Officers confirmed that Havering had a low rate of delayed transfer of care but it was important not to compromise quality. Complaints about hospital discharge were considered by the Adult Safeguarding Board. The Group Director at the Council also met with the Director of Nursing at BHRUT to look at serious case alerts. It was accepted that some problems with discharge remained but the overall situation was improving. The CCG Chief Operating Officer also held quarterly meetings with BHRUT to discuss patient discharge issues. Liaison also took place with the PALS service, Healthwatch, GPs and Councillors.

The CCG was discussing with NHS England the reasons for late discharge of cancer locally and it was important that there were sufficient services available if awareness of the possible signs of early cancer was to be raised. A further proposal was to base MacMillan cancer nurses in some GP practices. Pancreatic cancer was suggested as an issue that would benefit from an awareness raising campaign although officers explained that the symptoms of this type of cancer were not clear cut. Diet, alcohol intake and smoking were all factors in pancreatic cancer.

A reported case of a six month delay in a patient receiving cancer treatment should not have taken place as officers confirmed that there were specific standards for treatment of this kind such as a two-week pathway.

Work on improving communication between GPs and the new Joint Assessment and Discharge Team was continuing and the Health and Wellbeing Board would shortly be asked to approve measures to produce a greater integration of IT systems between the Council and the NHS. The CCG would also continue to pursue improved IT integration with BHRUT. Data protection was an issue in IT work but the Government was addressing this. Further details of the specific case would be supplied to the CCG Chief Operating Officer in order that he could investigate further.

Further details of work in all these areas were contained in the Health and Wellbeing Strategy which was available on the Council's website. It was also planned to use existing staff (both Council and those of partner organisations) in new ways of working with an emphasis on being more locality-based. The overall lead on this work at the Council was the Leader of the Council - Councillor Steven Kelly.

The Committee **NOTED** the update.

40 HAROLD WOOD WALK-IN CLINIC

The CCG Chief Operating Officer explained that the contract for the walk-in centre (formerly polyclinic) covered the walk-in service, wound care and phlebotomy. The contract had started with the former Havering Primary Care Trust but some parts of the contract including for the walk-in centre were now with the CCG. The primary care part of the contract was held by NHS England. Responsibility for the contract could not be changed until the contract expired in December 2015.

Wound care such as stitches removal could be provided at the walk-in centre or at some GP surgeries. Officers accepted that this was confusing for people and so wished to develop a cluster model to ensure treatment closer to people's homes.

The clinic was open 8 am to 8 pm seven days a week and 52% of Havering patients attended during the morning. Officers explained that patients presenting in the evening would be redirected if it was felt that they could not complete their treatment by 8 pm. Of 2,620 patients seen at the walk-in clinic after 6 pm in the last two weeks, only 90 had been redirected elsewhere. A decision to redirect would always be made a clinical member of staff.

It was confirmed that there was a doctor on duty for walk-in patients throughout the centre's opening hours i.e. from 8 am to 8 pm. Most patients presenting with injuries would however be seen by a Nurse Practitioner while those presenting with illnesses would be seen by a GP. This was because Nurse Practitioners were A&E trained although an A&E GP also worked at the walk-in clinic for five sessions a week. The Nurse Practitioners at the walk-in clinic were also able to prescribe.

There was a defined waiting area for the GP practice and the rest of the waiting area was allocated to the walk-in centre. If patients needed a referral for tests etc they would, after being examined, be referred back to their own GP for this. Patients presenting in a serious condition would be stabilised as far as possible (an IV drip could be inserted if needed) and then referred to A&E if necessary. There were agreed pathways between the walk-in clinic and Queen's Hospital A&E. It was accepted that the Harold Wood centre saw more patients needing to go to A&E than other walk-in clinics elsewhere.

Officers accepted that reported cases of walk-in centre staff refusing to remove stitches should not have taken place. It was thought this may be related to difficulties in people obtaining GP appointments. This service was available at the clinic and such reports could be followed up. The CCG would also look at the clarity of information re stitches removal that was given to patients at Queen's Hospital. Post-op clinics (booked by appointment) were run at the walk-in clinic by nurses.

A representative of the Patient Participation Group for the walk-in centre felt that the centre offered a very good service. Officers confirmed that the waiting time at the walk-in clinic was normally two hours and at 6.30 pm that evening there had been 22 patients waiting to be seen. Children or people presenting with urgent conditions would always be seen even if they arrived a few minutes before the closing time. The CCG was also looking at extending urgent care generally in Havering next year with for example some GPs opening later at night. It was also noted that the Patient Participation Group would shortly allow patients to submit comments on the walk-in centre via e-mail.

Officers agreed to implement a suggestion that the name of the doctor and nurse on duty be put on a display board at the walk-in centre entrance. The CCG Chief Operating Officer would bring to a future meeting of the Committee the outcome of work on why patients presented at the centre as more ill compared to other similar walk-in centres. It was accepted that there were issues around access to GPs and this had led to a bid for funding from the Challenge Fund. Members felt that services should be made more widely known to the public. The 'Don't Go To A&E' campaign had been effective but this had led to an increase in people attending the walk-in clinic.

The Committee **NOTED** the update and **AGREED** to arrange a visit to the walk-in centre.

41 UPDATE ON PLANS FOR ST GEORGE'S HOSPITAL

The CCG Chief Operating Officer explained that the CCG had a number of priorities including moving services from hospital into the community, improving urgent services and primary care and ensuring better integrated working with the Council. The population of Havering was increasing in age and there were also many new communities arriving in the borough.

The above factors had led to a wish to introduce a new, innovative development on the St George's Hospital site. This could include services such as a GP-led primary care centre, assessment and diagnostics, planned and unplanned care for older people as well as flexible working space.

The proposed primary care facility could bring existing GPs together and offer extended hours with greater access. Four local GP practices had expressed an interest in moving onto the St George's size which, if this took place, would give a practice size of at least 10,000 patients.

The Outline Business Case for the project had not been finalised as yet and the CCG would work with local people on the plans. The expansion of community treatment teams also needed to be taken into account in the St George's plans.

The decision making process had now changed and the CCG had to submit a case for change to NHS England. It was also clarified that the CCG did not own the St George's site as ownership had been transferred to NHS Property Services. The current annual maintenance costs for St George's were approximately £500,000 per year.

The new development would use around 15% of the St George's site and be located at the front of the site with good access. There had already been engagement with the Havering Health and Wellbeing Board, Over-50s

forum etc and further engagement would follow once approval had been granted for the next stage of the project. The CCG would receive a final decision on their submission from NHS England but timescales would need to be confirmed.

It was hoped to submit the CCG documents to NHS England in February and to get feedback from NHS England on the proposals by early summer. The preferred option for the site had not been decided on at this stage. The Chief Operating Officer confirmed that there would not be a polyclinic-style facility on the site. It was also not definite that there would be any beds in the new development but the CCG would like some integrated care beds to be put on the site.

Members emphasised that local residents had asked for more specific information on what would be on the site but the Chief Operating Officer responded that it was essential to demonstrate a need for and value for money of any services put on the St George's site. Beds on the site were likely to be very short stay for older people requiring monitoring or stabilisation. It was also possible that there may be some urgent care on the site for example the Out of Hours service.

Members felt that they needed a more strategic overview of the CCG's plans for health services in Havering as a whole. It was therefore **AGREED** that the CCG should explain its overall future strategy at the Committee's next meeting.

Mapping of current health facilities was mainly held by NHS Property Services although the CCG would have to cover this in the outline business case for St George's. NHS Property passed the cost of any empty health service buildings in Havering onto the CCG. The Chief Operating Officer accepted that parts of some buildings were unused although this was less common in Havering than it was in Barking & Dagenham or Redbridge.

It was uncertain at this stage if rehabilitation beds, currently located outside the borough, would return to Havering. It was possible that services of this kind may be better located outside the Havering area.

NHS Property Services would decide on how building work could be funded and this could potentially include a Private Finance Initiative. There had however been no decision on this as yet.

The Committee **NOTED** the update.

42 MINUTES OF HEALTH AND WELLBEING BOARD

The Committee felt that the minutes were quite minimal but did give the main points discussed by the Health and Wellbeing Board. There were no specific issues raised.

The Committee **NOTED** the minutes.

43 URGENT BUSINESS

A representative of NHS England briefed the Committee on proposals to close a GP surgery in Branfill Road, Upminster. The surgery was staffed by only one GP who had expressed a wish to retire from full-time work and whose current contract expired in June 2014.

The surgery's list was relatively small at around 1,700 patients which meant it may not be viable to procure a new contract. Patients could be encouraged to register with other local GPs of which there were a number in the nearby area. The surgery's list size was decreasing and it could only offer four hours of nursing per week.

The surgery's current GP was proposing to work part-time for another local practice so patients would have the option of continuing to see their existing doctor if they wished. The surgery premises were also not considered fit for purpose.

For all the reasons outlined above, NHS England felt that the surgery should be closed and patients registered with other local practices. The CCG Chief Operating Officer confirmed that the CCG supported the proposals as there were a lot of other practices in the local area.

It was anticipated that there would be more such cluster models in the future, particularly as cluster models of GPs became more prevalent. The NHS England officers confirmed that there were currently seven applications in progress from Havering GPs who wished to move premises. It was important for GPs to work together and GPs should not purchase premises until the move had been approved by NHS England.

Given the situation as explained by the NHS England and CCG officers, and in view of the large number of alternative surgeries in the local area, the Committee **AGREED** to support the closure proposal.

It was **AGREED** to ask NELFT officers to attend the next meeting to give an update on the position with their new site in London Road and to invite BHRUT to attend to give a general update on issues at Queen's Hospital, with particular emphasis on the proposed extension of the Urgent Care Centre at the hospital.

Chairman

MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD

Commitee Room 2 - Town Hall
8 January 2014 (1.30 pm – 3.30 pm)

Present

Cllr Steven Kelly (Chairman) Cabinet Member, Individuals, LBH
Dr Atul Aggarwal, Chair, Havering CCG
Conor Burke, Chief Officer, Havering CCG
Anne-Marie Dean, Chair, Health Watch
Joy Hollister, Group Director, Social Care and Learning, LBH
Cllr Paul Rochford, Cabinet Member, Children & Learning, LBH
Dr Gurdev Saini, Board Member, Havering CCG
Alan Steward, Chief Operating Officer (non-voting), Havering CCG
John Atherton, NHS England
Cllr Andrew Curtin, Cabinet Member, Culture, Town and Communities, LBH

In Attendance

Mary Pattinson, Head of Learning and Achievement, LBH
Elaine Greenway, Consultant in Public Health (Acting), LBH
John Green, Transformation Programme Manager, LBH
Louise Dibsdall, Senior Public Health Strategist, Public Health, LBH
Lorraine Hunter, Committee Officer, LBH (Minutes)

Apologies

Cheryl Coppell, Chief Executive, LBH
Dr Mary.E. Black, Director of Public Health, LBH
Councillor Lesley Kelly, Cabinet Member, Housing & Public Protection, LBH

83 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman announced details of the arrangements in the event of a fire or other event that would require evacuation of the meeting room.

84 **APOLOGIES FOR ABSENCE**

Apologies were received and noted.

85 DISCLOSURE OF PECUNIARY INTERESTS

None disclosed.

86 BHRUT - CQC INSPECTION AND SPECIAL MEASURES REPORTS

The Board held a discussion on the recent implementation of special measures at Queen's Hospital following the CQC Report.

Member representatives from BHRUT stated that there had been nothing in the report that they were not aware of. It was a government decision to put BHRUT into special measures which at the time were not clearly defined and that this was the first occasion for BHRUT under the new regime. The appointment of a National Hospital Inspector has deemed the organisation as performing poorly based on inspections over the years. It was to be hoped that this was now an opportunity for the organisation to transform. Following the Trust Development Agency review of the organisation's leadership and governance, Ian Carruthers, formerly Chief Executive of the South West Health Authority, had been appointed to review leadership arrangements. The Board had previously expressed their concerns about governance. The CCGs were due to be interviewed the following week and that Local Authorities were also invited. On a positive note, the implementation of initiatives through the Urgent Care Board and Integrated Care were making progress and it was important that these continue so as to build on the good work done thus far.

The Board agreed to await the outcome of the leadership review by Ian Carruthers when there should be an opportunity for the Health and Wellbeing Board to respond.

87 SAFEGUARDING UPDATE

Members of the Board received an update on Safeguarding issues within the borough.

Brian Boxall, the new Chair of the LSCB was also chairing the Adults Safeguarding Board.

Additional resources had been allocated by BHRUT following several issues around Learning Disability clients receiving treatment. There had also been some concerns around the lack of engagement with GPs, however, there was now a GP representative sitting on the Havering Learning Disability Board.

Child deaths in the borough were small in number and no significant trends had been identified.

The NSCPP were launching the Underwear Campaign on 13 January 2014 raising awareness on child sexual abuse aimed at both children and parents.

The LSCB would be discussing the issues around self-harm within ethnic communities at their next meeting following referrals from certain wards in the borough. There was currently on-going dialogue with the Black and Minority Ethnic (BME) Forum and that the Chairman of the LSCB would receive an update in due course.

88 **INTERIM REPORT ON CHILDHOOD OBESITY**

The Board received a presentation from Elaine Greenway on Tackling Obesity in Havering.

In 2006/2007 Obesity cost the NHS £5.1 billion per year in comparison to £3.3 billion caused by disease associated with smoking. In comparison to other countries, the UK was on a similar gradient to that in the US. The health risks posed to obese Adults and Children are listed as follows:

Adults

- risks to health: heart disease, stroke, Type 2 diabetes, some cancers
- associated with muscular skeletal and respiratory diseases
- social difficulties (e.g. isolation / mental health)
- employment (employability, sickness absence)
- implications for social care (housing adaptations, specialist carers)
- associated with socio-economic status

Children:

- risks to health, including Type 2 diabetes
- can lead to stigmatisation, bullying, low self-esteem and
- exclusion from social interaction
- associated with socio-economic status

It was noted that during 2006-2008, Adult obesity in Havering was 27.3%, Children at Reception class was 11.2% but this figure doubled to 19.9% by the time children reached Year 6.

Obesity is not just a medical problem but a complex issue influenced by many associated factors such as:

- Physiology (genetic predisposition, resting metabolic rate)
- Individual physical activity (recreation, occupational activity, domestic activity)
- The environment (school sport, transport policy planning)
- Social psychology (education, media, peer pressure)
- Individual psychology (self-esteem, body image, stress)
- Food production (food labelling, salt content, fat content)

- Food consumption

The Foresight Report of 2011 into obesity made the following recommendations:

Local leadership
Strong partnerships between Local Authority (public health, transport, licensing, planning, environment, regeneration, etc.) CCG, other professional groups, voluntary sector, and community

Address the obesogenic environment: the healthy choice is the easy choice:
- the built environment
- active travel and transport policy, review local schemes and enhancements from a pedestrian or cyclist perspective
- nutrition: standards / signposting to healthy food options

Support to individuals
- advice and signposting by health professionals (preventative and for weightless: physical activity, nutrition, behaviour change)
- weight management services

Training:
- Education and training programmes for healthcare and frontline professionals
- Health impact assessment

Havering had a number of assets in place to address the problem of obesity including:

- Leadership (Health and Wellbeing Board)
- Sports infrastructure (parks / facilities / public and private gyms)
- Physical activity strategy
- Schools support for healthy lifestyles (e.g. Schools Sports Partnership, free breakfasts)
- Voluntary sector (Havering Sports Council, Havering Circle)
- School meals and Meals on Wheels
- Healthy walks & Havering Active
- Active travel: walk to school programme / cycling
- Love food / hate waste

- Library services (on-line resources / newsletters / volunteers)
- Primary care (GPs (Health Checks) / pharmacists)
- School nurses, health visitors, midwives
- Data: National Child Measurement Programme & Active People
- Breastfeeding friendly environment

Havering would require a joined up long term commitment to tackle the obesogenic environment. It was recommended that an action plan be put in place over the next eight weeks to give support to settings and individuals that can influence children's health and weight including pre-conception, maternity, early years, school nurses and health visitors. In addition, to provide advice, signposting and support for adults via primary care, libraries, business, voluntary, community and faith sectors.

The Board agreed that obesity is a complex subject and requested that the presenter report back in two months following more research, in particular, into how other boroughs are addressing the issue.

89 **JSNA DEMOGRAPHICS CHAPTER**

Members of the Board agreed to defer this item to a later meeting.

90 **ASSISTED TECHNOLOGIES**

The Board received the report on Assisted Technologies presented by John Green and were asked to note the following:

Since 2011, significant work had been undertaken that has resulted in greater use of AT by adult social care clients, underpinned by improved operational efficiency in assessing, referring, providing, installing and monitoring equipment. The provision of Fair Access to Care Services (FACS) eligible AT now stood at nearly 1,500 individuals, predominantly pendants, with a further 2,500 or more FACS eligible clients under consideration to have AT as part of their care package.

To identify the benefits delivered by AT, two cohorts had been monitored over an extended period of time to provide an analysis of a number of key measures. The monitoring is to continue on a quarterly basis to further improve the robustness of the analysis reported. The cohorts are:

- Cohort A - ASC clients who receive AT and homecare (70 at outset)
- Cohort B - ASC clients who only receive homecare (407 at outset)

The three key benefits measures are:

- Benefits Measure 1: General impact on hospital admissions as indicated in ASC systems

- Benefits Measure 2: Reductions in admissions due to falls from health data
- Benefits Measure 3: Impact on admission to residential/nursing care from ASC data

Benefits measure 1

Cohort A, (AT and homecare) is less likely to be admitted to hospital than cohort B (homecare only) after a period of 18 months by a margin of 25.02%. This indicates that the application of AT will have a beneficial impact on reducing hospital admissions. To validate this there should be an actual impact on hospital admissions.

Benefits measure 2

Having used ASC data to evidence the apparent decline in hospital admissions health data relating to admissions due to falls has been analysed. This indicates that there is a correlation between the increased number of pendants in the community and a reduction in hospital admissions due to falls of 44% in 2013 compared to 2011 – which would convert to an estimated annual saving of £2.24M3 – or if attributing 50% of this to AT then £ 1.12M.

Benefits measure 3

Cohort A (AT and homecare) are less likely to be admitted into residential or nursing care by a margin of 5.9% than cohort B (homecare only). Cohort A also demonstrates that of those who are admitted there is significant delay in the elapsed time from when they start to receive services until admitted of at least 3 months but this is likely to be significantly longer. A delay of 3 months in the start of a typical residential care package costing £25,000 indicates a gross benefit of £6,250. However, the average cost of domiciliary care prior to admittance to residential care is £12,500 or £3,125 per quarter. The net saving is therefore £3,125 per person (£6,250 less £3,125). If these numbers are factored up, with approximate numbers entering residential care of 300 per year, the projected minimum annual saving would be £937,500.

In January 2013 a survey was conducted for recipients of AT and their carers. The survey asked a series of questions focused on general feelings of wellbeing and safety, levels of help and support and incidents of admission to hospital. Generally the responses were extremely positive from both carers and users. Other observations included:

- In regard to questions around feelings of well-being, 80% - 90% of users and carers agreed that people generally ‘feel better’ with the AT in place
- Between 50% and 60% of respondents agreed that AT prevents escalation to hospital or residential care
- There is a general similarity of response between users and carers

- In light of the more tangible benefits, the survey included indicating the sense of well-being imparted by the AT and the support service behind it. It provides some explanation, by explicit answers and by the implied 'feel good', why some of the benefits identified are being delivered.

The Health and Wellbeing Board noted and supported the benefits of AT and that Havering Adult Social Care and Havering CCG were working together in partnership to increase the use of AT and maximise benefit realisation. AT is currently funded through S256 funding and this is to be continued throughout 2013/14 and is committed for part of 2014/15.

91 **UPDATE ON SEN BILL**

The Board received the Havering Special Educational Needs Project Update presented by Mary Pattinson.

It was noted that the legislation was currently going through parliament and is due to become law next year. The report outlined the key measures, provided progress reports and highlighted any implications or issues. A SEND Project Team with representatives from across education, children's, adults, parents and health services had been set up. A project plan had been produced and working groups had been set up to cover all of the major changes. There was also a Parents Forum and an advocacy group working at gathering the views of children and young people.

It was important to ensure that Havering is well placed to implement the changes in time for September 2014. In addition, a number of Local Authorities across the country had received funding as pathfinders for the new approach. Havering was working with Bexley and Bromley who are London Pathfinder Champions. A major communications strategy was also being planned so as to avoid misinformation.

92 **REPORT ON JOINT ASSESSMENT AND DISCHARGE**

The Health and Wellbeing Board received the report on the revised proposals with regards to the Joint Assessment and Discharge Service (JAD). The new proposals had been discussed at the Integrated Care Coalition meeting on 14th October. While all partners signed up to the principle of a joint discharge team for patients with complex needs, London Borough of Redbridge was unable to join an integrated service covering BHRUT at this stage. The Integrated Care Coalition partners asked for an urgent redesign of the JAD proposal to take into account London Borough of Redbridge providing a separate hospital social work service for Redbridge residents who may need social care services at the point of discharge. Revised staffing structures and operating procedures have now been developed taking into account the reduced budget available and the need to ensure Redbridge residents are not disadvantaged. Board members were referred to Appendix 1 of the attached report.

The Board considered the revised proposals and agreed to support them. It was noted that a review on JAD resources would be presented to the Board in six months.

93 **ANY OTHER BUSINESS**

No other matters were raised.

94 **DATE OF NEXT MEETING**

Members of the Board were asked to note that the next meeting would take place on 29 January 2014 at 1.30 pm (Special Meeting). The next scheduled Health and Wellbeing Board meeting was on February 12 2014 at 1.30 pm.

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Chairman