MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD
Town Hall
10 December 2014 (1:30pm – 3:30pm)

Present

Cllr. Steven Kelly (Chairman)
Dr. Atul Aggarwal, Chair, Havering CCG
Cllr. Wendy Brice-Thompson, Cabinet Member for Health
Cheryl Coppell, Chief Executive, LBH
Cllr Meg Davis, Cabinet Member for Children and Learning
Anne-Marie Dean, Chair, Healthwatch
Joy Hollister, Group Director for Children, Adults and Housing, LBH
Alan Steward, Chief Operating Officer, Havering CCG

In Attendance

Phillipa Brent-Isherwood, Head of Business and Performance, LBH
Mary Pattinson, Head of Children's Services, LBH
Claire Still, Communications Officer, LBH
Andy Beesley, Committee Administration Manager, LBH (Minutes)

60 CHAIRMAN'S ANNOUNCEMENTS

The Chairman advised those present of the arrangements in case of fire or other event that may require the evacuation of the meeting room.

61 APOLOGIES FOR ABSENCE

Apologies for absence were received from Conor Burke, Dr Gurdav Saini and Mark Ansell.

62 DISCLOSURE OF PECUNIARY INTERESTS

No disclosures of pecuniary interest were made.

63 MINUTES

The minutes of meeting held on 12 November 2014 were agreed as a correct record and signed by the Chairman.

64 MATTERS ARISING

From the previous minutes (12 November 2014), the matters arising were:

Local Safeguarding report – it was agreed that the Chairman would write to the Metropolitan Police to raise concerns regarding the level of resources directed towards child safeguarding.

Child Sex Exploitation Peer Review – the findings of the Peer Review would be presented at a future meeting of the Board.

Meetings with NELFT – it was commented that there should be more frequent meetings with NELFT which would build upon the annual meeting. A themed discussion was suggested as a means of encouraging such an arrangement.

65 BHRUT SYSTEM PLANNING UPDATE

Cheryl Coppell gave a presentation which provided the Board with an overview of the current BHRUT health economy.

The overriding message was that BHRUT was making positive strides forward. A new team at BHR had been implementing plans for productivity improvements with a focus on ensuring that such plans were consistent, complimentary, measured and performance managed across the system and that financial targets were reconciled.

The presentation identified specific pressures in the system. Whilst improvements had brought in additional monies (£87.4) this also brought additional burdens. For instance, it was critical that some of the short term initiatives in the winter resilience programme did not impact upon more long term plans which BHRUT was operating.

Similarly, there was a significant pressure in the system based on demand, with acute pressure experienced in A&E attendance rates which were up 4.4% from the previous year. This was however within commissioned activity levels which allowed a 4% rise for demography. In addition, more work would be required to reduce the average length of stay in hospital despite BHR having one of the best DTOC performances in London.

Leadership and clinical resources were also identified as a current pressure. BHRUT had only recently fully recruited its leadership team and as such it would require time before it became fully functional. The Trust was also experiencing a shortage in A&E consultants. And finally, citizen satisfaction remained low across the system despite high satisfaction in the new care in the community initiatives.

There were however significant opportunities across the system, these included:

- A strong high level buy-in of local system leaders
- A new management team at BHRUT which had identified real productivity and management issues and increased communication with stakeholders

- Non-recurrent funding approved to test initiatives
- All Better Care Fund plans had been approved in the second highest category
- An opportunity to accelerate and prioritise demand management activity in order to tackle the financial deficit

Moving forward, a number of key recommendations were made. Critically, BHRUT delivery needed to be focused around one overarching programme plan. This would enable individual initiatives to be linked together to focus on whole system demand, dependencies to be understood, resources prioritised and the planned source of efficiency and transformational savings made much clearer and transparent.

In addition, clinical ownership of change needed to be strengthened as delivery intensified with the attraction of a mass of clinicians central to this. Also, there needed to be continued strengthening of the relationships between primary, secondary and community care clinicians.

Such key recommendations had been encapsulated into a 5 year delivery strategy. This would enable the reprioritisation of resources, the reconfiguration of services and the commissioning / decommissioning of services to ensure that overall objectives were met.

In the short term, it was explained that the focus was on reviewing critical areas for system delivery through plan alignment. It was suggested that this could be best delivered through a series of strategic workshops.

Mrs Coppell was thanked for delivering a useful and informative presentation.

66 INTEGRATED PERSONAL COMMISSIONING

Dr Atul Aggarwal provided the Board with a presentation on a new NHS initiative concerning complex care and integrated personal budgets. 'Health 1000 – complex primary care practice' was a new model of primary care focussed on active population health management. One capitated budget would provide total care for patients who must have 4 diagnosed long term conditions.

It was explained that the initiative would provide 100 complex care patients (from Health 1000) with the ability to commission their own care through Personal Health Budgets. Bids had been submitted to the national panel with a decision expected on 16 December.

Dr Aggarwal commented that there was a need to better manage the small cohort of patients who had high levels of demand. Achieving the balance between managing that level of demand alongside low demand patients was critical in ensuring that patients received the appropriate level of care.

In addition, voluntary and third sector organisations had been commissioned locally to support personalised care planning, advocacy and service ‘brokerage’ for individuals enrolled in the programme. Age UK would be the local provider.

Dr Aggarwal emphasised that the programme was in its pilot stage and that there would be issues to learn along the way. Board members were supportive of the initiative and agreed that it was important for patients to have power over their own care. There were however some concerns about how personal budgets would be managed and utilised and how the wider care needs of the patient’s family would be considered.

Dr Aggarwal agreed to report back to the Board meeting in March 2015.

67 PRIORITIES FOR CHILDRENS HEALTH

Joy Hollister provided the Board with a presentation on the work undertaken by the Children’s Trust on the priorities for Children’s Health.

It was explained that the Children and Young People’s Plan (CYPP) was the overarching strategic plan for all services that directly support children and young people in Havering. It provided the framework within which services to children and their families would be planned, commissioned and delivered to tackle some of the causal aspects of inequality in outcomes for children.

The Children’s Trust was responsible for overseeing the Plan and used it as a tool to support and challenge services in fulfilling Havering’s vision for local children.

Board Members were informed that the Plan was based on evidence taken from past performance, needs assessments, consultation with local families and agreed priorities between service users and partners.

Significant progress and improvement had been made since the establishment of the Children’s Trust; in safeguarding, in educational attainment and in the wider achievements of children and their communities.

The Plan identified 3 key strategic priorities:

- Increase the rate of children who live in poverty-free households
- Increase the proportion of children at a healthy weight
- Improve the health, wellbeing and education outcomes for the most vulnerable children

It was explained that the Children’s Trust Board had four main sub groups, charged with developing the delivery plan associated with each priority and reporting progress to the Children’s Trust Board.

The Child Poverty Executive oversaw the reduction in the rate of children who live in poverty-free households, while the SEND project group and Children's Improvement Board deliver the actions relating to improving the health, education and well-being of vulnerable children.

Board Members were informed that the priority of increasing the rate of children at a healthy weight was overseen by the Obesity Strategy Group.

The CYPP Action Plan set out the overarching activities for delivery for each of the priorities and provided the framework for monitoring success alongside timescales.

Following a question from a Board Member, Joy Hollister accepted that the Children's Trust needed to have a more strategic joined-up approach with the Health and Wellbeing Board and was confident that would be achieved with the newly appointed Chair of the Children's Trust Board and other changes in membership.

Mrs Hollister was thanked for providing a useful and informative presentation.

68 SEN GOVERNANCE

The first of two reports to the Board detailed the arrangements for Joint Commissioning between Havering Clinical Commissioning and the London Borough of Havering for children, young people and their families with SEN and disabilities (0-25).

By way of background it was explained that Clause 26 of the Children and Families Act 2014 required local authorities and CCGs to commission services for special education, health and social care for children and young adults from 0-25 with SEND jointly. This includes putting dispute resolution procedures in place for when agreement cannot be reached. The new duties were in conjunction with The Health and Social Care Act 2012 which requires Health and Wellbeing Boards to develop Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies both of which support prevention, identification, assessment and early intervention and a joined up approach from those providing services.

It was explained that whilst it would take some time to achieve a highly effective system it was important that the principles of an excellent service were agreed from the outset. The proposed principles were:

- All decisions are based on a clear rationale for improving outcomes and are linked to organisational and partnership priorities
- Commissioning should make sure that we get the most out of every pound we spend
- Commissioning should always focus on delivering efficiencies, outcomes and quality

- Commissioning should always focus on evidence based practice
- All services are systematically commissioned
- Commissioners should make sure that outcomes are sustainable in the long term
- Children, young people, their families and communities must participate meaningfully
- Commissioners plan strategically to move resources to preventative and early intervention services
- Commissioning function exercisers independent of decision making from internal and external providers
- Commission in partnership with other commissioning bodies locally or regionally, so as to maximise efficiency
- Commissioners must ensure that approaches are compatible with EU and UK law, regulations and guidance
- Decisions must be transparent and fair
- Our commissioning approach should not disadvantage small or medium sized enterprises in Havering
- There should be only one strategic commissioning plan for all SEND services
- Community involvement in delivering local services will be encouraged

Commissioning for outcomes – All contracts will include:

- Outcome-based performance targets so as to ensure the delivery of services that focus on outcomes
- A cycle of monitoring so that performance can be measured
- Quality standards that can be monitored so as to ensure the overall quality of provision. This will include consumer feedback

The report also set out the activities which would form the joint commissioning cycle. It was noted that a Joint Health & Local Authority Commissioning Working Group had been meeting since the autumn of 2013. It was proposed that the Joint Commissioning Working Group become the formal sub group for the Joint Health & Local Authority Commissioning Working Group.

It was noted that a commissioning report would be produced annually and submitted to the Joint Commissioning Board for approval before being submitted to the Health and Wellbeing Board.

In addition, it was explained that the Act required arrangements for dispute resolution where agreement cannot be reached between the local authority and CCG over the provision of services. It was anticipated that the sub group would reach agreement in most instances. In exceptional case the Chair of the Joint Commissioning Board would have power to resolve such matters.

The detailed arrangements would come into effect from September 2014. Arrangements for joint commissioning would be included on the Local Offer website once approved by the Health and Wellbeing Board.

HWBB agreed the protocol and procedures as set out in the report.

The second report detailed the annual submission by the Joint Commissioning Group which was referred to in the previous report.

It was noted that the Joint Commissioning Group had met on seven occasions since October 2013 and had reviewed the commissioning of:

- Therapy services
- Short breaks/respite care
- CAMHS

It was also noted that the CCG and Local Authority had been working towards identifying the joint commissioning priorities for both services in the coming years. This would result in more clearly defined roles and responsibilities between the two, less duplication of service delivery and funding and a seamless service user experience for those who engage with the service.

It was also mentioned in the report that further joint commissioning priority areas for coming years would include:

- Respite care and short breaks
- Equipment
- Reviewing therapy services including Occupational health and physiotherapy

The Board noted the report.

69 **CHIEF EXECUTIVES REPORT CONTAINING EXEMPT INFORMATION**

The Board received a verbal update from Joy Hollister on progress with the development of the Dementia Strategy.

The Board agreed the recommendations as set out in the report which are available in an exempt appendix to the minutes.

70 **UPDATES**

DoH underfunding

It was reported that the funding allocation from the DoH was to increase with officers entering into negotiations to establish the amount to be received. Members of the Board remarked that the increased funding was welcome news and congratulated Cheryl Coppell on her efforts to secure the additional funding.

District Nurses

An update on this matter would be presented to the January meeting when the business case will have been prepared.

Better Care Act

The Board noted that preparations were well underway with particular attention focussed on ensuring that the correct governance arrangements were in place. The Board was reminded of the enormity of the challenge the Local Authority faced with the the Care Act and the risks associated with it.

71 ANY OTHER BUSINESS

Increased GP opening hours

The Chair requested that a report be presented to the January meeting on the recent announcement by the Government that GP services would operate 7 days a week with additional emergency appointments made available to patients. Comments made by the Chair and supported by some Board Members suggested that the success of the new arrangements was mixed with particular criticism attached to the publicity, or lack of it.

72 DATE OF NEXT MEETING

It was noted that the next meeting of the Board would take place on 14 January 2015.

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Chairman