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HEALTH & WELLBEING BOARD

AGENDA

Wednesday 9 April 2014
1.30 – 3.30 pm

Committee Room 2 Town Hall

1. CHAIRMAN'S ANNOUNCEMENTS

   The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

2. APOLOGIES FOR ABSENCE

   (If any) – receive

3. DISCLOSURE OF PECUNIARY INTERESTS

   Members are invited to disclose any pecuniary interest in any of the items on the agenda at this point of the meeting.

   Members may still disclose any pecuniary interest in any item at any time prior to the consideration of the matter.

4. MINUTES (Pages 1 - 6)

   To approve as a correct record the minutes of the Board meeting held on 19 March 2014 and to authorise the Chairman to sign them.

5. MATTERS ARISING

   To consider any matters arising from the minutes.

6. HEALTHWATCH ANNUAL REPORT 2013-2014 (Pages 7 - 22)

   To receive the Healthwatch Annual Report.

   Presented by Anne-Marie Dean.

7. BETTER CARE FUND FINAL SUBMISSION

Verbal Update – for noting.

Alan Steward.

8. HAVERING RESPONSE AND IMPLEMENTATION OF FRANCIS REPORT RECOMMENDATIONS

Report to follow if available.

Presented by Alan Steward and Barbara Nicholls.

9. VIOLENCE AGAINST WOMEN

Report to follow if available.

Presented by Joy Hollister.

10. ANY OTHER BUSINESS

11. DATE OF NEXT MEETING

Members of the Board are asked to note that the next Health and Wellbeing Board Meeting will be held on Wednesday May 7 2014 at 1.30 pm.

MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD
Committee Room 2 - Town Hall
19 March 2014 (1.30 pm – 3.30 pm)

Present:

Cllr Steven Kelly (Chairman) Cabinet Member, Individuals, LBH
Dr Atul Aggarwal, Chair, Havering CCG
Mark Ansell, Consultant in Public Health, LBH
John Atherton, NHS England
Conor Burke, Chief Officer, Havering CCG
Cheryl Coppell, Chief Executive, LBH
Cllr Andrew Curtin, Cabinet Member, Culture, Town and Communities, LBH
Anne-Marie Dean, Chair, Health Watch
Cynthia Griffin, Group Director, Culture, Community & Economic Development, LBH
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

In Attendance

Lorraine Hunter, Committee Officer, LBH (Minutes)
Pippa Brent-Usherwood, LBH
Sarah Thomas, LBH

Apologies

Councillor Lesley Kelly, Cabinet Member, Housing & Public Protection, LBH

104. 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.

105 APOLOGIES FOR ABSENCE

Apologies were received and noted.

106 DISCLOSURE OF PECUNIARY INTERESTS

None disclosed.

107 MINUTES

The Board considered and agreed the minutes of the meetings held on 12 February 2014 and authorised the Chairman to sign them.

The Board considered and agreed the amended minutes of the meeting held on 11 December 2013 and authorised the Chairman to sign them.

108 MATTERS ARISING

None.

109 JOINT ASSESSMENT AND DISCHARGE TEAM

The Health and Wellbeing Board considered the progress report on the Joint Assessment and Discharge (JAD) team and were asked to note the following:

- The Service Manager had been appointed and had begun working with the staff teams around the operational model, including end to end assessment processes.
- Work was underway to draft the S75 agreement that would formalise the governance arrangements, including budgets, staffing and delegated authorities, to the host organisation – London Borough of Barking & Dagenham.
- Staff consultation was planned to begin from the end of March 2014 to run for 30 days and meetings were underway with unions.
- The Joint Assessment and Discharge Service (JAD) would consist of around 50 health and social care staff, with a staff budget of c. £2m.

The Service would be arranged into Ward Groups within Queen's Hospital and 1 Ward Group in King George's. Each Ward Group would consist of a Manager and 7 or 8 JAD workers, who would work with the wards' multi-disciplinary teams (doctors, nurses and therapists) on a 7 day working model. The JAD would be the single point of contact for all referrals of people who may require health and/or social care support on discharge. As previously agreed, the JAD would not deal with referrals of people who may require specialist rehabilitation services.

The development and implementation of the JAD was supervised by the Integrated Care Coalition and the Urgent Care Board. There were regular Executive Steering Group meetings with senior representation from each participating organisation with the London Borough of Barking and Dagenham as the 'host' organisation. It had been agreed that the Steering Group would become the "governing body" for the service.

The JAD proposals needed to unify with BHRUT improvement plans currently being drafted, to ensure complementary alignment and acknowledging the significance of specialist measures and the requirements they may bring.

The service required a dedicated operational policy which was also under development. Key headings and structure were now being tested against staffing and organisational requirements.

The target date for commencement was June 2014.

110 UPDATE ON CARE BILL

The Board received a presentation on the changes to the Care Bill which had been described as the most fundamental changes for a decade. The bill was due to have its final hearing in the house and should have Royal Assent by April 2014. The focus of the bill was very much around people's well-being being at the heart of very decision that is made. It was also proposed to put carers on the same footing as those that they care for. There would be a new focus on preventing and delaying need for care and support rather than intervening at crisis point and Personal budgets would be put on a legislative footing for the first time which people would be able to receive as direct payments if they wish. In short the bill would:

- reform the funding system for care and support, by introducing a cap on the care costs that people will incur in their lifetime.
  ensure that people do not have to sell their homes in their lifetime to pay for residential care, by providing for a new universal deferred payments scheme;
- provides for a single national threshold for eligibility to care and support;
- gives new guarantees to ensure continuity of care when people move between areas, to remove the fear that people will be left without the care they need;
- includes new protections to ensure that no one goes without care if their providers fail, regardless of who pays for their care;
- has new provisions to ensure that young adults are not left without care and support during their transition to the adult care and support system.

A major programme of work was underway to produce the regulations and statutory guidance. Draft regulations and guidance for 2015/16 would be published for public consultation in May 2014 with the final publication of regulations and guidance in October 2014.

The main direct financial implications were:

- The upper capital threshold for means-tested support will rise to £118,000 (currently £23,250) from 2016/17.
- A cap will be set at £72,000 for the maximum contribution anyone will make to adult social care.
- People in residential care will pay a contribution of around £12,000 yearly towards general living expenses – 'hotel costs'.
- There will be a zero cap for people who turn 18 with eligible care and support needs.

- A national minimum eligibility threshold will be introduced. This is likely to be substantial – however substantial, it will be more far reaching than at present.
- A requirement to provide, review and update an 'independent personal budget' for people who have eligible care needs but do not meet financial criteria.
- This notional budget will allow the individual to progress towards the care cap. It will be based on the amount that the local authority would pay for care – not the amount the self-funder might choose to pay.
- Introduces the 'Care Account' – to be managed by LA – and transferrable if the person moves.
- Care Account will include all care and support received – including services received in their own home
- Spending on care & support will be 'metered' by LA to a maximum of the cap - £72,000
- To start the 'meter' – individual must first be assessed by the LA.
- The 'deferred payments' scheme, whereby the cost of care is offset by the future sale of the client's home, will be cost neutral to local authorities and therefore interest and administrative fees will be allowed.
- Where a client receives care outside the home borough, the second borough will be required to take the original care and support plan into account and to provide a written explanation if it differs.
- The duty to prevent, delay or reduce the need for care and support will apply to both carers and people with care needs.

The Board noted the changes and the implications for Havering.

111 BETTER CARE FUND

Members of the Board were advised that the draft document had been submitted to NHS England. Work would continue on the document prior to final submission on April 4 2014.

The Chief Executive who attended the Department of Health Local Government Steering Group advised that the Department of Health viewed this initiative with much interest, however, it would be necessary to make clear in the risk assessment that there were significant risks involved due to the local hospital currently being placed in special measures.

The Board member from NHS England advised that that the submission from Havering was very strong and would be happy to provide more feedback.

The Board agreed that the final submission of the Better Care Fund application being signed by the Chairman prior to April 4 2014.

112 HAVERING, BARKING & DAGENHAM, REDBRIDGE CLINICAL COMMISSIONING GROUP 5 YEAR STRATEGIC PLAN

The Board noted the Draft 5 Year Strategy Plan for BHRUT CCG and approved the plan in its current form for submission to NHS England. The

final draft would be submitted in June 2014. It was noted that a number of proposals lacked finer detail, however, a more robust plan would be available before June 2014.

The representative from NHS England was asked to enquire who the designated signatory was for the document.

113 TROUBLED FAMILIES

The Troubled Families programme was aimed at turning around the lives of 120,000 troubled families in England by 2015. Local authorities were tasked with identifying and working with an agreed number of families on a payment by results basis.

As of March 2014, the agreed figure for Havering of 415 households had been identified and that the figure now exceeded 500. The programme was approaching the end of a three year period and the Board was asked to note the following measures implemented by the Troubled Families team and partner agencies in dealing with complex families:

- Better coordination, collection and use of data especially social care, education, and crime data in order to develop long-term strategies and provide earlier help for vulnerable people.
- Establishing closer links with Homes and Housing, especially as there has been an increase in housing related issues relating to welfare reforms;
- Embedding Whole Family assessments in order to encourage supporting agencies to focus on the needs of the whole household;
- Focussing on Troubled Families in order to develop bespoke thinking that will make real changes for families and the services they receive; and
- Evaluating what services are working and identifying effective practice in order to highlight inefficiencies and the duplication of work.
- Co-locating school nurses with Early Help;
- Embed Troubled Families work and Payment by Results within services to ensure business as usual.

The aim of the Programme is to identify and then address the key factors that cause families to escalate into complex, high cost, high need ones. The national criteria as set down by the Department for Communities and Local Government had been created to tackle key themes which included;

- Crime & Anti-Social Behaviour (including being the victim of domestic violence)
- Education
- Being in receipt of work related benefits

Local authorities were allowed to include their own criteria to reflect local needs. For Havering, these included domestic abuse, substance misuse,

suffering mental health problems, having debts, being a single parent and housing issues.

Havering had received in excess of £160,000 from the Department of Communities and Local Government for the successful turnaround of families in Havering. This money was being passed on directly to those agencies that have evidenced that they have worked with a family to "help turn them around".

The Board were advised that the programme was being extended for a further five years and that a new phase with different criteria was being developed. Central Government wanted to look at school attendance and exclusion, however, Havering did not operate an exclusion policy and would have to request special dispensation from the government.

Members of the Board were reassured that troubled families not deemed relevant to the new criteria would still be identified. Officers advised that this depended on the family concerned, however, there were a number of professionals such as school nurses, community midwives who could link up and identify such families.

The Board noted the report.

114 ANY OTHER BUSINESS

(i) As part of the Dementia strategy, the Board were advised of discussions with NELFT and Barking & Dagenham regarding the provision of facilities for people with dementia. A paper was in preparation which had yet to be agreed by the CCG and NELFT and would be brought to the Board at a later date.

(ii) The Board would receive a draft plan on tackling obesity at a later meeting.

(iii) The Chairman requested that future reports provide more specified information with measurable indicators and timescales.

(iv) The Acting Director of Public Health would look into plans for a campaign on MMR immunisation.

115 DATE OF NEXT MEETING

Members of the Board were asked to note that the next meeting would be held on April 9 2014.

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CHAIRMAN

Report to the Health and Wellbeing Board on the development and progress of Healthwatch Havering in its first year 2013/2014

Contents

Executive Summary

1) Background
2) The key priorities for 2014/15
3) What we aim to achieve
4) How we work
5) Our governance
6) How Enter and View is used
7) About our programmes of work which enable us to understand what people need
8) About our team

Appendix 1 Example of the Action plan for Hospital Services team

Appendix 2 demonstrates the network of organisations which we work with

Executive summary

This paper sets out our role, the way we work and the progress which has been achieved in the first year of Healthwatch Havering.

As Healthwatch is a new national concept, to help provide a good understanding of the role, the sections on **'What we aim to achieve'** and **'About how we work'**, uses direct aims and objectives from Healthwatch England. This report then flows down these aims and ways of working and translates them into our local practice and provides examples of our work.

Our overall approach is to develop programmes which provide us with a good network, building up a detailed picture of the service, and gaining a clear understanding of what is important to the users and their families and to share our findings.

We are strongly committed to working jointly across the Borough to share information and to work as part of the whole system that enables good commissioning and provision of health and care for the people of Havering. We use our powers of Enter and View carefully, recognising that the best and most productive relationships are nurtured and mature over time.

The strength of our work is entirely based in the strength of our volunteer team. They lead and set the priorities and objectives for each work stream. The volunteers base this on their personal knowledge, the experiences that people and organisations share with us and the national and local agenda.

In our first year we have undertaken 6 public events,

- 1 in conjunction with the CCG on intermediate care teams
- 5 cross Borough events 'Have your Say with Healthwatch Havering' on Learning Disabilities and Dementia

The outcomes from these are shared with everyone who attended, our colleagues in health and social care and on our website.

In our first year we have been supported and well received by all our health and social care colleagues and this has considerably helped us to become established and able to undertake our role

1) Background

Healthwatch Havering is part of Healthwatch England whose Chairman is a member of the CQC Board. The Health and Social Care Act formalises the relationship between Healthwatch England, the Secretary of State, NHS England, Care Quality Commission, Monitor and English local authorities.

We are the local independent consumer champion for health and care. This means we always start with people. We understand what people need and lobby for change on behalf of consumers.

2) The key Priorities for 2014/2015

We have identified 6 key priorities for 2014/15 these reflect areas where we have been alerted to concerns, there are changes in service provision, will support overall health and wellbeing of people.

- End of Life Care
- Frail and Elderly Care within the Emergency department
- Access to Primary Care
- Access to Health checks and immunisation
- Continue the programme of Care Home visits
- To identify a project working with Young People

3) What we aim to achieve

Our job is to champion the needs of children, young people and adults. We know that if we can make things better for the most vulnerable in our communities, we will all benefit.

Our work covers health and care and by covering both health and care this allows us to see how providers interact with each other and where their system fails to join up different aspects of an individual's care.

Understanding what matters most to our local people, especially those least included, by always starting with their needs and rights.

- *An example of this would be helping a parent get access to an annual health check for their child with learning disabilities*

We are ambitious - our role is to say where change is most needed. But we are realistic and provide solutions that improve services for consumers.

- *An example of this would be following an Enter and View visit a recommendation to the CCG for the prioritisation of a local care home to receive dedicated GP practice. Another visit resulted in the employment of an additional Activity Co-Ordinator*

4) How we Work

We say where change is most needed. Sometimes we give advice formally, using our powers to raise issues of concern or where we feel we are not getting an adequate response.

Often, we work together with partners to influence their thinking at an early stage and to help them get the design of services right from the start.

- *An example of this would be the joint work with the Borough on key areas to support the challenges and opportunities for Special Needs and Disabilities groups particularly children and young people*

We draw together people's experiences of health and care, expertise from the voluntary sector to establish a local picture of what works and what doesn't.

- *An example of this would be our report to the CQC prior to the inspection of BHRT*

We value knowledge and we seek out data and intelligence to challenge assumptions with facts.

- *An example of this would be the use of the London Ambulance Blue Light data and the CQC data which helped us to prioritise the visits to nursing and care homes; so we could understand the reasons the homes had requested the emergency service*

We keep the debate positive and we get things done.

- *An example of this would be the planned visit to a local GP practice to discuss with them the number of complaints and concerns that we have received about access. We have undertaken a 'mystery shopper' exercise and aim to get a better understanding of the practices problems and if possible offer help to improve the position for patients.*

We work in partnership with the public, health and care sector, voluntary and community sector.

- *An example of this would be the 5 open forum events we held on 'Dementia and Learning Disabilities' over a two week period in February/March. Inviting local people and organisations to join us to 'Have your Say with Healthwatch Havering' so that we can all **'hear each other and learn together'***

We learn from specialists and experts', building on what is already known, not going over old ground

- *An example of this would be our Lead on Learning Disabilities intends to shadow social care services in Learning Disabilities in order to learn how the system works. He also meets with groups such as People First, meets their members and is learning how to communicate effectively in order to better understand their needs.*

We celebrate and share good practice in health and care

- *An example of this would be the opportunity we had to be part of the audit in the Emergency Department at Queens, which was commissioned by the Urgent Care Boar. This identified genuine deficiencies in the health system for frail and elderly people. This work is now leading the development of a new approach to care for frail and elderly people in our community*

5) Our Governance

Board Accountability

Healthwatch Havering was formed in April 2013 and by June we had set out the arrangements for

- The role and membership of Healthwatch Havering
- Management structures for the boards
- The role of Lead/Active/Support Members
- Annual General Meeting
- Committees

We formally published our governance structure and arrangements at our public launch in August 2013. As a Board we agreed that we would review the appropriateness and relevance of the structure in January 2014, and in conjunction with our volunteer members this has been amended to reflect how the organisation has developed and responded to the challenges and opportunities

There is an open and transparent structure for making decisions which enables our volunteer members to influence and determine work prioritisation.

- *An example of this would be the Lead Volunteer Member in Social Care determines and recommends to the board the prioritisation of Enter and View visits.*

We meet monthly as a board and we formally report and discuss our financial accounts and how we have used the funds with our volunteer members. Members of the public are welcome to attend our meetings.

We work hard to be open and transparent

- publish our reports on our website
- the joint public consultation with the CCG is published on the website and a copy of the report is shared with every attendee
- recent evidence collected at public forums such as 'Have Your Say with Healthwatch Havering' will be published and on our website shortly

Our Staff and Volunteer Handbook contain the Nolan principles for standards in public life these shape and support the way we work

People Accountability

Our people are our greatest asset, without their dedication and commitment to wanting to make a difference within their local community it would not be possible to achieve change in services on behalf of individuals and the community.

All Lead and Active Members have a dedicated training programme which provides them with a set of competencies that enable us to be able to deliver our statutory role. A handbook for volunteers has also been developed specifically to support these roles.

All members have the following training before they work on behalf of Healthwatch

- *DBS check*
- *Level 1 Safeguarding Children and Adults*
- *Enter and View*
- *Deprivation of Liberty (DOLS)*
- *Mental Health Awareness training*
- *Dementia awareness, plans to have further in depth dementia awareness training to support visiting of care/residential home*

A training fund is established within our budget and all members are encouraged to identify additional training or events that will enhance their role and experience

6) How Enter and View is used

The legal powers of Healthwatch Havering

The legislation states that anyone who commissions or provides publicly-funded health and social care services has a duty to help Healthwatch to involve local people in the commissioning, provision and scrutiny of those services by allowing Healthwatch to:

- Obtain patient views about their experiences of, and perceived need for, local services
- Make written recommendations on the standard of provision, including whether and how services could or ought to be improved.

The providers of health and social care services should:

- Allow the authorised representatives of Healthwatch to enter and view any services or premises that are providing publicly-funded care
- They are required to provide information about any publicly-funded services or premises when requested by Healthwatch

We take our responsibilities in respect of Enter and View very seriously.

The board approves every individual Enter and View visit. Where there is to be an unannounced visit two Directors review the proposal and planned visits require one Director to approve them.

- All Enter and View visit requests must identify 3 reasons why the visit is deemed necessary
- A work plan which includes the names of the visiting team must be prepared
- A planning meeting prior to the Enter and View is undertaken
- On completion of the visit a de-brief is undertaken immediately and serious concerns are notified to the nominated director and where appropriate to the responsible statutory agency
- A draft report is prepared and issued to the home within 10 working days for comment; the home is allowed to make changes of factual accuracy.
- The final report is shared with the home, the appropriate statutory agencies, and is placed on our website. It is formally reported at the next board meeting.

7) About our programmes of work which enable us to understand what people need

We have been developing dedicated programmes of work, these are demonstrated below and Appendix 1 gives the example of the Hospital Teams Action Plan.

These enable us to get a comprehensive understanding of

- Ways in which we can jointly measure and define good care,
- The rights of people and how these are supported

- The challenges and opportunities within the health and care environment
- Joint approach to collecting and sharing information and overall provision

We manage the process by

- Set Priorities for six months ahead;
- Reviewed on a monthly basis with the executive team and adjusted to accommodate any new issues or concerns e.g. feedback from public forums
- Progress is reported at our monthly meetings
- Evidence and information is shared with our partners usually at formal meetings
- Where appropriate immediate contact is made to ensure urgent concerns are shared and known.

➢ **Social Care Work stream**

Developing networks across the Borough

- Monthly Borough Safeguarding Meeting since January 2014
- Monthly Borough Quality Assurance Team meeting since January 2014
- Regular meetings with Care Home Providers commenced in August 2013
- Quarterly meetings with local CQC team

Enter and View programme for Care Homes

- Number of homes visited from December to March 2014 = 5
- Number planned for April 2014 to September 2014 = 15 (5 every two months)

Extending this role 2014/15

- Discuss and develop locally the CQC's work on 'End of Life' care
- More extensive training on Dementia
- Establish a better understanding of 'Domiciliary Care'

➢ **Hospital Services Work stream**

Developing networks across the Borough

- Meetings with the Deputy Director of Nursing at Queen's hospital
- Member of St. Francis Hospice board
- Member of the team attends Queen's board meetings as an observer
- Key high profile meetings - CQC, Coroner Reports
- Attendance at JOSC on Acute Service reconfiguration in respect of Cardiac and Cancer services

Enter and View programme for Hospital Services

- Visits to Queens will commence once the Trust has published its proposals to respond to the 'Special Measures' position
- St. George's Maternity Services visit in early April

Extending this Role for 2014/2015

- Care of the Frail and Elderly in the Emergency Department
- Discharge processes once the new joint Borough arrangements have been in place for 6 months
- Alcohol and Drug recovery programme
- End of Life Pathway
- Review of the waiting times for Chemotherapy services

➢ **Learning Disabilities Work stream (**this role began in February 2014**)**

Developing Networks across the Borough

- Member of the Learning Disability Health Pathway Group at BHRUT
- Member of the Learning Disability Partnership board
- Member of the Children with Disabilities and Special needs forum

Enter and View programme for Learning Disability services

- Planned visits will commence in Autumn 2014
- There will be joint visits undertaken between the Learning Disabilities team and the Social Care team, with a particular emphasis on Dementia

Extending this role in 2014/2015

- To 'shadow' the key members of the Boroughs Learning Disabilities team
- To visit as many providers/users and organisations as possible to enable us to map the provision
- Determine the level of provision and consultation with users, carers and families by and with NELFT
- Investigate issues which are raised by people about the health and social care provision e.g. the provision of yearly health checks

➢ **Primary Care Work stream (**this role begins in April 2014**)**

Developing Networks across the Borough

- To liaise with the PERF (CCG)
- A member of the North East London Quality Surveillance Group
- A member of Over 50's Forum

Enter and View programme for Primary Care

- Planned Enter and View visits will commence in Autumn 2014
- These visits could be combined with the Hospital team where appropriate

Extending this role for 2014/2015

- To explore and assess the 'Access' provision to primary care
- To seek advice and support from Public Health and NHS England on the provision of health checks/screening
- To look at the provision of diagnostic services within the community

8) About our team

We are a private company with a board which consists of a Chairman, Company Secretary, Director and General Manager. Between these four individuals there is board and operational management experience in health, local government, independent contractors to the NHS and the voluntary sector. This team is fully involved in the day to day running of Healthwatch and actively works with all of our partners across health and social care.

The team of volunteers have a very diverse background, senior community midwife, director of commissioning; police detective inspector, senior manager of care homes, educational assistants, works manager, councillor, benefits advisor, nursing, media design, psychotherapist and many more.

Each volunteer brings a wealth of knowledge and experience which they share to support both each other and the people of Havering.

All our team is trained to the same standard. This enables the Lead Volunteers to identify some very unique skills to support the individual work plans and provides every volunteer with an opportunity to be part of any team.

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Healthwatch Havering - Hospital Team Action Log

No	Work Programme	Lead	Comments	Status
1	Cancer Services		As there have been no other complaints to HH about the waiting times apart from BW. This has been decided to put it on hold until September 2014.	**On Hold Until September 2014**
2	End Of Life Care	**Emma**	To liaise with Pam Court, Chief Exec of St Francis Hospice and contact the CCG about how the programme is developing.	Ongoing
3	Accident & Emergency	**Terry**	As Queen's is under special measures, it was felt that an E&V visit would not add any value.	**On Hold until September 2014**
4	Patient Discharge	**Diane M**	Diane to compare the reports from the LINk patient discharge report and the protocol from BHRUT	**Ongoing**
5	Planned Care	**Emma**	Decided to examine this later in the year. To see how the Community Treatment Team has embedded.	**On hold until September 2014**
6	Marie De-Jesus RIP	**Debbie**	After the meeting with BHRUT and HH and recommendations made. This matter is now closed.	**Closed**
7	Cancer Services Centralisation	**Ian Buckmaster**	Ian to report back	**Ongoing**
8	BHRUT Action Plan	**Debbie**	To put on hold until the new CE of BHRUT has been embedded.	**On hold until September 2014**
9	BHRUT Service Reconfiguration	**John/Terry**	On hold for the reason above	**On Hold until September 2014**
10	Alcohol and Drug recovery	**Terry/Joan**	Visit planned to the team 1 April 2014	**Ongoing**
11	Enter and View to maternity	**Debbie**	Visit to take place in the near future	**Ongoing**
12	Enter and View to elderly wards at BHRUT	**Debbie**	To be examined in June, reasons to be given to	**Onging**

			HH Board before	
13	Phlebotomy	**Joan**	Joan to contact CCG asking why only one person on duty	**Ongoing**
14	Westland Avenue Clinic	**Terry**	Terry had enquired if the NHS had contacts there. It was decided that this is not a line of enquiry for HH	**Closed**

Appendix 2 Working in partnership

Statutory meetings

Health & Wellbeing Board
Urgent Care Board for Barking & Dagenham, Havering and Redbridge

Overview & Scrutiny Committees

Health
Individuals
Children's Services
North East London Joint Health Overview & Scrutiny Committee

Across Borough Meetings

Authority Meetings

Social care team attend

- Havering Adults Safeguarding Board
- Quality Assurance Team

Learning Disabilities team attend

- Children with Disabilities and Special Needs Strategy Group
- Winterbourne Steering Group
- Learning Disability Partnership Board
- Positive Parents

Other Organisations

- **St Francis Hospice Clinical Governance Group**
- **CQC**
- **Over 50's Forum**
- **Providers Forum**
- **MIND**
- **Havco**
- **Havering CCG CVS Forum**
- **PERF (CCG)**
- **HUBB**
- **Children with Disabilities and special needs group**

Pan-London Meetings

- **NHS England (London) Quality Surveillance Group**
- **North East London Quality Surveillance Group**
- **CQC Dementia Advisory Group (a national body)**
- **HW Local Peers meetings /Local Government Association (LGA)**
- **UCLP Development of the Frail and Elderly work**
- **Healthwatch Network meetings with north east London**