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