MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD
Committee Room 2 - Town Hall
7 May 2014 (1.30 pm - 3.45 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, BHR CCGs
Cheryl Coppell, Chief Executive, LBH
Anne-Marie Dean, Chair, Health Watch
Cynthia Griffin, Group Director, Culture, Community and Economic Development
Alan Steward, Chief Operating Officer (non-voting), Havering CCG

In Attendance

Dr Maurice Sanomi, Havering CCG
Phillipa Brent-Isherwood, Head of Business and Performance, LBH
Barbara Nicholls, Head of Adult Social Care, LBH
Lorraine Hunter, Committee Officer, LBH (Minutes)

Apologies

Cllr Andrew Curtin, Cabinet Member, Culture, Town and Communities, LBH
Joy Hollister, Group Director, Social Care and Learning, LBH
Councillor Lesley Kelly, Cabinet Member, Housing & Public Protection, LBH
Cllr Paul Rochford, Cabinet Member, Children & Learning, LBH
Dr Gurdev Saini, Board Member, Havering CCG

34 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.

35 APOLOGIES FOR ABSENCE

Apologies were received and noted.

36 DISCLOSURE OF PECUNIARY INTERESTS

None disclosed.

37 MINUTES

The Board considered and agreed the minutes of the meeting held on 19 March 2014 and authorised the Chairman to sign them.

The Board considered and agreed the minutes of the meeting held on 9 April 2014 and authorised the Chairman to sign them.

38 MATTERS ARISING

The Joint Assessment Discharge project is due to go live on 1 June 2014, in the meantime, staff consultations are proceeding.

It was noted that the regulations on the Care Bill would be available at the end of the month.

A letter from NHS England providing feedback on the Better Care Fund had been received by the Health and Wellbeing Board. The Board member representing NHS England advised that there had been some national anxiety regarding the political inferences and that more work was required by NHS England, however, Havering was one of six successful boroughs in bidding for funds.

The Board were informed that Havering was the best performing borough in London and 13th nationally in turning around "Troubled Families." The Chairman suggested that Havering should offer to conduct borough pilots for other schemes.

The Chairman commented that officials at NHS England appeared to be less than timely in approving GP surgery buildings and cited a practice in Rainham as an example. It was agreed that the NHS England Board member would investigate and requested that the Chairman forward all relevant data on the site.

39 CHALLENGE FUND UPDATE

The Board were advised that the tri-borough bid for government funds paid from the Prime Minister's Challenge Fund had been successful, and the Chief Officer of BHRUT CCGs thanked all those on the Health and Wellbeing Board and at NHS England for their support. The allocation of funds at £5.6m was one of the largest in the UK which would be used to improve Primary Care in the borough. A number of plans were currently being looked into jointly with NHS England colleagues and it was agreed that a report would be made available to the Board at the July meeting.

40 INDEPENDENT CARE COALITION UPDATE

The Board received a presentation from the Chief Executive Officer of Havering who also chairs the Independent Care Coalition (ICC).

The Independent Care Coalition was originally formed because of issues around the local hospitals. The ICC brought together key partners within Outer North East London to develop improvement programmes across health and social care. Since the establishment of the ICC, NHS (London) had asked that a number of partnership tasks be undertaken and these had been added to the original role of the ICC so as to prevent a range of difference partnership groups operating in a unco-ordinated manner. The Urgent Care Board (UCB) acted as a sub group of the ICC. The ICC was not a decision making body and all decisions on contracts or spending were enacted through the relevant governance structures such as Health and Wellbeing Boards, Clinical Commissioning Group (CCG) Boards and Provider Trust Boards.

The original programme, agreed by the ICC was to improve community capacity in order to prevent avoidable presentations at Accident and Emergency and hospital admissions. Due to the high incidence of frailty, including older people presenting at A&E, the community responses were targeted at this group. In order to reduce unnecessary hospital admissions, a range of services were piloted and these have now been mainstreamed as part of the CCG contractual arrangements and the Better Care Fund. These are as follows:

a) Integrated Case Management (ICM)

The Havering Integrated Care (IC) Team comprise of a GP, Community Matron, District Nurse, Social Care Lead and Care Liaison Officer and deliver appropriate care to patients in the community so as to reduce avoidable hospital admissions. In addition, they also deliver a high quality service for high risk patients. There are six clusters across Havering with a Community Matron and Integrated Care Liaison Officer allocated to each.

Quarter 4 data identified that Havering was on target for caseloads with 2053 service users receiving support in 2013/14. Key Performance Indicators for 2014/15 would aim to facilitate improved performance in areas identified in the in-year diagnostic e.g. a greater focus on effective management of caseloads and throughput of the service.

b) Community Treatment Teams (CTT)

The CTT consists of doctors, nurses, occupational therapists, physiotherapists, social workers, and support workers. The CTT provide the following:

- Short term intensive care and support to people experiencing health and/or social care crisis to help them be cared for in their own home rather than be referred to hospital.
- Support for people to return home as soon as possible following an acute/community inpatient stay where this is required or appropriate.
- A single point of access to intensive rehabilitation at home or in a bed in a community rehabilitation unit if necessary.

- CTT runs in all three boroughs from 8am – 10pm, seven days a week which align with peak attendances in A&E and therefore should help to relieve the pressure on A&E.

Performance data for 2013/14 indicated a good performance in the Queens hub with 1576 referrals received of which 78% did not go on to be admitted to hospital. The community spoke was also rated green on performance against target, with 2707 referrals received; 94% of which were treated and maintained at home without the need for an acute admission.

c) Intensive Rehabilitation Service (IRS)

The team consists of nurses, occupational therapy staff, physiotherapy staff and rehabilitation assistants with access to a geriatrician as required via the Community Treatment Team. It aims to provide an alternative to admitting patients to an inpatient unit for rehabilitation by supporting people in their own homes where it is appropriate to do so. The in-home support provided is intensive and involves between one and four home visits each day, depending on the patient's needs. The service operates from 8am – 8pm, seven days a week.

Trial of the new intensive rehabilitation service went live from November 2013 allowing people to be rehabilitated at home rather than in a non-acute bed. Performance data for 2013/14 showed that Havering received 159 referrals against a target of 69. Patient satisfaction was good and continues to be monitored monthly.

Nursing Home Scheme

Baseline conveyances by London Ambulance Services (LAS) from nursing homes was 320 in the first quarter. In the second quarter, this reduced to 294 and 317 in for the third quarter.

In order to prevent unnecessary conveyances to hospital from nursing homes, 31 homes in Havering have signed up to the scheme.

Intermediate Care (CTT/IRS)

A paper detailing progress and performance of the trials of these programmes and recommendation as to next steps following the trial period was submitted to CCG Governing Bodies in January 2014. All 3 CCGs agreed the continuation of the trial of CTT/IRS 2014/15 with a view to:

- A review of the model in one year following further evidence
- finalising the proposed model of intermediate care in partnership with the local authority, and;
- consulting on any significant service changes for 2015/16.

A nomination for the HSJ value in healthcare awards regarding the new model of intermediate care has been submitted by NELFT and the CCGs.

Community Health and Social Care Service (CHSCS)

Community Health and Social Care Teams development to progress in 2 stages:

1. NELFT are to reconfigure identified services (community nursing, ICM, Therapies, MH link worker) into locality based teams. In Havering, the first stage of CHSCS went live on 28 April 2014.

2. Plans to consider integration of partners outside of NELFT e.g. Social care and others. In Havering, proposals are currently being discussed re: piloting better integration between community (CHSCS) and secondary care via an MDT approach for those particularly complex patients that ICM are finding difficult to manage within the average 8 weeks. The pilot is due to go live in one cluster in May.

Non Acute beds

2013/14 data identified that referral to transfer rates continued to meet 72 hour targets (22 hours on average). Some additional 'winter pressure beds' opened during the first week of January 2014 and closed in early April 2014. The number of beds required to manage demand in this period was significantly less than in previous years and was also less in number than predicted which may have been due to winter capacity modelling.

A&E Attendances and LAS conveyances to BHRUT

Latest information shows that there were reductions in A&E attendances within BHRUT and that Local Ambulance Service conveyances to local hospitals in BHRUT were also showing a reduction. The Chief Executive tabled the following figures which depicted the impact of the ICC on the reduction of emergency, hospital admissions and care transfers.

BHR – Quarter 3 in13/14 compared to Quarter 3 in 12/13

A&E attendances – reduced by 6.59%
Non Elective Admissions - reduced by 14.35%
Delayed Transfers of Care – reduced by 25.5%

Havering – Quarter 3 in 13/14 compared to Quarter 3 in 12/13

A&E attendances – reduction in overall attendances by 12%
Non- Elective Admissions – reduced by 9%

End of Life Care

The Integrated Care Coalition have agreed that end of life care will be a priority. The Barking & Dagenham, Havering and Redbridge end of life

subgroup of the Integrated Care Coalition (ICC) have agreed five priority areas which are:

- GP end of life training
- Strengthen co-ordination of end of life services
- Case for investment in community nursing
- Consider the BHR approach to CMC
- Provide guidance on local applications following he recommendations from the national independent review of the Liverpool care pathway (LCP)

Havering end of life group has the following key actions:

- **BHRUT Improvement plan -** Contains actions to improve consistency of end of life care across sites and BHRUT wards and improve end of life training.
- **Dying matters week -** 12th to 18th May 2014. Havering CCG is working with St Francis Hospice, London Borough of Havering and other local organisations on this project aimed at raising public awareness of end of life issues.
- **Standardised DNR forms** - the group is working up a plan for introducing and implementing a fit for purpose 'do not attempt cardiopulmonary ressusitation' (DNARCPR) form. NELFT have a policy already for this.

The Frailty Academy has been set up to ensure that lessons from all of these initiatives are learned and developed with effective mainstream services. The Frailty Academy is a virtual academy comprising clinicians and other staff such as the Local Authorities, Social Care, nursing professionals and academics from University College London. There are currently 34 participants enrolled in the Academy from multi-professional and multi-agency backgrounds including LAS, NELFT, BHRUT, Age UK Redbridge, and Havering Care Association. The curriculum is well developed and a range of improvement and innovation materials have been designed across four phases of delivery: Understand, Co-create, Plan & Test, Adopt & Diffuse.

There are further projects planned including the setting up of a website to provide a starting point for discussions around frailty.

Resources

Confirming resources for the programme work remains a priority. Immediate needs for the project teams include administrative and analytical support, and communications support. It is proposed that the Programme Director is asked to scope requirements.

In linking to the rest of the system, it was noted that a manager has been appointed to the Joint Discharge team and staff consultation processes were continuing. The Re-commissioning of urgent care centres at the acute hospitals was underway. The BHRUT Improvement Plan was submitted

following special measures introduced at BHRUT hospitals. The new plan ties more directly into ICC work streams that demand management into and out of the acute trust and efficiency and improved clinical leadership inside the acute trusts.

The Chairman commented on the need to maintain discussions about the provision of future health services within the three boroughs particularly due to the increase in populations.

The Chief Executive advised that there was a lot more work to do over the coming two to three years, however, the five year plan for the local health and social economy would be available in June 2014.

The Chairman on behalf of the Board thanked the Chief Executive Officer for a most detailed and informative report.

41 DEMENTIA STRATEGY/DEMENTIA CENTRES

The Chairman welcomed Dr M. Sanomi, Clinical Director and Chairman of the Dementia Partnership Board who gave a presentation on the Havering Dementia strategy. The Board were asked to note the accompanying report including the draft document on the Joint Dementia Strategy for Havering 2014-2017 and the Dementia Strategy Toolkit.

Dementia remains a high national and local priority. Since the launch of the Government's National Dementia Strategy in 2009 (Living Well with Dementia: a National Dementia Strategy), numerous additional national policy guidelines and initiatives have followed, which included:

- Prime Minister's Challenge on Dementia
- The Mandate
- Joint Commissioning Framework: National Dementia Strategy
- Outcomes Frameworks for Public Health, Adult Social Care, and Health, all with specific reference to dementia
- Establishment of National Dementia Action Alliance
- The Care Bill
- Dementia: A state of the nation report on dementia care and support in England

Dementia and dementia care, therefore, is a key issue at a national level and would remain so, given the overall changing and ageing population. Within the National Dementia Strategy (DH, 2009), there is a requirement for all local areas to have a joint commissioning strategy for dementia. Despite the fact that the National Strategy ends in 2014, it is felt both important and timely to produce a joint strategy for Havering. It is vital that the public, stakeholders, commissioners and providers develop a shared vision of aspirations for the future with regard to dementia care and services.

Havering has one of the highest proportions of older people in London and it is estimated that 3,275 people aged over 65 years have dementia. This figure is

predicted to rise to 3,794 by 2020. Further work is required to fully understand the local level of need for people with early onset dementia (before the age of 65). Dementia in Primary Care aims to identify specific groups of people at higher risk of developing dementia including those with a learning disability, at an early stage.

Both key commissioning organisations, that is, Havering CCG and LBH, are committed to working together, with dementia identified as a key shared priority area by the Health and Wellbeing Board. New and emerging structures within both organisations will provide an added impetus and focus for co-ordinated commissioning in the future.

The local Dementia Partnership Board meets on a bi-monthly basis and is accountable to Havering's Health and Wellbeing Board. The Dementia Partnership Board brings together key commissioners across the health and social care economy. The Board will oversee and monitor the delivery of this strategy and implementation plan. The key highlights being:

- Setting out the vision and principles of dementia care
- Describing the current position, mapped against the locally agreed pathway
- Developing an integrated community based service model for Memory Services
- Work being undertaken with BHRUT to improve services within the hospital for people with dementia
- Mapping of total resource for dementia across the system, amounting to £14,673,914
- Supporting the Implementation Plan to be overseen and monitored by Dementia Partnership Board
- Prototype of Dementia Dashboard in development

Thus far, a number of actions had been completed included the development of the local Dementia Action Alliance (DAA) and the multi-agency Steering Group was in place and reporting to the Dementia Partnership Board. A review of the Dementia Advisory Service had also been completed with agreement to commission the service for a further three years and there was a revised service specification in place for the Memory Service. The Board were also asked to note that there had been an improvement in local dementia diagnosis rate from 39% to 46%.

A number of outstanding priorities remain and there is still much to be done in achieving the vision for dementia care and support in Havering such as:

- Further awareness raising across the community, via the vehicle of sign up to the Dementia Action Alliance, which is the favoured model for the development of 'dementia friendly' communities and is effective in reducing stigma.
- Developing a cohesive and whole system approach to the commissioning of dementia services via partnership working with health, public health and social care.

- Commissioning and providing a range of high quality services which are accessible, integrated and in line with local levels of need, both now and in the future. This will need to take full account of the predicted increases in levels of need and demand on services.
- Developing robust data and reporting systems for services across the dementia pathway, in order to fully understand the impact of the predicted increase in demand and its impact on services.
- Ensuring that the workforce is trained to develop and acquire appropriate competencies and skills in dementia care and end of life care.
- Providing access to high quality services in the community, including advice, information, housing support and leisure activities which enable people with dementia and their carers to live well.
- Ensuring that people have access to early intervention support and advice, as well as timely access to assessment and diagnosis, in line with the Government's aspiration for achieving a diagnosis rate of at least 66% for each local area by 2015.
- Co-production of service specifications and delivery with providers/ commissioners / service users.

The Board noted the contents of the presentation and accompanying reports. It was confirmed that hospital staff received training in dementia care, however, the Board wanted reassurance with regards to patients with dementia who were receiving specialised end of life care and what provisions were made for them and for staff training. It was therefore agreed that the Clinical Commission Group would provide an update on this particular aspect.

The Chairman thanked Dr Sanomi for his presentation and requested that a more detailed plan and update be provided at a later meeting.

42 INTEGRATED MASH AND DEVELOPMENT OF COMMUNITY MARAC FOR ADULTS

The Board received a presentation from the Head of Business and Performance on the integrated Multi Agency Safeguarding Hub (MASH) pilot and development of the Community Multi-Agency Risk Assessment Conferences for adults.

Following the development of the MASH scheme for children and young people in Havering, a pilot scheme to include the safeguarding of adults would be commencing on June 9 2014. Officers advised there were many benefits in utilising the MASH hub for adult safeguarding. The unit was secure, had strong protocols and there was the opportunity to share vital information with partners so as to make informed decisions.

The Children's and Young People MASH had been operating since 2012 which had resulted in fewer contacts actually becoming referrals to Children's Services. In addition, more referrals were becoming assessments and there had been a reduction in the duplication of reports to Children's Services. In addition, cases were also being referred to other services. The Police were currently receiving 20 alerts a week through the MASH hub.

In integrating children's and adults, there would be the benefit of managing demand and again the opportunity to share information. This would also prompt change in police alert (MERLIN) analysis as currently a third of the number of MERLIN alerts received weekly received no services. It was also important to note that many adult issues affected children such as domestic violence, parental substance misuse and adult mental health. A number of children's MERLINS had led to raised concerns about the adults within the same household.

The Board were advised that upon receipt of a referral, this would be triaged and rag rated on a risk basis. Red equated to immediate serious harm and action would be taken within four hours. Amber was not considered as immediate and action would be taken within one working day. Green stipulated that there were concerns about an individual but these were not critical.

Officers advised that the scope of the pilot was somewhat limited to acting on Adult Merlins and Safeguarding Alerts. The co-location of the Child Abuse and Investigation Team (CAIT) desk and the development of community MARACs – Multi-Agency Risk Assessment Conferences Panel would lead to a more efficient use of resources.

Partners in the scheme were London Borough of Havering, Metropolitan Police, NELFT, Clinical Commissioning Group, Probation Service and London Councils.

In setting up the scheme, the following had been arranged:

- Staffing structure agreed and new jobs being advertised
- Referral process and pathways for adults agreed
- Terms of Reference, Risk Assessment, referral form and chairing arrangements for Community MARAC agreed
- Accommodation and IT
- Governance arrangements and Steering Group
- Performance Management Framework
- Communications Plan

It was planned to enter into an Information Sharing Agreement and Table top exercise. In addition, there were plans to hold a "Dry run" of a Community MARAC meeting.

The next steps are:

- Deliver Communications Plan
- Go live 9 June
- Sources of contacts
- Reasons for contacts
- Turnaround times
- Agency participation in information sharing
- Changes in RAG ratings

- Outcomes of contacts
- Referrals to Social Care progressing to assessment
- Repeat referrals
- Professional disagreements
- Compliments and complaints
- Case studies
- Case audits
- Qualitative evaluation in September or October 2014

The Chief Executive Officer thanked the presenters for an informative report and requested that the Health and Wellbeing Board received future reports on how the project was proceeding and to highlight any issues.

43 **ANY OTHER BUSINESS**

None raised.

Chairman

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