MINUTES OF A MEETING OF THE HAVERING SHADOW HEALTH & WELLBEING BOARD

13 March 2013, 1:30 pm – 3.30 pm
Havering Town Hall, Romford

Present

Cllr Steven Kelly (Chairman) Deputy Leader of the Council, LBH
Cllr Andrew Curtin, Cabinet Member, Town and Communities (Culture), LBH
Conor Burke, Accountable Officer, Havering CCG
Dr Gurdev Saini, Board Member, Havering CCG
Mark Ansell, Acting Director of Public Health, LBH

In Attendance

Kathy Bundred, Head of Children & Young People's Services, LBH (for item 129)
Dr Harpal Flora (and associates), Consultant, Barts Health NHS Trust
Dr Alex Tran, Board Member, Havering CCG
Sean Cable, Committee Officer, LBH (minutes)

Apologies

Councillor Paul Rochford, Cabinet Member, Children & Learning, LBH
Cllr Lesley Kelly, Cabinet Member, Housing, LBH
Dr Atul Aggarwal, Chair Havering CCG
Cheryl Coppell, Chief Executive, LBH
Joy Hollister, Group Director, Social Care and Learning, LBH
Alan Steward, Chief Operating Officer (non-voting), CCG
Julie Brown, HWB Business Manager, LBH

137. MINUTES OF LAST MEETING

The Board agreed the minutes of the meeting held on 13 January as a correct record.

138. MATTERS ARISING

Meeting in public

The Chairman informed the Board that meetings would be public starting with the Board's next meeting in April.

End of Life Training

Members were informed that Dr Saini had been meeting with the Board's Business Manager to agree a mutually acceptable position and the final report arising from those discussions would come to a future Board meeting.

Public Health Benchmarking

It was noted that benchmarking indicators for public health were not yet established and as such a further report on this would be coming to a future HWB meeting.

139. NORTH EAST LONDON ABDOMINAL AORTIC ANEURYSM SCREENING PROGRAMME

The Board received a presentation on a new national programme being established to offer screening for men over the age of 65 to detect Abdominal Aortic Aneurysm (AAA). It was explained that this condition was characterised by the widening of a vessel, specifically the aorta (the largest vessel in the body) and resulted in either the weakening or bursting of the vessel.

Members were informed that the chance of survival after a ruptured aneurysm was 20 out of a 100, however, when aneurysms were detected through screening the survival rate was 97-98%. There were approximately 6000 deaths from ruptured AAAs each year.

Most AAAs were detected whilst looking for other problems, therefore, the AAA screening programme was being rolled out to detect the condition in men aged 65 and over, who were said to be the group at the greatest risk. 2013 was the last phase of the roll out of the programme and Havering has a key area as it is the London borough with the highest number of men over the age of 65. It was suggested that some 6762 scans were anticipated.

The screening programme itself was described as non-evasive with the capacity for self-referral by patients. The screening team was flexible and the programme could be undertaken in a variety of health or community settings, without needing to be strictly medical facility. Typically, the team would hold three to five sessions in a week period.

The Board urged the delivery team to contact the local medical committee of GPs to raise awareness amongst clinicians of the service. It was further suggested that the team liaise with the new Director of Public Health for the borough once in place to ensure widespread awareness of the programme.

140. CANCER UROLOGY

The Board considered an update from Dr Alex Tran, CCG Board member, on proposals to remodel urological cancer services. The proposals centred on the idea of an integrated network of providers. For urological cancer plans were for a centre of excellence for complex surgery with satellite sites providing non-complex services.

The most likely site for this centre of excellence was to be University College Hospital. BHRUT was interested in bidding to be the centre of excellence but had since pulled out of contention leaving UCH the only centre in the running to offer the service. Non-complex sites would be focussed on one particular type of urological cancer, with one centre for bladder and prostate and one for kidney.

The intended plan for surgery and recovery at the centre of excellence was 1 day surgery for prostate cancer, 7 days for bladder, and 3 days for kidney with recovery for all such cancers taking place at the local satellite centres. The concern about the proposals was that teams were being dismantled, with opposition from local groups.

Board members expressed some concern that the proposals would impact financially on BHRUT, but CCG representatives informed the Board that complex surgery offered very little activity (or financially remuneration) relative to its total activity. Complex surgery was not a particularly lucrative practice. It was thought likely that overview and scrutiny would oppose the proposals and one problem that the model was being informed by data based on American patients. Travel into London would be problematic for patients requiring complex surgery and seemed to jar with the guiding principle for patient choice.

Members were keen that the Board should drive the response to proposals and expressed concern at the quality of information and its circulation. It was judged that much of the information that had been passed around was very misleading. The Board needed to know exactly what was being proposed and who was making the decision, as well as who needed to consulted. One Board member, it was confirmed, would be attending an event at which the issues would be explained to clinicians.

It was agreed that the Group Director, Social Care & Learning would attend the consultation event for clinicians to gain more information about the proposals and would report back to the Board.

141. FOLLOW-UP DISCUSSION ON PRIORITY 1 (EARLY HELP FOR VULNERABLE PEOPLE)

The Board considered a follow up verbal report from the Council's Head of Children & Young People's Services on services around early help for vulnerable people, which was one of the priorities in the Health and Wellbeing Strategy.

The Board was informed that early help for children was a particular kind of service tailored to children before they find themselves at risk of significant harm. The service was chiefly delivered through paired children's centres which operated on a 'hub and spoke' model, by which more services were offered through centralised units. Health partners were involved in the

children's centre offer, which also drew on the resources of the Troubled Families programme and had CAMHS support.

The Board was informed that domestic violence was the driver of the child protection plan and early help through children's centres was offered to those at the verge of becoming involved in social services. It was stated that the borough had been deemed to be less successful in terms of child protection plans by Ofsted.

The move towards a more integrated early help offer, through children's centres, was starting in the centre of the borough, to change the least challenging area, whilst the more challenging area (which would pose the greatest challenge to resources and management) would be tackled once the offer was firmly established.

The Board agreed that another paper should come to the Board in due course updating members on progress made and on comments from Ofsted.

142. HAVERING CCG – FINAL COMMISSIONING STRATEGY PLAN

The Board considered a report from Havering's CCG seeking approval for the CCG's CSP and QIPP plans to ensure that they were consistent and mutually supportive of the Health and Wellbeing Strategy 2012-14.

Since November 2012, Havering Clinical Commissioning Group had been developing its Commissioning Strategy Plan (CSP) and Quality, Innovation, Productivity and Prevention (QIPP) Plan in readiness for the financial year 2013/14.

This process had sought to identify and prepare to deliver a suite of projects that would:

- Meet the CCG's statutory responsibilities from 1st April 2013 under the Health and Social Care Act 2012
- Deliver priorities to improve the quality, safety, patient experience and outcomes of the health services that the CCG commission
- Support partners in the delivery of joint projects, services and wider Havering priorities
- Make £11 million of savings during 2013/14 to prevent a budget deficit

CSP and QIPP Plan development had involved heavy consultation with the CCG's key stakeholders, including the Health and Wellbeing Board, wider local authority, patient groups and voluntary sector. The CCG had ensured consistency of the CSP's priorities with the Health and Wellbeing Strategy (pages 2-3) and where appropriate, that the projects incorporated key Health and Wellbeing Strategy actions.

The CCG were now in a position to share the final draft CSP, within which the QIPP Plan was outlined (this report was submitted to the Board).

Additionally, Havering CCG was required by the NHS Commissioning Board (NHS CB) to produce and submit a 'Plan on a Page' to outline plans for 2013/14, which were also to be shared with the Board.

The next steps for CSP and QIPP Plan finalisation were:

- 20th March – Havering CCG Board sign off
- 5th April – submission to the NHS CB

The Board was informed that the CCG would be formally authorised from the 1 April 2013, with 6 conditions out of 119. Other areas had fared less well, with Waltham Forest having 25 conditions and Basildon 67. Havering's CCG was one of the best in London.

Responding to questions, the CCG representatives explained that the budget for the priorities contained within the CSP were still being finalised, with programme budgets due to be finalised imminently. A budget paper would be coming to the CCG Board within the next few weeks. It was felt that the CSP and the HWBS represented the best example of joint-working many members had ever seen between the NHS and local government.

Havering's CCG had a budget of £270 million with a target for 4-5% savings which was an average target compared to other CCGs. The CCG cluster (comprising Barking and Dagenham, Redbridge and Havering CCGs) had helped with the budget deficit at Queens to the amount of about £10 million, but there was no provision to assist Queens in the next financial year.

The Board noted the CSP.

143. ST GEORGES STRATEGIC OUTLINE CASE

The Board considered a report from Havering's CCG updating members on the St George's Strategic Outline Case (SOC) and to advise of progress in the development of the Outline Business Case (OBC).

Senior leaders from health and social care in Havering, along with senior leaders from Barking and Dagenham and Redbridge, had formally agreed to work together to improve integrated care and had agreed seven integrated care coalition principles. The integrated care strategy principles formed the foundations for developing the St George's SOC. The SOC built on and supported the strategy for integrated health and social care services in Barking and Dagenham, Havering and Redbridge. The integrated care SOC outlined the high-level direction for the development of integrated care and built on existing, successful examples of integrated care, such as integrated case management. Integrated case management (ICM) was currently being implemented in Havering, and formed the foundations for the transformation of delivery of care for people with long term conditions.

Working closely with our key partners the CCG had created a vision for a centre of excellence in Havering.

The Board noted the report.

144. ST GEORGES LEGIONELLA OUTBREAK

This item was deferred until further notice as the report had not yet been released from NELFT, the organisation which had conducted the investigation.

145. HWB DEVELOPMENT WORKSHOP FEEDBACK

Members stated that the workshop had been similar to many of the other events that had been organised and perhaps could have been more productive and informative.

146. FEEDBACK FROM 'CHALLENGE, LEARN, INSPIRE, CELEBRATE' EVENT

The member who attended the event stated that it had been useful.

147. DATE OF NEXT MEETING

The Board noted that the next meeting was due to take place on Wednesday 8th May 2013.