MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD
Town Hall
10 September 2014 (1.30 - 3.55 pm)

Present

Councillor Steven Kelly (Chairman)
Dr Atul Aggarwal, Havering Clinical Commissioning Group (CCG)
Mark Ansell, Consultant in Public Health, LBH
Councillor Wendy Brice-Thompson, Cabinet Member for Health
Conor Burke, Chief Officer, BHR CCGs
Councillor Meg Davis, Cabinet Member for Children and Learning
Anne-Marie Dean, Chair, Healthwatch Havering
Joy Hollister, Group Director, Childrens, Adults and Housing, LBH
Alan Steward, Havering CCG

In Attendance

Philippa Brent-Isherwood. Head of Business and Performance, LBH
Angela Hellur, Improvement Director, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
Matthew Hopkins, Chief Executive, BHRUT
Barbara Nicholls, Head of Adult Social Care, LBH
Dr Maurice Sonomi, Havering CCG

Anthony Clements and Jan Grainger, Committee Administration, LBH

1 CHAIRMAN'S ANNOUNCEMENTS

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

2 WELCOME AND APOLOGIES

Apologies were received from Cynthia Griffin, Group Director – Culture, Community and Economic Development.

3 DISCLOSURE OF PECUNIARY INTERESTS

There were no disclosures of interest.

4 MINUTES AND MATTERS ARISING

At the request of the Chairman, this item was deferred to the next meeting.

5 BHRUT IMPROVEMENT PLAN

The Trust Chief Executive reported that Steve Russell had now started as Deputy Chief Executive. A number of nurses from Portugal had recently been recruited to the Trust and there were 85-90% permanent nursing staff in A&E (compared to 50% last year). Some 40% of midwife posts were vacant however. The overall nursing vacancy rate across the Trust was 11%.

Reasons why nursing staff moved on were being investigated. Nationally, demand for the nursing workforce was outstripping supply particularly as the Francis report had made hospitals recruit more nurses. The South Bank University Nursing School based in Havering was still used to recruit nurses. The Chief Executive would check if BHRUT had withdrawn funding to nursing students at the South Bank University site.

As regards recruitment of doctors, all training grade posts were filled but A&E rotas meant there were a lot of locum mid-grade doctors. Twenty posts had been offered following recruitment in India and four doctors had now started. Some of the remainder were however now asking for more money and negotiations were in progress. BHRUT were meeting with UCL Partners in the next week to discuss how to attract new cohorts of junior doctors to BHRUT. It was also hoped to attract a visible consultant leader for A&E.

It was suggested that the Trust should get the relevant Colleges to support its recruitment work. The Trust also needed College support for its work looking at different models of staffing with senior doctors. The Board agreed that recruitment was a wider system problem and that greater awareness of the issues would help. It was agreed that recruitment across the system should be raised at the next Chairman's briefing.

The Trust Chief Executive stated that the aim was to treat all patients on a waiting list within 28 days. There was however a backlog of around 4,500 patients awaiting treatment with 250-300 of those still untreated beyond 18 weeks. It was hoped the Trust would stabilise the position by March 2015.

The Queen's Hospital pharmacy was already operating seven days per week but with shorter opening hours at the weekend. The Chief Executive confirmed that approximately the same number of people were discharged from Queen's each day but 40% of these were discharged after 8 pm. It was essential that medication was got to people earlier to allow a quicker discharge. Dispensing of medicines the day before discharge could be undertaken but only if a junior doctor had written up the prescription. Of approximately 100 discharges each weekday, it was aimed to discharge 10 people by 10 am and 20 people by 12 pm.

Extra pharmacy posts had been funded but these still needed to be filled and this work needed to start by the end of September. Work was also ongoing with college principals to fill pharmacy posts. The Group Director

offered to assist in getting this message to local college principals. The Trust Chief Executive agreed to consider allowing local pharmacies to fill hospital prescriptions in order to speed up the discharge process. There was a VAT issue on certain medications being dispensed locally but it was felt this could be managed. Atul Aggarwal would discuss the matter with Angela Hellur and it was agreed that an update should be given at the November meeting of the Board.

An interim solution had been developed for the issue of accommodation for the joint assessment and discharge team. Work was also underway to produce a more long-term solution which would involve co-locating people. It was felt this would be more effective at King George rather than Queen's. All posts in the joint assessment and discharge team had now been filled. It was accepted however that staff would only be retained if the accommodation was suitable. The Trust Chief Executive accepted that a clear timeline and communication with staff was needed and a weekly update to staff on accommodation could be produced.

The Queen's renal dialysis service, run by Barts Health, needed to move elsewhere. This did not need to be on an acute hospital site. It was accepted that it had not been possible to secure the site for the service that had originally been proposed. The sexual health service location was not a significant problem although retendering of the service may lead to a move. Accommodation issues could be raised at the next meeting of the North East London group and a report back given at the next meeting of the Board.

A recruitment consultant had been engaged to assist the Trust's recruitment of a Medical Director. It was hoped that existing Medical Directors or senior clinicians would apply for the position. Interviews for the position were expected to be held in late October. It was felt useful if representatives of the CCG could be on the interview panel.

6 BETTER CARE FUND

It was explained that previous applications to the Better Care Fund had been withdrawn by Government at a national level. The ambition of the Fund was however unchanged.

Officers were now more assured that sufficient funding would be available for 2015/16. The 2016/17 year was however likely to be difficult and eligibility criteria etc was not yet known. It was emphasised that the Better Care Fund was not new money but was a reallocation of money from the NHS and social care.

The number of schemes in the Havering Better Care Fund action plan had been rationalised and a particular concern were the new responsibilities for support to carers that had been placed on the Council. The Health and Wellbeing Board would lead on this while a new Joint Commissioning Board would carry out the day to day work. This Board would be meeting in shadow form from October 2014, chaired jointly by Adult Social Care and CCG officers.

It was noted that BHRUT was felt to be a risk given hospital operational pressures and uncertainty over the Trust's workforce to deliver the Better Care Fund work. The Chairman felt that the implications of the Dilnott report should also be mentioned as a risk. The implications of the Care Act were also not fully known at this stage.

Risk measurement had been undertaken in accordance with guidelines and risk levels were felt to be on the cusp for BHRUT and over the cusp on financial issues. It was felt the final version of the submission should state that the CCG needed support from the Trust Development Authority in order to mitigate the problems at BHRUT. The McKinsey work could also be quoted in the background section. It was felt it should also state that the Better Care Fund allocation in no way represented the population of Havering.

There was felt to be a bigger risk from the non-delivery of the Strategic Plan than posed by the Care Act. The total risk was approximately £300 million over the next five years and it also felt that the submission should make the point that NHS costs were not absolute, unlike those of Local Authorities.

The section on contingency planning and risk sharing needed further work although a workshop on this had been held on 27 August. A diagram would be inserted to show the balance of risk between the Council and the CCG. The risk between commissioners and providers would also need to be considered.

Information was given in the submission about the financial implications for the Council budget as well as comparative data with neighbouring Councils. Schemes to manage demand were also detailed. It was suggested that details of the large number of care homes in Havering be included as well as graphs showing the underfunding of the CCG and large numbers of elderly people in the borough. The final document was due to be submitted by 19 September.

It was noted that the Government performance target on admission avoidance of 3.5% may not be achievable.

It was agreed that sign-off of the final document be delegated to the Chairman and that it was unlikely that a further meeting of the Board would be needed to discuss amendments. The Board recorded their congratulations to the team who had worked on the template.

7 RESPONSE TO HEALTHWATCH DEMENTIA/LEARNING DISABILITY REVIEW

The Board noted that the Havering Dementia Partnership Board had been established in order to allow movement as quickly as possible on dementia which was a growing issue for the borough. Dr Sonomi – Clinical Director for dementia at the CCG, explained Havering's targets for each main 'statement' of the National Dementia Strategy.

Diagnosis of dementia in Havering had improved due to better coding of GP patients and it was hoped to reach the national target of 67% of the estimated total of people with dementia being fully diagnosed. Performance on patient decision making and support for carers was also quite high. The number of Havering care homes with dementia champions was already high (40) although a target had been set to increase this to 43 by 2015/16. It was suggested that dementia care homes could be added to the schedule of enter and view visits by Healthwatch Havering. Most people with dementia continued to live outside of care homes.

Targets were also set around dignity and respect, particularly on consulting with dementia service users and carers when designing services. It was felt that the butterfly scheme to indicate hospital patients with dementia problems should be more widely publicised. There was now more engagement with dementia sufferers and carers in general medical consultations.

It was clarified that healthchecks for people with learning disabilities were monitored by the GP practice improvement lead. A user friendly version of the dementia action plan was also being produced. The numbers of shared care plans had increased as the need to avoid unplanned admissions had increased the requirement on GPs to do this.

An appropriate building for a shared dementia hub had been identified as the Victoria Hospital was no longer considered fit for purpose. It was agreed to invite a representative of NELFT to the next Chairman's briefing in order to discuss this issue further.

8 URGENT BUSINESS

There was no urgent business raised.

9 DATE OF NEXT MEETING

The next meeting would be held on 15 October 2014 at 1.30 pm.

Chairman