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HEALTH & WELLBEING BOARD

AGENDA

Wednesday, 15th October, 2014
1.30 - 4.00 pm

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 - 12)

   To approve as a correct record the minutes of the Committee held on 13 August & 10 September, and to authorise the Chairman to sign them (attached).

5. MATTERS ARISING

   To consider the Board's Action Log

6. LIFE STUDY

   Professor Carol Dezateux, UCL

7. CARE ACT/ BETTER CARE FUND

   Joy Hollister

8. COMPLEX CARE

   Havering CCG Officers

9. END OF LIFE CARE

   Conor Burke

10. ANY OTHER BUSINESS

11. DATE OF NEXT MEETING

MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD
Town Hall
13 August 2014 (1.30 - 3.05 pm)

Present

Cllr. Steven Kelly (Chairman)
Mark Ansell, Consultant in Public Health, LBH
John Atherton, NHS England
Cllr. Wendy Brice-Thompson, Cabinet Member for Health
Conor Burke, Chief Officer, BHR CCGs
Cllr Meg Davis, Cabinet Member for Children and Learning
Anne-Marie Dean, Chair, Healthwatch
Cynthia Griffin, Group Director, Culture, Communities and Economic Development, LBH
Dr Gurdev Saini, Board Member, Havering CCG
Alan Steward, Chief Operating Officer, Havering CCG

In Attendance

Phillipa Brent-Isherwood, Head of Business and Performance, LBH
Barbara Nicholls, Head of Adult Social Care, LBH
Wendy Gough, Committee Officer, LBH (Minutes)

Apologies

Dr Atul Aggarwal, Chair, Havering CCG
Cheryl Coppell, Chief Executive, LBH
Joy Hollister, Group Director, Social Care and Learning, LBH

13 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman announced details of the arrangments in the event of a fire or other event that would require evacuation of the meeting room.

14 **APOLOGIES FOR ABSENCE**

Apologies for absence were received and noted.

15 **DISCLOSURE OF PECUNIARY INTERESTS**

There were no pecuniary interests declared.

16 MINUTES

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

17 MATTERS ARISING

The Chairman was keen to see that the Better Care Fund was benefitting all people and was interested to hear the update on the agenda.

18 HEALTHWATCH ANNUAL REPORT

The Board received the Healthwatch Havering Annual Report 2013/14. The report had been written in line with the standards set out by Healthwatch England and outlined the work that had been carried out with local organisations.

The launch of Healthwatch both nationally and in Havering in April 2013 coincided with the emerging concerns about standards of care in health and social care settings. Locally, concerns arose following a series of adverse Care Quality Commission (CQC) and other reports about care in Queen's Hospital and in several residential care homes. Healthwatch Havering had a dedicated team who deal specifically with the concerns raised with Queen's Hospital, and were about to submit their findings to the CQC prior to its inspection.

All the recommendations that had been made on the concerns raised in respect of care homes had been taken on board and the specific care homes now had an action plan to follow. It was noted that when inspections are made, checks such as ensuring the bath taps were working were also included.

Recently Healthwatch Havering had been developing relationships with the local community, and had worked on services for people with Dementia and for people with a Learning Disability.

The Board noted that all contact that is made with Healthwatch Havering was logged, and whilst there may not be immediate investigations, the details of the complaint were kept should further concerns be raised.

The report set out a number of different actions and priorities including those established by the Health and Wellbeing Board. Healthwatch Havering, from their perspective, had set out the priorities in the following order:

- The CQC inspection of Queens Hospital (Priority 7: Reducing avoidable hospital admissions).

- Frail and Elderly Members of our community (Priority 5: Better integrated care for the 'frail elderly' population and Priority 1 Early help for vulnerable people).
- The Better Care Fund (Priority 8: Improving the quality of services to ensure that patient experience and long-term health outcomes are the best they can be).
- The Care of Children in our Community (Priority 6: Better integrated care for vulnerable children).
- Joint Strategic Needs Assessment (Supports the development of all the 8 priorities).
- Dementia Strategy (Priority 2: Improved identification and support for people with dementia).
- Children and Families Bill (Priority 1: Early help for vulnerable people).
- Specialist and Cardiovascular Services (Priority 3: Earlier detection of cancer)
- Childhood Obesity (Priority 4: Tackling obesity).

Healthwatch Havering felt that the joint working with the Board and its partners had been carried out effectively and had achieved a lot in the last year.

The Board agreed that further work needed to be done to the JSNA. It was the document that fed into the community, but needed to be more detailed to achieve real outcomes. It was agreed that the work being done by other boroughs should be researched to get some best practice and to be aware of emerging issues. The JSNA needed to be a more practical document.

The Board felt that Healthwatch Havering were doing a good job and that its members should be very proud of their excellent work.

19 **INTERMEDIATE CARE CONSULTATION**

The Board received a presentation on the Intermediate Care Consultation. Intermediate care was services that provided people with specialist nurses, therapists and other professionals without them needing to go (or stay longer) in hospital.

The services could be provided in different places, including people's own homes, community rehab units or in residential homes. The CCG had been trialling the expanded community treatment team (CTT) and a new intensive rehabilitation service (IRS) in Havering. The CTT was a team of doctors, nurses, physiotherapist, social workers and others providing short term support to people experiencing a health or social care crisis. The care was

provided at home so that there was either no need to go into hospital, or the stay was shorter. The service ran 7 days a week from 8am to 10pm.

The IRS was a team of physiotherapists, occupational therapists, healthcare assistants and others. They provided intensive physiotherapy and other therapy in a patient's home. The visits could be between one and four a day depending on the need. The service ran 7 days a week from 8am to 8pm.

The consultation so far had looked at the options available. From the current feedback, it was clear that:

- the community beds were the primary option for rehabilitation/ intermediate care
- people were having to wait longer to access the service and there was no service at weekends
- people often had to stay longer in hospital which increased the risk of contracting further infections

The CCG had evidence that suggested there was a consistently high patient experience and satisfaction from the new service. People were able to access the service more confidently; there was a single point of contact and improved response time. People had more choice and were getting better quicker with less likelihood of being admitted/re-admitted to hospital. There was also evidence that the community beds were not being used as much with people being treated at home (29 unused beds during the trial).

Of the five options available, it had been agreed that the preferred option was Option 5. This was to continue with the CTT and IRS, to reduce the number of community beds, and to locate those beds to one site at King George Hospital. This would mean that running only one unit would ensure that staff were much more efficient and flexible, it would also be the most affordable option.

The Board discussed about retention of staff and how they could work together to ensure the attraction of employment within the borough. There were a number of avenues that could be pursued including the University College of London, other Educational establishments as well as the general marketing of the opportunities that there were in the area.

It was agreed that an update on Intermediate Care and the JAD be brought to the October meeting.

20 **VIOLENCE AGAINST WOMEN**

The Board received a report on Domestic Violence in Havering. The report gave an overview of the situation in Havering and the associated Health and Wellbeing implications for victims, their children and the wider community.

The Board noted that whist there was a lot of good practice and support within this area, there was still room for improvement.

The definition of Domestic Violence had been widened and now included people from 16 years old. It was not just physical violence, but included coercive and controlling behaviours. It was also very broad and was not gender or ethnicity based. The Board agreed that with the increase of reports of historical sexual abuse, people were finding it now more acceptable to report acts of abuse.

The Board was asked to consider refreshing the JSNA for Violence Against Women and Girls (VAWG) given the changing demographics in the Borough and to support the Havering Community Safety Partnership to develop a joint VAWG strategy for Havering. Members felt that this should include the provision for men too, since there was only a difference of 2% of reported cases in the borough.

It was important that the JSNA was updated and early interventions put in place to prevent repeat reports. There was support already available in the form of advocacy and Womens Aid, however there were no specific services for children.

The Board agreed that it was important that the views of people who had used the services were sought and to ensure that the service encompassed same sex relationships and people with disabilities. Each group would need to be signposted to a different solution dependent on their situation.

There was a newly formed group to deal with VAWG who had only met twice; they were looking at drafting a strategy to take the actions forward. This could feed into the JSNA which could be jointly agreed by the Health and Wellbeing Board and the Havering Community Safety Partnership.

It was agreed that the action plan should be brought back to the December meeting together with actions and implementation dates.

21 BETTER CARE FUND

The Board were provided with an oral update on the Better Care Fund. The HWB was reminded that it needed to resubmit its submission on 19 September. A finalised submission would be brought to the meeting on 10 September with the agreement that the Chairman could sign off the final version.

The submission looked at cost pressures in Nursing Care and Informal Carers.

22 COMPLEX CARE

This item had been deferred until the September meeting.

23 DATE OF NEXT MEETING

Members of the Board were asked to note that the next meeting would be held on Wednesday 10 September 2014 at 1:30pm.

Chairman

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