MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD
Committee Room 2 - Town Hall
15 April 2015 (Times Not Specified)

Present:

Councillor Steven Kelly (Chairman)
Councillor Wendy Brice-Thompson, Cabinet Member – Adult Services and Health
Councillor Meg Davis – Cabinet Member – Children & Learning
Atul Aggarwal, Chair, Havering CCG
Anne-Marie Dean, Chair, Healthwatch Havering
John Atherton, Head of Assurance North Central and East London, NHS England
Alan Steward, Chief Operating Officer, Havering CCG
Conor Burke, Accountable Officer, Barking & Dagenham, Havering and Redbridge CCGs
Cheryl Coppell, Chief Executive, LBH (for part of the meeting)

Also present:
Claire Still, External Relations Officer
Jade Fortune, Public Health Strategist

One member of the public was also present.

109 **CHAIRMAN'S ANNOUNCEMENTS**

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

110 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from:
Andrew Blake-Herbert, Group Director – Communities and Resources
Joy Hollister, Group Director – Children, Adults and Housing, London Borough of Havering Sue Milner, Interim Director of Public Health, London Borough of Havering
Dr Gurdev Saini, Clinical Director, Havering CCG

111 **DISCLOSURE OF PECUNIARY INTERESTS**

No pecuniary interests were disclosed.

112 **MINUTES**

The minutes of the meeting held on 11 March 2015 were agreed as a correct record and signed by the Chairman.

113 MATTERS ARISING

Item 103: BHRUT hospital admissions. There had been a slight recent drop, but the total was relatively static. There had been a drop of about 1% in the meeting of A&E targets with a significant dip expected in January, but otherwise totals remained the same. At Queens, looking at the seasonal variation, there was an overall drop in performance in meeting the A&E targets, but there were grounds for optimism as it was the right direction of travel.

There were issues within the Care Board around the Joint Assessment and Discharge team due to the reduction in size of the team. The Health and Wellbeing Board wanted some reassurance about how the team was to work. The reorganisation which created the Joint Assessment and Discharge team – hosted by Barking and Dagenham (and set up jointly with NELFT) – had shown a very good improvement of management organisation. The reduction in staff level was due to the funding being cut, but for the time-being those members of staff were being kept on (to June) whilst attempts were made to put in place other funding arrangements. In the short term, funding was covered, but planning for its replacement was needed now.

Conor Burke reported that Winter Planning had cost £5m and that projects were being reviewed to see what could be kept and what dropped. He reminded the Board that it needed to be aware of these funding issues. Doubts were expressed about the Primary Care Strategic Commissioning framework.

Item 106: Primary Care Commissioning – Orchard Village. Alan Steward stated that the CCG were looking for a move to different facilities, partly due to CQC requirements. They were in the process of negotiating a move from the current clinic accommodation. It was asked whether this would have greater medical capacity and the answer was that it would provide more than the existing facility as it would include a “walk-in” centre and a practice on the estate. The Chairman expressed his concerns about this being an under-resourced area within Havering. He was assured that there would be more local control than previously.

The Chairman emphasised the need to have a medical practice on the estate and asked for more information to come to the next Chairman’s Briefing. He said that there was a need to provide a ”proper” service to what was, he added, the most deprived area in the borough. He felt that there needed to be an end to the referrals to Harold Wood. This was not good. He was informed that temporary measures would be in place shortly.

Dr Aggarwal observed that there would be some 10,000 people in the area and there was a need to match service provision to the population’s needs.

The Chairman agreed saying that there would be a huge demographic swing and there would be a need to model all provision for the area over a ten year period. He wondered whether there would be a large influx of people from Barking & Dagenham. It was observed that there would be a large Somali population growing in the area and he added that this was what the HWB should be doing: looking closely at the infrastructure required.

Anne-Marie Dean observed that there was a need to inform the population about what services were available and how they could be accessed.

Item 107: The Chairman asked whether the Federation Hub had received any publicity and was informed that a full page advert had been placed in the Romford Recorder as well as advertising in other local papers. The Chairman was concerned that advertising needed to be more widely presented as newspaper sales and general circulation were falling. Other media needed to be exploited.

Anne-Marie Dean stated that there was a need to ensure that reception staff etc. were properly briefed and trained to ensure they could advise properly. The problem was that it was difficult to get all the staff together at the same time due to their different shift patterns. She added that it was happening, it just needed developing.

The Chairman asked how many people were using the Hubs. It was stated that in the Romford Hub there was a 50% - 60% take-up of this new service. He asked whether there was scope for a third hub at the northern end of the borough and was reminded that the Harold Wood Centre had a walk-in facility so there was a possibility that one in Harold Hill could be used. There had been a pilot trial of weekend openings. This closed at the end of March (this had always been the intention) and was now being evaluated. The Chairman observed that the Romford Hub should receive more promotion that the Astra Close Hub.

A question was asked about the funding of the hubs. Conor Burke replied that once the initial funding from the Prime Minister's Challenge Fund expired, the CCG would continue to match-fund them from the Nuffield Trust (LBBD). If the hubs failed to prove effective, it would be wrong to continue to seek funding and the availability of the PM's Challenge Fund was very much dependent on the outcome of the General Election. The Chief Executive added that funds could be taken from other services to use where it was most needed. There was an element of dual running, so the Challenge Fund money would be useful.

Conor Burke stated that hospitals needed to cover their costs. This would not be easy, particularly in light of their reduced income. This would challenge most to manage themselves more efficiently.

The issue concerning the retirement of many of the borough's General Practitioners was raised. The reality was that Havering was likely to be particularly hard hit as it differed from the rest of London – and even the rest of the country - as most of its current GP partners were reaching – or soon

would be reaching – retirement (50% were already over 60) and there were serious concerns about what was being done to secure GP cover for the future. Conor Burke stated that he had only taken over primary care a fortnight earlier and so was only beginning to get to grips with the problem, but he agreed that it needed to be addressed as a matter of urgency because it took a long time to produce a GP.

The Chairman said that there was a need to look at single practice issues. One in three GPs said they were "fed up" and wanted to leave general practice whilst the General Medical Council had fewer numbers becoming qualified.

Dr Aggarwal added that new doctors were expressing a preference to be salaried rather than become partners. This could have an unfortunate effect when current partners came to retire; indeed, many returned to work even though they were officially in retirement. It was because of this that accurate figures in respect of GPs in an area could be skewed. To add to the problem, the earlier creation of "nurse-practitioners" was misleading – they simply did not exist.

The Chairman observed that to make matters worse, there was no accredited course for training health-care assistants who would help take pressure from GPs. He was of the opinion that such a course needed to be set up as a matter of urgency. He also wondered whether it would be feasible to employ underused education establishments and whether, if a suitable course could be found, the Board could set it up.

Conor Burke stated that this issue about aging had an impact across all health-care areas, for example: 50% - 60% of all care workers were over 50. The situation for the future did not look very promising.

Reference was made to the Commissioning Board and that it should become a Transformation Board. Anne-Marie said that it was the responsibility of the CCG and should be held in public and that perhaps a paper should be provided. Alan Steward replied that he would bring one to the next meeting.

114 REVIEW OF ACTION LOG

The Board decided that this should be considered at the next development session by which time some of the elements should have been filled in.

115 INTEGRATED MASH PILOT - PROGRESS UPDATE

The Council Chief Executive informed the Board that the Multi-Agency Safeguarding Hub (MASH) had been short-listed for an award which was due to be announced imminently. The formal multi-agency audit in the Children's Agency had produced good results. Most areas had reached their targets – though there were some areas where improvements could

still be made. It was clear that there was a need for better communication between agencies, though overall things were moving in the right direction. Once again, Havering was leading the field. The MASH had been very well received and this was good for staff – indeed, the morale of those working in Children's Care was high. Those asked said that even though they were under considerable (and rising) pressure, they felt supported, so this was all very positive.

116 COMPLEX CARE (HEALTH 1,000)

Conor Burke tabled a document concerning Individualised Personal Commissioning (IPC) on behalf of Havering CCG. He reminded the Board that this involved the hubs and referenced a new type of primary care relating to those who suffered from multiple conditions (a minimum of five), which could encompass a whole range of issues crossing several agencies. The basic concept was that the GP was not always best placed to decide what mix of support a patient needed and that whilst most of those receiving this sort of care package would be elderly, that need not always be the case.

The funding to pilot this came from a successful application to the PM's Challenge Fund. So far, 79 patients had been taken onto the scheme and this was indicative that the scheme's target of 1,000 by the end of the year would be achieved. Conor explained that this would be rolled-out across Barking & Dagenham, Havering and Redbridge and it was estimated that it ought to attract some 2,000 patients across the three boroughs.

So far the data showed that - including costs – each patient would cost between £25 - £30,000 and receive 24/7 support and advice. The bottom-line was that the team would deal with everything on behalf of the individual. Conor explained the illustrations. These had been put together from the accounts of those now using the pilot and showed how they perceived the change between having to arrange each component of their care themselves, to having a team member take control of the process and ensure that what they experienced was trouble-free and seamless.

The idea was to release the individual from the anxiety and frustration associated with complex socio-medical problems (which were usually encountered by patients who were probably least able to cope and more vulnerable than those with simpler, or single issues) and by removing the multiple and frequently conflicting processes, empower them to use their commissioning capacity effectively and within a secure, supported environment. It was, he said, the provision of a "concierge" service.

Not only were patients recording that they were now less stressed, but staff too were reporting that they were happier. It appeared that because the patient was more relaxed and confident, many underlying problems which raised tension between the practitioner and patient were correspondingly lowered or removed altogether.

Patients now considered that they were able to fulfil some life ambitions. The ethos of the team was to facilitate these ambitions and aspirations. The fact remained that some 30% of those on the programme would die within the next 12 months, so it was imperative that the team focussed on their needs – and delivers those expectations - and not simply provide immediate "care".

The team were, in fact "care negotiators". It would broker well considered and approved care plans. A Care Negotiator would work with an individual patient to provide a tailor-made package for that person – a package that factored in that person's aspirations. Care negotiators would come from the voluntary sector and it was hoped to empower them further by providing essential funding. They would give a percentage of their budget to the patient for them to manage.

IPC would provide a directory of approved services from the healthcare market and patients would make their own choices. This was potentially a model for the future of provision of healthcare across the nation. Nowhere else in the country was piloting such a scheme and while there were undoubtedly risks, the outlook was potentially good.

The Chairman asked how it was proposed to expand across the three boroughs. Conor replied that King George had facilities and a clinic would be set up in Havering as soon as possible – though the teams were mobile, so the lack of a site in Havering should not prove to be a disadvantage.

Dr Aggarwal said that he would be meeting a medical director who had some 25 patients who might benefit from the programme. A question was posed about where assessments were to take place, and it was considered that they should be undertaken where the patient lived and not centrally as that was not necessary and ran counter to the patient-centricity of the scheme.

The Chairman asked whether there were sufficient patients to fill the places on an on-going basis and was assured by Dr Aggarwal that this would indeed be the case as some 50% of those put forward would take up the scheme and with a mortality of around 30% and an aging population, there should be no shortage of patients to keep the scheme moving forward. It was also a flexible scheme as it could embrace new conditions and accommodate unusual combinations of them. He cited references to diabetes and hypertension (30% of the population), COPD (25% of the population). These areas alone cost some £30m pa.

A question was asked about how this would be greeted by GPs as it would impact on their funding, but in answer, overall a GP would only lose £65 per patient per year – the greatest cost was in respect of hospital treatment.

The Chairman asked what would happen to those who missed the criterion of five conditions – even if those they had were unusual. Were there plans to provide something running in parallel to cater for those patients? In response Dr Aggarwal said that there was a need to be creative with provision. Integrated case management was important and different

solutions needed to be tried. He mentioned that health analysis could be integrated A&E attendance forms.

Anne-Marie Dean added that this depended on the relationship between the A&E and the practices. It couldn't all come from the GP, A&E needed to be proactive in alerting practices about frequent attendees. She drew attention to the need for "befriending" those who had mental health and/or social care issues and felt that social networks were very important.

The Council Chief Executive observed that Havering had a seemingly paternalistic stance in respect of social care. With reference to the scheme, nothing was really known, there was no data: no attrition rate and no-one had yet left the scheme. With regards to funding, the PM's Challenge Fund money would run out – it was only meant to last two years, but it needed to be remembered that this was being conducted as an experiment. It was set up as such and programmed to run for two years.

Anne-Marie Dean added that if the experiment proved successful, there would be less dependence on GPs. At present it was more of a medical rather than a psychological process, but the psycho/social elements were real. She said that loneliness and uncertainly were factors which needed to be built in. There was a need to reassure people.

The Chairman suggested that perhaps NELFT should be considered as a topic for discussion by the Board. The Chief Executive said that studies needed to be more evidence-based as with work on the Care Act.

117 ANY OTHER BUSINESS

Members were reminded about the recent CQC inspections. When the report had been published concerning BHRUT, it would be brought to the Board.

118 DATE OF NEXT MEETING

The next meeting would be held on 19 August 2015, 13:00, CR2, Havering Town Hall.

Chairman