MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD
Committee Room 2 - Town Hall
11 February 2015 (1.30 - 3.55 pm)

Present:
Councillor Steven Kelly (Chairman)
Councillor Wendy Brice-Thompson, Cabinet Member – Adult Services and Health
Councillor Meg Davis – Cabinet Member – Children & Learning
Atul Aggarwal, Chairman, Havering CCG
Conor Burke, Chief Officer, Barking & Dagenham, Havering and Redbridge CCGs
Cheryl Coppell, Chief Executive, London Borough of Havering
Anne-Marie Dean, Chair, Healthwatch Havering
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
Alan Steward, Chief Operating Officer, Havering CCG

Also present:
Pippa Brent-Isherwood, Head of Service and Business Performance, Adult Social Care
Anthony Clements, Principal Committee Officer
Diane Egan, Community Safety Team Leader
Gemma Gilbert, NHS England

85 CHAIRMAN'S ANNOUNCEMENTS

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

86 APOLOGIES FOR ABSENCE

There were no apologies for absence.

The Board expressed disappointment at the lack of representation once again from NHS England. The Clerk to the Board would confirm if a letter asking NHS England to nominate a new representative had been sent out.

87 DISCLOSURE OF PECUNIARY INTERESTS

There were no disclosures of interest.

88 MINUTES

The following amendments to the minutes of the meeting held on 14 January 2015 were noted:

Conor Burke was present at the meeting.
Joy Hollister gave apologies for the meeting.

On minute 81 – Primary Care Co-Commissioning, the allocation to clinical commissioning of the NHS communal budget split was 60% rather than as stated.

The Board expressed its severe dissatisfaction at the quality of the front page of the agenda and in particular that number of Board Members were given the incorrect organisation. The Clerk to the meeting apologised and would pass these views back to the officer concerned.

89 MATTERS ARISING

An agreement on the dementia centre was due to be signed on 13 February and Tapestry had agreed to move site.

A joint meeting with the Chairmen of neighbouring Health and Wellbeing Boards was due to take place on 12 February.

The Board's action log was not considered due to this not being included in the agenda papers.

90 WINTER COMMUNICATION PLANNING AND HOSPITAL PERFORMANCE IN A&E

The CCG Chief Operating Officer explained that the 95% target for meeting the 'four hour rule' at Queen's Hospital A&E would not be met every week but that local health economy was improving. The pattern of performance was varied and it was noted that there was not a direct correlation between performance and levels of attendance at A&E.

Large numbers of patients were now treated by the Community Treatment Team and Intensive Rehabilitation Service rather than at A&E. The GP Federation access hub also worked to move demand away from A&E. Seventy per cent of available appointment slots at the access hubs were now being used and appointments were now available at weekends as well as in early evenings.

There was now more demand for the Urgent Care Centre at Queen's and a triage system had been introduced at the front of A&E and had proved successful in allocating patients to the correct stream for treatment. It was clarified that it was not optional for doctors to work in triage and that there were enough staff available to provide this service. The Community Treatment Team also had a hub in A&E (in addition to teams working in the community) and had also proved successful in reducing demand from A&E.

The majority of the problems related to the admitted side of A&E attendances when for example hospital beds were not available. The A&E

assessment unit was often used prior to admission to wards and it was accepted that at night there was an element of keeping older patients in A&E for observation. BHRUT was working to bring forward discharges to earlier in the day and to address issues with where the hospital pharmacy may be delaying discharge. Patients were often able to wait in the discharge lounge, freeing up beds at an earlier stage.

The CCG had also purchased more community beds to create temporary capacity and allow more discharges from hospital. The Joint Assessment and Discharge Team had lowered the number of delayed transfers of care of which there currently a total of eight cases. This was an example of better working with partners taking place.

There were approximately 100 simple discharges (where people could return to their own home without any additional support) at Queen's each day but these needed to take place earlier in the day. The scheme aligning GPs to care homes was also working to reduce the number of hospital admissions.

The A&E position had improved overall with better operational links between services and better management of demand. Patient flow was improving but earlier discharge was still needed. The new leadership at BHRUT had been cooperative and a new medical director and ED consultant had recently been appointed. There remained significant challenges for the hospital but the Trust was focussed on the key issues. It was noted that the hospital would be receiving an inspection from the Care Quality Commission (CQC) in three weeks and that this was taking the attention of the management team. Healthwatch Havering had been asked by the CQC to look at different aspects of BHRUT services.

Issues such as how the ambulatory care service could be utilised more could be addressed by the Programme Board. It was felt community pharmacies could be used in order to speed up discharge. Pharmacies could also be used more for minor ailments although the chief operating officer felt that pharmacies made a relatively minor contribution to the overall issues. The Chair of the Local Pharmaceutical Committee also wished pharmacies to be used for minor ailments more but it was to ensure value for money for any investment in pharmacies. The Chairman felt that discussions should also be held with other representatives of pharmacies. The Chair of Healthwatch Havering added that the issue of discharge medication in the hospital needed to be organised better. It was also now easier to obtain drugs out of hours from e.g. supermarket pharmacies. The Chairman added that too many drugs were also thrown away in care homes.

It was agreed that communications such as the 'Don't go to A&E' campaign should continue in order that people were aware of where they needed to go for the appropriate treatment. Newspapers, pharmacy bags, buses and posters had all been used for the current campaign. Alternatives to A&E were also promoted digitally via an App and website and through the CCG

Twitter account, A digital service guide was also available for NHS staff. Leaflets had been targeted towards parents of young children and a booklet had also been produced for older people that had been sent to GP surgeries, libraries etc. It was suggested that the Council e-mail database could also be used to advertise this.

It was clarified that the advertised phone number for advising which GP surgeries were open at the weekend related to the non-GP Federation weekend hub.

The Chairman explained that it was hoped to have weekly articles in the Romford Recorder and that this could also be used to publicise the 'Don't Go to A&E' campaign. It was **AGREED** that Councillor Kelly would take this forward.

The Chairman thanked the CCG Chief Operating Officer for a comprehensive report.

91 **COMPLEX CARE UPDATE**

It was **AGREED** that a paper on this area would be brought to the April meeting of the Board.

The Chief Officer for the local CCGs explained that funds had been received from the Prime Minister's Challenge Fund to set up a complex care organisation – Health 1,000, the first such organisation in the UK. This would involve one dedicated team looking after people, across the three local boroughs who had four or more long term conditions. There was very significant of providing treatment to this group of people.

The complex care organisation had been established in early January 2015. Contracts were now in place, focussing on the 1,000 people with the most complex range of conditions. The organisation was based at King George Hospital but was looking for a satellite base in Havering.

Twenty people had registered with the service in the last three weeks and this rate was expected to increase over the coming months. Directors of NHS England had visited the new scheme which was seen as a pioneer of national work. The Health 1,000 project was being evaluated by the Nuffield Trust and feedback could be brought to the Board on this. Social workers for the scheme were also being recruited.

It was planned to use this model to focus in the future on children and young people, particularly those with co-morbidities where care and treatment costs could be very high. The programme would concentrate on 750-800 children across the three boroughs and an initial expression of interest had been submitted.

The Chairman wished to ascertain that Redbridge were still committed to the scheme but felt that the Health 1,000 programme could be featured as an article in the Recorder newspaper. The 2,000 people with the most complex conditions were responsible for £60 million of local budgets, It was noted that end of life care was also an issue for this group.

It was confirmed that Healthwatch supported both Health 1,000 and the proposed programme for children and young people. The Chairman suggested that the former St Bernard's Day Centre could be used for the latter project although it was noted that this site was not owned by the Council. It would be checked who was paying for the security costs at the St Bernard's site.

The Board **AGREED** that it was pleased with the Health 1,000 project and with the proposed organisation for children and young people.

92 **CHILDREN'S SERVICES SELF-ASSESSMENT**

The Group Director – Children's, Adults and Housing reported that Children's Services had been on an improvement journey since the service's last OFSTED inspection. There was a rising population in the borough and Havering was the highest net importer of children and families in London. There was an increasing level of diversity in Havering with many children not having English as a first language and pockets of deprivation.

Havering was seeing its highest recorded numbers of children protection plans and Looked After Children. There were also more incidents of children being taken into care and of Section 47 initial child protection investigations. The Council wished to support children to realise their potential and to focus on early intervention and protection. Children's Services had a similar vision to support excellent outcomes by helping communities to help themselves.

When the service was last inspected by OFSTED two years ago, a clear focus had been found on early intervention and prevention. Recent initiatives had seen the introduction of 1:2:1 parenting support for parents with drug or alcohol issues. A strengthened family training programme had also been introduced. Housing officers had also now been placed within Early Help Services.

OFSTED had found motivated staff with manageable caseloads. Since the inspection, caseloads had increased but staff were now more motivated. There was a new children's commissioner within the CCG and a new commissioning manager had also been appointed in children's services. A lot of trained social workers were now choosing to stay within Havering.

OFSTED had previously found that the Common Assessment Framework was not embedded in Havering but this had now been replaced by the Early Help Assessment Process. The previous performance management framework had been found by OFSTED to be underdeveloped but the

quality assurance framework now used in the directorate was very good. Cases were audited on a six-weekly basis as well as monthly with police and health.

A Child Safety Performance Board was chaired by the Leader and a Children's Services Improvement Board also met regularly. The Multi-Agency Safeguarding Hub (MASH) was operating well. The Community MARAC was also performing effectively in providing help to the most difficult cases not meeting other thresholds. The Local Safeguarding Adults and Children's Boards had the same Chairman, allowing a useful crossover of work.

Placement stability for children was now much improved and there was better tracking of cases. Looked After Children participated in reviews and gave feedback annually during activities at the Stubbers Centre. Permanency planning if children if children were unable to return to the parental home now started at an earlier stage.

Challenges for the service included using too many agency staff and assessments and personal education plans taking too long to complete. The appointment of the Virtual Head was helping with this latter issue however.

The service's IT systems needed to be developed and training for social workers on the existing CCM system was commencing next week. Once the Care Act had been introduced fully, it was felt that a new IT system may be needed. Budget reductions and demand management were ongoing issues, as was the constant legislative change in this area.

Work in progress included the recent appointment of a new participation officer to improve corporate parenting. Fostering recruitment had improved but it was accepted that education of Looked After Children needed to be better. A principal social worker, covering both children and adults was about to be appointed.

The Chairman welcomed the update, feeling that the service was maintaining performance on less funding.

93 DOMESTIC VIOLENCE STRATEGY (VAWG)

The community safety team leader explained that a domestic violence strategy group had been set up, chaired by Joy Hollister and with representation from partners organisations. A recent positive development had seen the Mayor's Office commission a pan-London Advocacy Service which would fund an additional 3.5 domestic violence advocates for Havering.

The domestic violence strategy as presented to the Board was currently out for consultation and comments were required by the end of February. Officers were confident that everything listed in the strategy was attainable

and within the remit of what could be achieved. If domestic violence were to be tackled, this would reduce demand on children's services by one third. The Chairman felt that the plan was too long and covered too many scenarios.

A total of 30 domestic violence champions had already been trained within social work teams in Havering and it was felt that other roles such as GP practice nurses could also be trained in this area. Volunteers were also being trained to try to increase the uptake of male victims of domestic violence. Officers would however consider if the service was being spread too thinly.

It was **AGREED** that the Chairman would raise some specific questions on the draft strategy with the Group Director.

94 PRIMARY CARE STRATEGIC COMMISSIONING FRAMEWORK

The Board was addressed by Gemma Gilbert from NHS England. It was noted that NHS England was collaborating with CCG colleagues on a strategic commissioning framework. The framework had been based on what patients had indicated they wanted – accessible services for people with complex care needs and care that was proactive. The Health 1,000 model recently launched in Havering was considered to be a good example of collaboration across the system. NHS England was aware of work taking place in Havering and was excited about the CCG pilot on children's services.

The framework helped to clarify the service offer around primary care. The Chairman emphasised that it had not proven possible thus far to get approval to develop the Orchard Village Health Centre. It was important that this was progressed, given the large population influx coming into the Rainham area.

The Chairman welcomed any projects and pilots for joint working that the Board could be involved with. Gemma Gilbert added that the three Local Councils and CCGs had agreed to support a joint approach to co-commissioning. The CCG bid for this had been successful and Councils were therefore key partners in the commissioning of primary care. The Chairmen of the three local Health and Wellbeing Boards were due to meet the following day.

It was accepted that specific opening hours were not currently included in GP contracts. NHS England assumed that practices would collaborate to provide services and the Havering Federation Hub was an example of this. Incentives were given for given for the development of new models of care such as Health 1,000, not for individual GP practices.

NHS England had tried not to over raise expectations of the new framework. It was felt workforce issues were likely to be the biggest challenge. It was noted that the Framework stated that all practice would be open 8 am – 6 pm Monday – Friday and 9 am – 12 pm Saturday. NHS England considered this to be an ambition however rather than the current situation. The framework would be published on the Healthwatch Havering website and Healthwatch Chair felt that the statement in the framework re GP opening hours was too categorical.

Conor Burke agreed to take forward producing a short additional document describing the current position in Havering and explaining that the Framework covered the whole of London. A case study supplement of existing work could also be circulated by NHS England.

The Board **NOTED** the position.

95 HEALTH AND WELLBEING STRATEGY FOR APPROVAL

Philippa Brent-Isherwood asked that any comments on the strategy could be fed back to her. Sue Milner added that she would make sure the most up to date data was included. Specific comments and issues raised included:

- Page 10 of the draft strategy – The projected rise in the children's population of 8.2% by 2016 was if anything a low estimate given the rises seen recently in Looked After Children and children on Child Protection Plans.
- Page 16 – It was felt that it should be noted that it was the Council as a whole that had to reduce budgets, rather than just Social Care.
- Page 17 – Officers confirmed people with long term conditions had the most complex and costly needs and posed the greatest challenges. It was noted however that savings could also be made across the rest of the population and that this section could be reworded to reflect this.
- Page 21 – It was suggested that the case study should be removed from the document as this was not part of the strategy.
- Page 24 – The data indicating a very low number of children recorded as having a learning disability would be checked for accuracy.
- Page 28 – The figures for the premature mortality rate in Havering would be clarified.
- Page 30 – Specific date on the numbers of hospital admissions that could be avoided would be included in the Action Plan to be brought to the next meeting of the Board. It was added that there was an existing policy to monitor older people who were discharged from hospital.

- Page 32 – References to the Council's ability to support independence for people in their homes would be included in the Action Plan.
- Page 34 – A definition of a child living in poverty would be needed as would an indication of at what point the Early Years Pathway would end.
- Page 35 - The data on the conditions responsible for avoidable hospital admissions would be checked to see if cellulitis needed to be included. The wards where there were particularly high rates of admission would also be clarified.
- Page 39 – The correct designation for Councillor Brice-Thompson would be added.

Subject to the above points the Board **AGREED** that that the strategy was of very good quality and the Chairman confirmed he was happy to sign off the document. It was **AGREED** that Philippa Brent-Isherwood would bring the Strategy Action Plan to the next meeting of the Board.

96 **ORCHARD VILLAGE GP**

It was noted that NHS England needed to update on this issue rather than the CCG. The Chairman explained however that Old Ford Housing Association was due to meet with NHS Property next week re the Orchard Village Clinic. It would be known by next week if an agreement on the issue had been reached. It was **AGREED** that, if this was not the case, representatives of Old Ford Housing Association and NHS England should be asked to attend the next meeting of the Board to explain the position.

97 **ANY OTHER BUSINESS**

Following misreporting in the media concerning alleged links between medicines and dementia, the Interim Director of Public Health tabled a briefing on this issue. The Chairman suggested this could be the subject of an article in either the Romford Recorder or Living in Havering.

98 **DATE OF NEXT MEETING**

The next meeting would take place on Wednesday 11 March at 1.30 pm.

Chairman

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