CITY OF WESTMINSTER

MINUTES

Health & Wellbeing Board

MINUTES OF PROCEEDINGS

Minutes of a meeting of the **Health & Wellbeing Board** Committee held on **Thursday 1st October, 2015**, Rooms 3 & 4 - 17th Floor, City Hall.

Members Present:
Chairman: Councillor Rachael Robathan , Cabinet Member for Adults and Public Health
Clinical Representative from the Central London Clinical Commissioning Group: Dr Neville Purssell (acting as Deputy)
Cabinet Member for Children and Young People: Councillor Danny Chalkley
Minority Group Representative: Councillor Barrie Taylor
Acting Director of Public Health: Eva Hrobonova
Tri-borough Director of Children's Services: Liz Bruce
Clinical Representative from West London Clinical Commissioning Group: Dr Philip Mackney
Representative from Healthwatch Westminster: Janice Horsman
Chair of the Westminster Community Network: Jackie Rosenberg

Also Present: Councillor Barbara Arzymanow and Louise Proctor (Managing Director, NHS West London Clinical Commissioning Group)

1 MEMBERSHIP

1.1 Apologies for absence were received from Dr David Finch (NHS England), Dr Belinda Coker (NHS England) and Matthew Bazeley (Managing Director, NHS Central London Clinical Commissioning Group).

1.2 Apologies for absence were also received from Dr Ruth O'Hare (Central London Clinical Commissioning Group) and Andrew Christie (Tri-Borough Executive Director of Children's Services). Dr Neville Purssell (Central London Clinical Commissioning Group) and Ian Heggs (Tri-borough Director of Schools Commissioning) attended as their respective Deputies.

1.3 The Chairman advised the Board that Dr Ruth O'Hare was standing down as the Chair of the Central London Clinical Commissioning Group (CCG). The Chairman wished to place on record her gratitude for the enormous contribution that Dr Ruth O'Hare had made to joint working in Westminster

and to the Board. The Chairman then stated that she looked forward to working with Dr Neville Purssell who would take Dr Ruth O'Hare's place on the Board and as Chair of the Central London CCG.

2 DECLARATIONS OF INTEREST

2.1 No declarations were received.

3 MINUTES AND ACTIONS ARISING

3.1 **RESOLVED:** That

(1) The Minutes of the meeting held on 9 July 2015 be approved for signature by the Chairman; and

(2) Progress in implementing actions and recommendations agreed by the Westminster Health and Wellbeing Board be noted.

4 CENTRAL LONDON CLINICAL COMMISSIONING GROUP - BUSINESS PLAN 2016/17

4.1 Dr Neville Purssell introduced the report and advised that Central London CCG's Business Plan for 2016/17 was based on its vision to deliver care that was personalised, localised, integrated and centralised. The personalised care would ensure each person's care was unique. A key aim was to provide an integrated journey for patients and there would be re-configuration of the Whole Systems Integrated Care (WSIC). Dr Neville Purssell advised that the general themes of the Business Plan were linked to the wider North West London themes. The Board heard that a lot of work was underway in transforming mental health services and the affordability of WSIC presented a number of challenges.

4.2 Daniela Valdes (Head of Planning and Governance, NHS Central London CCG) then set out Central London CCG's transformational objectives for Westminster in 2015/16. The Board heard that the CCG wanted to address Westminster's priority in inequalities by developing a clear plan to address key areas of focus arising from the Joint Strategic Needs Assessment (JSNA) for the tri-boroughs and the CCG would be working closely with the JSNA to achieve this. In addition, the CCG sought to confirm models of care for key areas by establishing clear, shared delivery models and supporting incentive approaches. It also sought to establish priorities for contracting by developing a set of 'must do' key performance indicators (KPIs) to be included in contracts relevant to Westminster's needs. Daniela Valdes emphasised that the KPIs should reflect equalities considerations as well as financial performance. Programmes were to be re-configured to ensure planned care and a shift in care from acute services to community care services was being undertaken. As well as the transformation in mental health services, the Board noted that primary care would be strengthened by increasing out of hospital initiatives.

4.3 In reference to the transformation in mental health services, the Board emphasised the need for a joined-up approach, particularly as some mental health services were provided by local authorities. It was commented that the proposal to have a clear strategy in place by June 2016 regarding primary care estates was ambitious. Another Member stated that it was important to demonstrate how partner organisations would work together, including health trusts, and that the partner organisations understood how they would work collaboratively. It was asked whether a joint commitment would be made by partner organisations and suggested that a common statement from the partner organisations be made to show how they would work together.

4.4 In reply, Dr Neville Purssell advised that the CCG was considering how it could bring some services out to the community, however finding available and appropriate accommodation was an issue. An assessment of what would be needed to provide more community services was required and Dr Neville Purssell acknowledged that this piece of work should be undertaken jointly with partner organisations, including local authorities. He advised that one of the WSIC's aims was to work with the providers network to maximise benefit both in terms of patients and in meeting financial challenges. Increasing the number of those in community care would take some pressure off acute services and allow it to focus on priorities, as well as being financially desirable. Daniela Valdes added that discussion was just beginning on how the partner organisations would work together and that some acute service providers were also willing to offer community services. The WSIC also sought to emphasise that organisations work collaboratively in partnership in meeting future challenges.

4.5 Jackie Rosenberg stated that her experience of attending Provider Network meetings of the Central London CCG demonstrated the scale of the challenges faced. She advised that she was working as the voluntary and community sector representative with colleagues, including with the Council's Social Services to design a Whole Systems new integrated model of care for those over 65 years of age and those with long term health conditions. A business case had been produced and it had been demonstrated how important contributions from the voluntary and community sector were. She spoke of the challenges of moving from the current model of care to a new model of care. She stated that investment would be needed to achieve the new model of care through 'invest to save'. However, no agreement on investment had been agreed as funds were not yet available and she felt that some organisations needed to set aside self-interest to facilitate this. The challenge was to make these funds available and she suggested that it needed to be driven from a larger scale than just the individual CCGs in order to make it affordable.

4.6 The Board recognised the enormous challenges faced in changing the model of care and recognised there was not a large amount of investment available to undertake this. It was requested that the the West London CCG Business Plan for 2016/17 be circulated to the Board. In reply, Louis Proctor (Managing Director, West London CCG) confirmed that the Business Plan would be circulated and the principles included focusing on mental health and a business case was being prepared for January 2016 in respect of WSIC to

take into account the number of people with long term health needs. Louise Proctor advised that the WSIC was similar to Central London CCG with some differences in approach and the Business Plan also outlined the journey of integration. There were also some differences on the technological platform used, with one IT system across all practices which facilitated joining up of records. Dr Neville Purssell advised that three 'test villages' were being set up in Central London as part of phasing in a care coordinating system by April 2016 which would eventually serve all the entire population.

4.7 A Member spoke of the big pressure in Westminster in respect of the GP estates and enquired whether West London CCG faced similar pressure. In reply, Louise Proctor advised that West London CCG was required to have an estates strategy by March 2016 that looked to understand what services and providers were currently in place, how the estate could accommodate this and what properties were available and she added that primary care estates were also a challenging issue for the West London CCG.

4.8 A Member enquired what steps were taken by the Central London and West London CCGs to ensure that providers were in tune with the business plans. In reply, the Chairman advised that providers met with CCGs on a quarterly basis to discuss such issues, whilst providers including Imperial College Healthcare NHS Trust also met monthly in respect of the Better Care Fund. She added that it was encouraging that Imperial College had also put themselves forward to be a community care provider.

5 WESTMINSTER HEALTH AND WELLBEING HUBS PROGRAMME UPDATE

5.1 Liz Bruce (Tri-borough Director of Adult Social Care) presented the report and advised that the main purpose of the programme was to ensure that resources that were already available were being used effectively and to make services more accessible, particularly for young people, who may be reluctant to access services in the way they were currently offered. The programme also looked to address supporting older people who may be socially isolated. Liz Bruce advised that the programme was now achieving better outcomes and in the longer term it was planning to change patient behaviour in order to help reduce costs.

5.2 Eva Hrobonova (Acting Tri-borough Director of Public Health) added that Public Health were involved in a number of initiatives in the programme, including the Newman Street Project temporary accommodation project. Meenara Islam (Principle Policy Officer) then provided further details on the Newman Street Project, which provided accommodation to single, homeless people with complex and multiple needs, including mental health issues. She advised that there were four floating support officers involved in the project who sought to identify the needs and aspirations of those staying at Newman Street and to help improve uptake of services for them. The project also sought to address preventative measures and was working with Great Chapel Street Primary Care Centre who were helping to improve access to services.

5.3 The Chairman stated that the Programme was at an early stage and was looking to intervene to help older and young people's needs at an earlier stage and to make services more accessible. She welcomed ideas from the Board. A Member commented that sport and leisure would play an increasing role in helping people to a healthier lifestyle and suggested that there was an opportunity to integrate activities at the Moberly Sports and Education Centre. Therefore, he suggested that thought be given as to whether Moberly Sports and Education Centre was an appropriate site to accommodate activities. He also felt that it may be more helpful to use the term 'professional support' rather than 'services'. In reply, Liz Bruce stated that there should be consideration as to how empty space could be utilised, whilst it was important to consider where professional services would be located and how would they be accessed. She emphasised the importance of sharing assets to help work in an integrated way. The Chairman added that those in most need may not be able to access sports and leisure centres, whilst the hubs could also provide virtual professional support and services.

5.4 A Member commented that were was a lot of expertise amongst community organisations and more effort should be made to engage with such organisations. For example, she stated that her organisation had played a key role in ensuring that the Newman Street Project happened. The Member stressed the importance of allowing voluntary and community organisations to contribute to the programme and at an early stage to help co-design and co-produce schemes. She suggested that a half day session be run to discuss ideas on how the programme can be taken further. Another Member also expressed an interest in her community organisation being involved and stated that a multi-organisational approach would be beneficial, particularly in early intervention work for areas such as domestic violence and young offenders.

5.5 The Chairman explained that the programme had been reported back to the Board at an early stage to ensure that suggestions and contributions could be made to help shape and develop the programme. She welcomed both community and health organisations to join the programme's Working Group. The Board agreed that Meenara Islam contact Members to nominate volunteers to become involved in the programme and the Working Group. It was also agreed that an update on the programme be provided at the next meeting.

6 DEMENTIA JOINT STRATEGIC NEEDS ASSESSMENT - COMMISSIONING INTENTIONS AND SIGN OFF

6.1 Colin Brodie (Public Health Knowledge Manager) introduced the item and stated that data from a wide range of sources had been taken to help inform future commissioning intentions for dementia. He advised that dementia rates were increasing and it was predicted that those with dementia would increase by around 55% in the next three years across the tri-boroughs. Dementia diagnosis rates were also rising because of improvements in diagnosis rates. The Board heard that most of the cost of supporting those with dementia fell on unpaid carers and adult social care, and so there would be a need to support, advise and empower cares to fulfil this role without a detriment to

their own quality of life. There was also a need to increase training for both paid and unpaid carers. Colin Brodie advised that because dementia services were provided by a range of services, better cohesion and collaboration was needed through well-coordinated information, advice, advocacy and outreach services. It was also recognised that people with dementia needed to receive parity of access across mental and physical health services.

6.2 Colin Brodie advised that the dementia Joint Strategic Needs Assessment (JSNA) was rated against National Strategy Objectives, NICE guidance and views expressed by people with dementia and their carers, qualitative research with clinicians and other supporting evidence. The key themes from the North West London Strategic Review of Dementia had highlighted the importance of achieving timely diagnosis, whilst balancing against support being available for post-diagnosis. Colin Brodie then referred to the 32 recommendations in the report on how dementia services should be provided.

6.3 Lisa Cavanagh (Interim Joint Commissioner – Dementia) commented that local authorities and CCGs needed to consider how the Dementia JSNA had informed them and she emphasised the importance of the need to ensure that dementia services aligned with the North West London Strategy. The Board heard that consultation with stakeholders about the proposals had been undertaken over August and September and data was being collected to assess whether there were any gaps in services. The information obtained would help inform development of service models and examples of good practice at centres would be identified to help improve services. Lisa Cavanagh advised that overall the aim was to provide enhanced dementia services. It was intended to provide a 'hub and spoke' model involving main hubs supported by resource centres. The recommendations had identified that there had been fragmentation of services and the hub model sought to align all services. Lisa Cavanagh sought views as to whether a Joint Health and Social Care Dementia Programme Board across the tri-boroughs was desirable.

6.4 The Board welcomed the recommendations in the report, however in respect of the recommendations concerning residential care, it was noted that this piece of work was already being undertaken by local authorities and CCGs on older people. In respect of a Joint Health and Social Care Dementia Programme Board across the tri-boroughs, it was commented that this would make sense in ensuring a more joined-up approach. It was suggested that a multi-agency forum be created to help support the changes to Dementia Services and that the model of residential care be replaced by extra care and other models of care. Another Member felt that more information was needed on how to address dementia to help voluntary organisations such as the befriending service in Westminster that worked with older people. She stressed that dementia was a public health issue and suggested that key supportive messages would be useful. The Board acknowledged that charities also did a lot of work on dementia.

6.5 Louise Proctor advised that there was a coordinator of care in terms of total needs for older people in WSIC and that work on dementia should be coordinated with this. The Board agreed that progress on the dementia JSNA

be reported back to the 21 January 2016 meeting. The Board also agreed that Lisa Cavanagh look into setting up a body to oversee implementation of the dementia strategy with a view to the body regularly report back to the Board. The Board signed off the Dementia JSNA.

7 WESTMINSTER PRIMARY CARE PROJECT UPDATE

7.1 Stuart Lines (Deputy Director of Public Health) introduced the report and advised that the project looked at future needs of primary care through assessing demographics, disease patterns and policy changes. He then introduced Damien Highwood (Evaluation and Performance Manager,) who gave a presentation on the three stages of the project. The first stage looked at demographics, including a record of projections, including breaking down into selected age groups, and developing a model linking population to future needs. The Board heard that the population had grown by 3% in the last year despite a fall in birth rates as death rates had also fallen. There had been a significant increase in those over 85 years of age, with numbers doubling in the last 13 years. Damien Highwood advised that the issue of accuracy for demographics also needed to be considered as it was complicated by factors such as the large numbers of second home owners in Westminster and the national and international flows of people in and out of the borough. Another issue was the percentage of population that were registered with GPs. Damien Highwood advised that the second stage involved overlaying other impacts on demand, whilst the third stage involved creating model development opportunities for the future.

7.2 Andrew Rixom (Public Health Analyst) added that 50% of the population were classified as fit and healthy with no health issues. Obtaining local data was also largely dependent on GPs sharing data with the local authority's data.

7.3 The Board welcomed the useful information that had been collated to date that would help inform where to focus future primary care services. A Member commented on the pressures on adult social care funding both locally and nationally if demand rose as projected. A number of interdependencies existed within primary care, such as the level of vacancies in NHS and how this related to immigration policy. Another Member remarked that it was important to tackle preventative illnesses through changing lifestyles and diet. She also suggested that consideration of what areas were experiencing a population increase in Westminster on a ward basis would be beneficial. It was commented that the impact of changes to the tax credit system should be factored in. It was also important to consider whether population was based on the Census or the register of GPs, whilst the challenges of delivering primary care whilst fewer new GPs and nurses were coming through also needed to be considered. It was noted that obesity and the effects of it had not been mentioned in the report and presentation.

7.4 In reply to the issues raised, Andrew Rixom acknowledged that tackling preventative illnesses through lifestyle and diet changes could be included as a factor for the model. Immigration was also a factor and the Board was advised that the death rate figures for those over the age of 85 was based on figures from the Office for National Statistics. It had been expected that the

death rate amongst the over 85s would continue to fall, however this had not been the case in the last three years. Andrew Rixom stated that cultural and behavioural elements also needed to be considered. He advised that GP lists in Westminster were variable in terms of whether they accurately reflected population and some patients, such as those in Queens Park and Paddington areas, may not be Westminster residents. Andrew Rixom acknowledged that obesity was also a factor and that it could lead to the prevalence of some diseases.

7.5 Damien Highwood stated that changes of policy, both at Westminster and national level, may also impact upon primary care and these would be factored into the model. It was important that the relevant partners, organisations and agencies reached an agreement into what the likely impact of changes to policy would be.

7.6 The Board agreed that phase two of the project should provide an overlay of the present situation and identify influencing factors, as well as taking stock of the existing GP provision. The Board agreed that the third phase should involve local authorities and CCGs considering how they would provide primary care services to meet future needs. The importance of ensuring that there was representation on all sides was emphasised. The Board also requested that Stuart Lines work with CCGs and NHS England in developing the Westminster Primary Care Project.

8 CHILDREN AND FAMILIES ACT UPDATE

8.1 Ian Heggs presented the report and advised that the Act represented significant changes to the way services are delivered to young people with Special Educational Needs (SEN). He advised that the Government had extended the time that Education Health and Care Assessments should be undertaken from 14 weeks to 20 weeks due to the problems local authorities were having in meeting this timeframe. In the case of Westminster and the other tri-boroughs, the proportion of SEN pupils was above the national average. The Board noted that the extension of some Education Health and Care Plans up to the age of 25 placed more financial pressures on local authorities as no additional funds were provided for this. However, a more joined-up approach was being taken and draft guidance was to be published in respect of post-19 education. There was also now provision of transport for post-19 year olds. Ian Heggs advised that a Parent Reference Group had been set up in April 2014 as part of the key theme of ‘co-production’. Although the Group was new, steps were being taken to strengthen its role.

8.2 A Member commented that the changes from a more personalised transport provision for SEN pupils to the current service involving larger vehicles had broken personal relationships and had been a stressful experience for some SEN pupils. He expressed concern about the additional financial pressures on local authorities to provide extended services and the stresses it placed on staff. In reply, Ian Heggs advised that additional temporary grants for SEN pupils were available and he would provide details to Councillor Barrie Taylor on this, as well as workload information for SEN staff. Ian Heggs added that finding high quality SEN staff was a national issue.

9 BETTER CARE FUND UPDATE

9.1 Liz Bruce presented the report and advised that a reduction in savings and benefits in delivering the plan was expected from the original forecast due to reductions in expected benefits arising from residential and nursing placements and Section 75 Agreements. As a result, a savings gap of £2.489m was forecast and some real financial challenges lay ahead. Liz Bruce drew the Board's attention to the revised expected savings as set out in the report. The Board noted that a Director for WSIC had been recruited.

10 PRIMARY CARE CO-COMMISSIONING UPDATE

10.1 Christopher Cotton (PA Consulting) presented the report and advised that the eight local CCG Co-Commissioning Joint Committees work was framed by the North West London Co-Commissioning Committee. Board Members were invited to represent the Board on the local Joint Committees. Christopher Cotton advised that the CCG chairs considered how primary care would look like in the future and discussed issues concerning implementation, funding and the model of care. The Joint Committees considered governance issues and proposals and regular updates on their work could be provided to the Board. Christopher Cotton added that co-commissioning would increase scope for pharmacies in the future.

10.2 Louise Proctor stressed the importance of ensuring the appropriate representation on the local CCG Co-Commissioning Joint Committees. She stated that striking the right balance with the role of NHS England was also important. Louise Proctor acknowledged that it was better to have a local conversation and to able to influence local decisions in co-commissioning, however it did present a more complex way of decision-making.

10.3 A Member commented on the challenges posed by primary care co-commissioning, such as the current fragmented nature of the provider network and the potential conflict of interest that may arise from an organisation that played both a commissioner and provider role. There were also concerns about the quality of service provided by new providers and their financial stability. The issue of how CCGs were faring in terms of risk management and risk assessment also needed to be considered. The Board concurred that conflict of interest was an issue. A Member requested more information on social services authorities and other local authorities in North West London in future papers. Another Member stated that the financial challenges could not be underestimated, particularly in respect of adult social care, and it was important that partners worked together closely to address this.

10.4 The Board emphasised the importance of local authority representation in terms of governance. The Board acknowledged that although the overall direction of travel was satisfactory, there were a number of elements that were challenging to manage. The Chairman indicated that more time would be given to discussing primary care co-commissioning at future Board meetings.

11 MINUTES OF THE JOINT STRATEGIC NEEDS ASSESSMENT STEERING GROUP MEETING HELD ON 27 JULY 2015

11.1 The Board noted the minutes of the Joint Strategic Needs Assessment Steering Group meeting held on 27 July 2015.

12 WORK PROGRAMME

12.1 The Board noted the current Work Programme.

13 ANY OTHER BUSINESS

13.1 There was no additional business for the Board to consider.

The Meeting ended at 6.16 pm

CHAIRMAN: _____ **DATE** _____