MINUTES of the meeting of Thurrock Health and Wellbeing Board held on 10th February 2014 at 10.00am

Present:

Board Member	Position	Organisation
Councillor Barbara Rice	Chair and Portfolio Holder for Adult Social Care and Health	Thurrock Council
Councillor John Kent	Leader of the Council	
Councillor Shane Hebb	Opposition Group Representative	
Councillor Joy Redsell	Opposition Group Representative	
Roger Harris	Director of Adults, Health and Commissioning	
Andrea Atherton	Director of Public Health	
Lucy Magill	Chair of Thurrock Community Safety Partnership	
Mandy Ansell	Chief Operating Officer	Thurrock Clinical Commissioning Group
Len Green	Lay Member Patient and Public Participation	
Andrew Pike	Director	NHS England Essex Area Team
Kim James	Chief Operating Officer	Healthwatch Thurrock

Apologies:

Board Member	Position	Organisation
Barbara Brownlee	Director of Housing	Thurrock Council
Carmel Littleton	Director of Children's Services	
Dr Anand Deshpande	Chair	Thurrock Clinical Commissioning Group
Ian Stidston	Director of Commissioning	NHS England Essex Area Team

In attendance:

Name	Position	Organisation
Ceri Armstrong	Strategy Officer	Thurrock Council
Jane Gregory	Administrator	
Dermot Moloney	Business Improvement Manager	
William Guy	Head of Commissioning	Thurrock Clinical Commissioning Group
Ade Olarinde	Chief Finance Officer	

Item	Key points and actions	Owner and deadline
1. Apologies for	Apologies as detailed.	

absence		
2. Additional items	The CCG's two-year operational plan was added as an additional agenda item.	
3. Declarations of interest	None	
4. Thurrock Draft Better Care Fund Plan	MA and RH presented and summarised the Plan. Key points included: • A section 75 agreement was required and would define the relationship between the CCG and Council – the agreement would be brought back to a future Health and Wellbeing Board for agreement. • It was vital for the governance arrangements to be right. • Delivery of the Plan's ambitions would require a shift in resource from acute to community services. • The focus of the Plan was on older people and unplanned care. • The BCF was the minimum amount to be placed in pooled funding arrangements – the expectation was that the CCG and Council would put addition elements of their respective budgets in to the pooled arrangements. • The Primary Care Strategy would be a key part of the BCF and the achievement of its ambitions. • Providers were being engaged through the establishment of a Strategic Leadership Group. Ade Olarinde, Thurrock CCG's Chief Finance Officer, provided an overview of the CCG's financial plan. Key points included: • The CCG had to produce a 2 year operational plan and 5 year strategic plan. The first draft of the 2 year operational plan was to be submitted on the 14th February – alongside and consistent with the BCF Plan. • Thurrock CCG's annual budget for 14/15 and 15/16 was estimated to be £187 million (including £4 million running costs). • Although modelling was still being carried	

	out, the CCG's QIPP challenge was estimated to be £10 million – the CCG was currently delivering 80% of its QIPP challenge. • The key challenge for the CCG in relation to the BCF was the additional £1.1 billion (nationally) that was expected to transfer from CCG core budgets in to the BCF – the CCG was working to identify and unlock this funding. • A target for the CCG (nationally) was to reduce emergency activity by 15% over five years. The targeted for elective activity was a reduction of 20% over 5 years. The Board raised a number of questions in relation to the draft BCF Plan: Data Sharing – how was this being addressed? • NHS and Social Care were already tracking patients through use of the NHS number. • AP stated that there was a potential risk concerning data sharing. • MA added that the CCG and Council were linking to the local Information Governance lead – Jane Marley and that the CCG were now an accredited Safe Haven. • RH added that operational teams explicitly asked their patients for permission to share any personal data and that this had not been a barrier to working across two organisations. Communication with BTUH was critical and this appeared to be lacking • Work was being carried out regarding the BTUH contract – including shifting resource currently at BTUH to community providers. This work was taking place in conjunction with Basildon CCG. It was agreed that this point might need to be made more visible within the BCF. Would the Public Health Grant sit within the BCF? • The PH Grant would currently sit outside the BCF as a ring-fenced grant. There	

	would be future consideration given to the grant being included as part of the BCF. Pooled Fund • AP commented on the rules and regulations that would detail how the BCF could be used. This included any funding added to the BCF pooled fund having to stay in the pooled fund – e.g. including any savings made. • It was possible that flexibility would be reduced if the BCF was expanded and local arrangements might need to be considered. • Further guidance was expected. **RESOLVED that the Thurrock Better Care Fund Plan be noted; that the steps and milestones being taken to develop the final draft be noted; and that the vision and direction of travel contained within the draft Plan be endorsed.** **Additionally:** **The Board agreed that a co-produced engagement plan be appended to the final BCF Plan.**	
5. CCG 2-year Operational Plan	(Item 2 refers) William Guy, Thurrock Clinical Commissioning Group Head of Commissioning, presented a summary of the emerging 2-year Operational Plan. Key points include: • There are five outcome areas that the Plan has to deliver against • Outcome 1 – although Thurrock are significantly above the national average, the area of concern was cardiovascular and cancer outcomes. In particular, there was an issue with individuals presenting with advanced stages of cancer for the first time at Accident and Emergency • Outcome 2 – Thurrock was in-line with this target. The focus would be on the difference in life expectancy between those who had a long-term condition (LTC) and a mental health condition, and	

	those who did not have a mental health condition alongside their long-term condition. There was to be a focus on respiratory conditions. The Mental Health Strategy would focus on LTCs to improve outcomes. • Outcome 3 – The focus was on Planned Care. The CCG performed well on this area. • Outcomes 5 and 6 – these were critical as they were areas where the CCG was struggling. The focus was on patient experience in and outside hospital, and the speed of accessibility. **RESOLVED that the Board agreed that Thurrock CCG's Operational Plan be an item on the March Health and Wellbeing Board.**	**WG**