HEALTH AND WELLBEING BOARD, 20TH JUNE 2019

PRESENT:

CALDERDALE COUNCIL MEMBERS
Councillors Baines MBE, Evans, Metcalfe, Wilkinson and T Swift MBE (Chair).
Julie Jenkins (Director, Children and Young People's Services) and Caron Walker (Assistant Director, Public Health – substitute for Paul Butcher).

CALDERDALE CLINICAL COMMISSIONING GROUP MEMBERS (CCG)
Dr. Majid Azeb, Dr. Steven Cleasby (Deputy Chair) and Dr. Matt Walsh

CALDERDALE DIVISION, WEST YORKSHIRE POLICE MEMBERS (WYP)
Chief Superintendent Richard Whitehead

HEALTHWATCH CALDERDALE MEMBERS
Helen Hunter

CALDERDALE AND HUDDERSFIELD FOUNDATION TRUST MEMBERS (CHFT)
Catherine Riley (substitute for Anna Basford)

SOUTH WEST YORKSHIRE PARTNERSHIP FOUNDATION TRUST MEMBERS (SWYPFT)
Tim Breedon

CALDERDALE VOLUNTARY ACTION MEMBERS (CVAC)
Dipika Kaushal

LOCALA MEMBERS
Diane McKerracher (substitute for Karen Johnson)

1 APOLOGIES FOR ABSENCE

Apologies for absence were received from Robin Tuddenham (Chief Executive), Iain Baines (Director, Adults Services and Wellbeing), Paul Butcher (Director, Public Health), Karen Johnson, David Birkenhead (CHFT), Anna Basford (CHFT), Dr. Adrian Berry (SWYPFT) and Amanda Garrard (Together Housing).

(The meeting closed at 12:05 hours).

2 MEMBERS' INTERESTS

(Councillors Baines MBE and MK Swift declared an interest as they are elected Calderdale and Huddersfield Foundation Trust Membership Governors).

3 MINUTES OF THE MEETING HELD ON 21ST FEBRUARY 2019

The Chair of the Health and Wellbeing Board proposed the non-voting membership of two Councillors and one representative from Locala on the Health and Wellbeing Board, at the start of the meeting to ensure members could participate in the meeting.

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RESOLVED that:

(a) the Minutes of the Health and Wellbeing Board held on 21st February 2019 be approved as a correct record and signed by the Chair;

(b) Karen Johnson, (or a Locala Representative) be appointed to the Health and Wellbeing Board with non-voting rights; and

(c) Councillors Shoukat and MK Swift be appointed to the Health and Wellbeing Board with non-voting rights.

4 QUESTION TIME

The Chair of the Health and Wellbeing Board invited members of the public to ask questions of any Member of the Board.

(A) Councillor Hutchinson asked the following question:

General Practitioners perform a vital role in coordinating the care of people in an increasingly fragmented NHS. The right for each person to choose their GP, rather than being allocated one by the state, was one of the key features when the NHS was created, in 1948. The *"Prospectus for commissioning a single alliance contract for Care Closer to Home"*, which was published in December 2018, states, in the final paragraph of Appendix A: *"Currently, clinical responsibility for all patients within their own homes (including residential and nursing) sits with the registered general practice. Moving to integrated closer to home care will necessitate the development of a new model for clinical responsibility for patients within their own homes and responsibility will no longer sit by default with General Practice."* This is a major departure from the close relationship between GP and patient that has been in force since 1948. This group of patients include many with multiple complex conditions, who are most in need of coordinated care across a range of services. Will patients who are temporarily housebound also cease to be the responsibility of General Practice? If they become more mobile, will they return to the care of their original GP? Can you give the public a clear explanation of the change in services that they would experience under these proposals? Who will take over the responsibility for coordinating their care for the rest of their lives?"

The Chief Officer, Calderdale Clinical Commissioning Group (CCG) provided a brief oral update at the meeting, in response to the question raised: It was agreed that this information needed to be explicit, and that responsibility lay with the individuals. Consideration had been made to the different ways this could be achieved, but ultimately the principle needed to be held clearly by the person carrying the responsibility. Integrated care may not need to be the general practitioner, however it was felt this was much to do with GP capacity and there were further discussions to be had.

As a follow-up to the original question, Councillor Hutchinson requested if this item could be brought back explicitly to the Health and Wellbeing Board to agree, once further conversations had been had. Would this opportunity exist?

The Chief Officer, CCG advised that clarity of the dialogue with service users was to be agreed.

The Chair of the Health and Wellbeing Board advised that a brief response would be provided outside of this Board meeting.

5 CALDERDALE CARES – A GENERAL UPDATE AND UPDATE ON PRIMARY CARE NETWORK

The Head of Service Improvement, Calderdale Clinical Commissioning Group (CCG) submitted a written report regarding the continued development and delivery of Calderdale Cares. An introduction to the strategy confirmed the importance of the Wellbeing Strategy and Inclusive Economy Strategy as two key strands of the place-based vision for Calderdale, building on the delivery of Vision 2024. The structure of the strategy focused on a life-course including: starting well, developing well, living and work well and aging well. Progress had been made and noted in a number of key areas.

The report had also been considered at Calderdale's Integrated Commissioning Executive (ICE) and focused on the following areas for consideration:

- Delivery of recommendations from the Integrated Commissioning for Better Outcomes Peer Challenge, (this took place in May 2018);
- Update on Care Closer to Home;
- Development of a Joint Commissioning Strategy;
- Update on Calderdale Cares; and
- Discussion on the Better Care Fund.

Calderdale's Wellbeing Strategy had been developed and its content tested with local organisations to enable presentation at this Board meeting. Members were requested to consider the update and any views or comments which had been taken into account as the work progressed. Primary Care Networks were due to go 'live' on 1st July 2019, and progress around the related systems was noted. There were a range of delivery vehicles in terms of communication and the engagement implementation strategy.

The Leader, Councillor T Swift MBE, advised members of the Board that Cabinet had agreed the appointment of Members to the Calderdale Cares Localities at its meeting on 18th June 2019. There was more work to be carried out by the Council in terms of work which involved membership and participation in the overall project, however this was deemed a separate responsibility, aside from the role of this Board.

The Chief Officer, CCG queried how the Board felt about Calderdale Cares, in terms of its closeness to the work and establishing clarity around what it is about. Members suggested if new members had been appointed to the Localities (including Ward Councillors), understanding and engagement was required in terms of better supporting Calderdale Cares.

The localities were at very different stages of development. Central was open to a lot of people in terms of development. The difference was to be made collectively, with a distinctive approach of a 'bottom, up' process rather than imposing a blueprint. The focus would be involving Members alongside the alignment of wider groups and willingness from GP's and community services in order to better support service users. Commissioning of Adults Services had been built into the framework and was ongoing with Directors for Adults Services and Wellbeing and Public Health.

The Health and Wellbeing Board was to consider what progress had been made since the pilot year, and look at substantial items of the meeting in terms of integration moving forward. The national picture reflected the time this had taken in other areas, and considered the move from the start of Calderdale Cares projects to progression phases.

The representative for Healthwatch acknowledged Calderdale Cares having the right ambition, however there were questions around the 'bottom, up' approach directly involving the public. How were the public being engaged? Did people understand the role in their personal health, how it worked, as well as how the system worked?

It was hoped the system would provide flexibility within the system for services being interchangeable; for example: wherever people made contact to receive care, whether outside their locality, they should be able to receive this. It was agreed this was a practical point and there would be further conversations and re-firming of relationships with people to be had throughout the changes. It was anticipated that the changes would improve outcomes throughout all areas of work within the system.

It was suggested the Cabinet paper on Calderdale Cares was shared, as it best described the work, and included the strategy for Calderdale and purpose of localities, which focused on use being 'the best' use and ensuring services were effectively joined-up. A clear narrative was required to ensure the impact of service delivery, alongside building and developing momentum.

The Health and Wellbeing Board had previously received presentations from some of the Localities and Members agreed this would be something to progress. Consideration was to be given to the patient voice being built into Health and Wellbeing Board meetings. Once an Informal Health and Wellbeing Board had taken place to firm up this in further detail, it would be submitted for consideration.

Members discussed the need to empower localities in their decision-making around delivery, capacity and resource. It was noted that although Calderdale Cares would promote the same working throughout Calderdale, some localities would have differences between targets to best support the community and area. It was felt that ongoing work would need to be closely monitored in relation to Calderdale Cares and the Primary Care Networks, including working with local people to ensure integration would come together fully and did not become a device for services being changed in a 'done to' approach, rather than 'done with'. A seminar was considered to encourage Member awareness and understanding of the Calderdale Cares work, to better support constituents. It was suggested an informal session would be undertaken and submitted to a future meeting.

Members noted the role the Health and Wellbeing Board had in communicating and being the interface surrounding this project. There had been some significant financial pressures on the system, and Members acknowledged there would likely be national announcements to react and respond to later in the year.

The report noted the oversight of funding by Calderdale's ICE, specifically in relation to the Better Care Fund (BCF) where there had been a significant decrease in the current year. The reduction in some additional BCF funding had impacted services, and was awaiting a further spending review later in the year. Members acknowledged the loss of £1.3m within the year, and less to follow in future years; consideration had been made in how the funding arrangements were to continue to be managed by ICE and recommendations had been made about how work was being funded, including shortfalls and pressures. An example of this work related to Adults, Health and Social Care, where packages of care and the implications of Delayed Transfers of Care (DToC) had previously been funded substantially by the BCF.

RESOLVED that the report be noted.

6 CALDERDALE HEALTH AND WELLBEING STRATEGY

The Head of Service Improvement (CCG) and the Senior Scrutiny Support Officer (CMBC) submitted a written report regarding Calderdale's Health and Wellbeing Strategy. In October 2018, the Health and Wellbeing Board agreed that an informal meeting refresh of its' Wellbeing Strategy and identified leadership from the Local Authority and Calderdale Clinical Commissioning Group (CCG) would take the work forward. The Wellbeing Strategy was set within the context of Vision 2024 and outlined the aims of this vision, which read:

> *"Our vision for Calderdale in 2024 is for a place where you can realise your potential whoever you are, whether your voice has been heard or unheard in the past. We aspire to be a place where talent and enterprise can thrive; a place defined by our innate kindness and resilience, by how our people care for each other, are able to recover from setbacks and are full of hope. Calderdale will stand out, be known, and be distinctive. A great place to visit, but most importantly, a place to live a larger life."*

The strategy was focused on people rather than services, as well as the best and most effective ways of pushing prevention, which was deemed successful in this respect. It was noted that the progress and delivery was crucial in moving the work of the strategy forward. Any work which had been undertaken in Task and Finish Groups needed to be prompt and pragmatic in order to ensure efficient delivery.

The Board agreed the approach taken in regards to the development of indicators which supported delivery of the Strategy. The Health and Wellbeing Delivery Group, representing the Health and Wellbeing partnership, was requested to have oversight of the Strategy's development as well as the delivery. It was agreed that initial small-scale engagement of the strategy should take place in advance of it's presentation.

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The key performance indicators were outlined in the report and Members discussed these at the meeting. The strategy was not to become a performance document, as there were other action plans and databases which would underpin the work delivered as a result of the strategy's implementation and measure the outcomes.
It was suggested that any consideration given to indicators for measurable outcomes would focus on the four key aims of the strategy, e.g. starting well, developing well, living and working well, and ageing well. Members discussed different examples of measured outcomes through existing partnerships and collaborative work, for example, the Domestic Abuse Hub, where there was lots of work and partners involved in the subject and the progress of work was monitored and measured through relevant meetings such as the Community Safety Partnership and action plans, etc.

Officers shared a report regarding additional engagement activity, following the Informal Health and Wellbeing Board meeting. Feedback from this meeting had shown people had positive views on the approach, vision and overall appearance of the strategy. Areas for further development were discussed regarding high level indicators, what the Health and Wellbeing Board would consider, what the ambition of the strategy was and what this would mean for the trajectory in terms of outcome measures. There would be further engagement from the public and formal consultation on the strategy, which Members welcomed prior to its final sign-off in August 2019.

It was suggested that the Annual Improvement Plan be submitted to the Health and Wellbeing Board for progress monitoring purposes, and upon sign-off of the Strategy, a launch event would be held in Calderdale.

It was noted that secondary school pupils and the implications around mental health and early intervention had been included in the Strategy, however primary school pupils had not been. Could this be included, and would consideration also be made to referencing the early years? The Assistant Director, Public Health agreed this would be included within the Strategy and outcomes were measured through the Schools electronic Health Needs Assessment (e-HNA) Survey, so would be effectively evidenced.

RESOLVED that:

(a) the draft report be noted;

(b) the final version of the Calderdale Health and Wellbeing Strategy be presented to the Health and Wellbeing Board, for adoption at the meeting to be held on 8th August 2019;

(c) the first version of the Annual Improvement Plan including targets and trajectories be prepared for an Informal Health and Wellbeing Board session, and signed off at the following formal Board Meeting; and

(d) the Highlight Report, (including progress and exceptions), be added to the Health and Wellbeing Board agenda as a standing item.

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7 UPDATE ON OUTPATIENT TRANSFORMATION

The Assistant Director (CHFT) gave a presentation regarding Outpatient Transformation, which outlined the existing pathway, the case for change, the engagement strategy, new models of working and progress - one year on. The Outpatient Transformation had transpired due to the traditional outpatient provision which had been subject to increasing pressures, growing demand and leading to 'less than ideal' patient experiences.

In 2017, 500 people undertook a survey regarding outpatient provision and 95% wanted out of hospital care delivered in a different way, e.g. digital use and reduction of hospital visits, with care being provided closer to home. New models of care studied avoidance of unnecessary referrals, increased use of technology to access more patients through virtual or other communication methods, and delivering care in the most appropriate setting, for example: nurse-led clinics for specialist services, and generic services which were accessible in community settings.

The progress one year on was noted as follows:

- System-wide governance;
- Portfolio of models and concepts;
- 2018/19 sort positive impacts on 8,000 patients;
- 2019/20 plans to look at 26,000 appointments;
- Enabler for other efficiencies such as ASI's, bank and agency staff;
- Maximise digital opportunities;
- Primary/Secondary Care Pathways in Pilot;
- Strong clinical buy-in;
- Patient experience;
- Learning from Pilots;
- EQIA;
- Sharing Experience;
- Communications – Videos, posters and webpages;
- NHSI Conference;
- Linked with other organisations nationally;
- Transformation and HSJ Awards.

Healthwatch assisted as key partners by delivering quality assessments, which involved lots of engagement from clinicians and patients. The feedback received was paramount in shaping the system in terms of moving forward. The health systems had some of the most advanced digital platforms in the country, and this was something which could be capitalised upon. There was still work to be undertaken around the remote monitoring of digital systems, in terms of apps for long-term conditions, appropriateness for specific patients and delivering care in the most appropriate settings. Healthwatch and CHFT had undertaken further work with patients to give further consideration to those groups and patients who may require adapted concepts where they were unable to use services, access groups, etc. A range of communication methods had also been implemented to ensure everyone was aware.

It was noted that the programme was not about releasing monies but doing things differently, although the positive impact may provide some savings over time. CHFT required strong clinical buy-in in order to develop programmes which would best benefit patients.

Members discussed the following issues:

- What impact had this had on waiting times for patients with longer-term illnesses or those requiring urgent treatment? In response, Officers advised that previously cancer pathways had a process where if GP's had a high suspicion of cancer in a patient, there would be a 'fast track' for patients; this would result in an appointment with the consultant, diagnostics tests and then a return for an appointment, which resulted in a target for treating patients within 62 days (with a referral by day 38) with treatment being delivered in Bradford at a specialist centre. The new pathway had seen a reduction in waiting times and patients treated within 28 days of their initial referral. Where patients were transferred to Bradford, this had taken place within 19 days.

- Would specific services be more readily accessible within communities? In response, Officers advised that for those patients who had heart problems, they would be able to access 48 and 72 hour heart monitoring equipment at their GP surgery. Any referrals or concerns would immediately be submitted to the hospital physiologist.

- What had the impact been in terms of appointments? In response, Officers advised that the impact had been on 8,000 appointments to date which had meant patients did not have to attend at hospital, or where appointments had been streamlined. The plans for 2019/20 appointments was approximately 26,000.

- Was the reduction of appointments (a third) deliverable? In response, Officers advised that although this had been a huge ambition, the delivery principles would be set to support this.

- What should the role of the Health and Wellbeing Board be in this transformation and was there decision-making required? In response, Officers advised that the Health and Wellbeing Board had two functions in respect of this transformation. Firstly, understanding this and helping to further shape the context, and secondly, the wider responsibility, e.g. leading edge transformation, good practice and lessons to share, patient access to the hospital, climate change in terms of car usage around the hospital etc.

- It was noted that this was not part of the Health and Wellbeing Board's governance role, but a responsibility of the NHS.

- Members raised concerns around the possible danger surrounding the restriction of patient access to the hospital and reduction of cost, however it was acknowledged that progress in terms of the reduction of waiting times and care pathways had been positive and much easier to navigate to date. In response,

Officers advised that there was further work to be completed but there were some good examples throughout the process so far.

- Had further consideration been given to vulnerable patients, children with learning disabilities, etc.? In response, Officers advised that work had been ongoing with Healthwatch for vulnerable people and those with Special Educational Needs and Disabilities (SEND) to trial pathways first prior to rolling them out.

- An example was given of a child with epilepsy who had had severe difficulty in engaging with clinicians on hospital visits and had become very distressed; the new pathway had allowed for the child and parent to be virtually assessed from home which had proved more beneficial for both the child and clinicians than any previous consultations.

- Members commented on the positive aspects of the report and how timescales had already been much improved as the work had been somewhat overdue.

- In some cases, having an appointment with a clinician reduced the need for further appointments later down the line. Were we being mindful of how discerning we were of tests when diagnostics were at the forefront?

- A number of patients had queried when their appointments would be and how they would find out. Unknown to patients, and use of technology and time/admin capacity around where they sit in the process? In response, Officers advised that appointments needed to be right, and moving forward the best ways of accessing this information through technology or otherwise would be sought. The pathway and productivity aspects of the project had been reviewed separately, however the next stage would focus on the ‘Patient Portal’ and how communication with patients could be better improved to ensure impacts on staffing and resources were not negatively impacted.

- Were the Primary Care Networks aware of this work? Members wanted to ensure information was shared with the wider healthcare community so they were appropriately informed. Would the outpatient transformation impact on secondary care resources more than specialist care in hospital? In response, Officers advised that conversations had been had with GP’s and work was ongoing with partners to ensure the system worked.

- With staffing and budget pressures on the health service, patient experience was highlighted as a concern in terms of once the pathway had been embedded. Would it be changed if required, or stuck? What safeguards were in place for patients? In response, Officers advised that this was not a ‘one size fits all’ system and consideration had been made to differences which may have to have been made.

- Members acknowledged the interface with staff being a positive service but highlighted some concerns around the pathways. Officers advised that as with any human-system, there would always be challenges around any changes, etc. but ultimately these would benefit patients primarily.

RESOLVED that the report be noted.

8 DIGITALISATION UPDATE

The Assistant Director of the Health Informatics Service attended the meeting and gave an oral update on digitalisation in Calderdale. There had been significant improvements made within the way CHFT utilised digital technology as a provider, specifically in relation to social care and health services. Work had been undertaken to ensure the infrastructure of digital support was robust, safe and appropriately safeguarded. Primarily work had been undertaken to link the systems with the Primary Care Network, with the next stages focusing on sharing GP and acute data. There were a number of practices which had been utilising the system as well as inputting onto it. Clinicians had had experiences in pulling data from the system to better support patients, and work had initiated with Adults, Health and Social Care to integrate data across both health and social care platforms.

Officers provided an example of data productivity in South West Yorkshire, where mental health providers and paramedics had had access to GP and Acute data, allowing a much quicker response to a patient, which led to speedier treatment on arrival at Accident and Emergency.

Members discussed the important of patient experience and the benefits for both public and staff, including enhancing the efficiencies that would come as a result of utilising such systems, e.g. finances, lessened demand on staffing (phone calls) and resources (letters, etc.). Administration staff at the hospital had already noticed the benefits, alongside health professionals.

National visits from NHSE, NHSX and NHS Digital had been undertaken which highlighted the significant transformation changes, referred to as ‘system changes’ with digital use. These visits noted that the service had ‘quietly got on with doing the right thing’. The system was reflective of a patient’s entire journey, and would only be shared and used in a collaborative way on gaining consent of the individual.

Councillor Wilkinson, Cabinet Member for Children and Young People’s Services (CYPS), questioned whether integration with CYPS was something which had been considered. Officers advised that Adults Services had been a first step to prove the integration concept and seek benefits, and due to the difference in systems, if CYPS was to be integrated this would need conducting twice due to the data transfer, however it would be the next stage if beneficial for all organisations.

Work had been undertaken to ensure those patients who were vulnerable or at risk were appropriately safeguarded and understood the appropriateness of data sharing between health, social care and other organisations. Members discussed those who suffered with mental health and the potential perceptions of patients. There would be further communication to deliver from all organisations in supporting health

professionals and the public in understanding these changes and the positive impacts.

RESOLVED that the update be noted.

9 UPDATE ON THE CHFT STRATEGIC OUTLINE CASE

The Assistant Director of Strategic Planning (CHFT) submitted a written report on the Reconfiguration of Hospital Services Strategic Outline Case. The report outlined the compelling quality and financial case for changes in the local health and care system from 2012 to date, and the ongoing work for all health organisations and partners to develop a safe and sustainable model of hospital and community care.

The Strategic Outline Case (OBC) had been submitted to NHSE and NHSI, which was a document available to the public. The next stage would involve an approval process, and results of this were expected by the end of 2019. Once the approval process had been completed, an OBC would be submitted to describe all aspects of changes with regards to the building and staffing. The OBC would be undertaken in engagement with staff, stakeholders, Health and Wellbeing Board Members, etc. and completed in 2020. The capital programme would provide £197m for the developments.

A recent engagement meeting regarding the project had been held in Brighouse with a wide range of partners. Would this programme be delivered throughout the rest of Calderdale so everyone was aware of the ongoing work and overall aim? This had been the launch of the initial project with staff and partners, however further work would be done as progress was underway.

Members discussed whether prevention and links to the Wellbeing Strategy had been considered for inclusion with either the Strategic Outline, or Business Outline Case? It was felt that there were other complementary strategies throughout partnerships, including those such as Care Closer to Home, Calderdale Cares, etc. which would attend to the population, health management and prevention aspects, amongst others. It was felt that these would not be included due to the nature of the project; sensitivity would be required in an initial public consultation and ensure the strong messages came through relating to improving the building for the community.

RESOLVED that the report be noted.

10 UPDATE FROM THE CHAIR OF THE WEST YORKSHIRE AND HARROGATE HEALTH AND CARE PARTNERSHIP

The Leader (CMBC) provided an oral report on the latest information and updates on the West Yorkshire and Harrogate Health and Care Partnership. The first meeting of the Partnership Board had been held, which had outlined a new part of the governance structure, involving Chairs of the Health and Wellbeing Board, Leaders and Chief Executives of the participating Councils and Health partners. The structure reviewed the purpose of the Board, where it would sit in terms of governance in an overall structure and how partnerships worked across all areas; it was noted some of these differences would differ from each area to the next. A 5 Year Plan was to be implemented across the partnership, with some elements of the NHSE directive

being adapted to suit the wellbeing needs of the people of West Yorkshire and Harrogate.

There had been £8.7m allocated as transformation funds across the partnership this year, and proposals would be taken from the different executive groups. Some funding had been identified to further support children and young people, which had been deducted prior to allocating the resource across the partnership. Development work was to coordinate vision and thinking across the board, and Members of the Health and Wellbeing Board discussed the need to evidence changes within the organisations through transformational work.

A recent report by Healthwatch regarding Question Time at Health and Wellbeing Boards was discussed at the meeting, and Councillor T Swift MBE suggested Members reviewed this to give consideration to the good practice.

The Chief Officer, Calderdale Clinical Commissioning Group (CCG) tabled a letter at the meeting on Integrated Care System Transformation Funding 2019/20 from the West Yorkshire and Harrogate Health and Care Partnership Board. It was agreed a response would be required from the Leader of the Council and Chief Officer (CCG).

RESOLVED that:

(a) the update be noted; and

(b) the letter received from the West Yorkshire and Harrogate Health Care Partnership regarding the Integrated Care System Transformation Funding 2019/20, be responded to by the Chief Officer (CCG) in consultation with Councillor T Swift MBE.

11 UPDATE ON MEMBERSHIP

The Chair of the Health and Wellbeing Board proposed membership under item 3/M1 of these minutes.

12 PREVENTION CONCORDAT FOR BETTER MENTAL HEALTH

The Director, Public Health submitted a written report regarding the prevention of mental health and encouraged sign-up from all partners. Signing up would commit organisations to a ‘Better Mental Health Consensus Statement’, in working together to prevent mental health problems and promote good mental health through local and national action.

Members agreed it would be useful for the relevant organisations to submit the Concordat to their respective governance meetings and approve sign-off.

RESOLVED that the Prevention Concordat be approved by all relevant organisations.

13 ITEMS FOR INFORMATION

(i) FORWARD PLAN

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The Policy and Partnerships Support Officer submitted a written report regarding the forward planner of agenda items to be heard at a future meeting of the Health and Wellbeing Board.

(ii) HEALTH AND WELLBEING BOARD FUTURE DATE

The date of the next formal Health and Wellbeing Board date would be held on 8th August 2019 at 10:00 hours; and the next Informal Health would be held on 25th July 2019 at 09:30 hours.

The Director, Children and Young People's Services advised the Board that a celebration lunch would take place in the Victoria Hall at 12:00 hours on 20th June 2019 where Council staff and Health colleagues would hear the headlines of the SEND Inspection outcome and congratulate them on their hard work.

RESOLVED that the forward plan and future dates be noted.