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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.30 pm	Wednesday, 10 April 2013	Committee Room 1 - Town Hall

Members: 12, Quorum: 3

BOARD MEMBERS:

Elected Members:	Cllr Steven Kelly, (Chairman) Deputy Leader of the Council and Cabinet Member for Individuals Cllr Andrew Curtin, Cabinet Member for Towns & Communities Cllr Lesley Kelly, Cabinet Member for Housing & Public Protection Cllr Paul Rochford, Cabinet Member for Children & Learning
Officers of the Council:	Cheryl Coppell, Chief Executive Joy Hollister, Group Director, Social Care & Learning Mary Black, Director of Public Health
Havering Clinical Commissioning Group:	Dr Atul Aggarwal, Chair, Havering CCG Dr Gurdev Saini, Board Member, Havering CCG Conor Burke, Accountable Officer, Havering CCG Alan Steward, (non-voting) Chief Operating Officer, Havering CCG
Healthwatch:	Anne-Marie Dean, Chairman, Havering Healthwatch

For information about the meeting please contact:
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What is the Health and Wellbeing Board?

Havering's Health and Wellbeing Board (HWB) is a Committee of the Council on which both the Council and local NHS and other bodies are represented. The Board works towards ensuring people in Havering have services of the highest quality which promote their health and wellbeing and to narrow inequalities and improve outcomes for local residents. It will achieve this by coordinating the local NHS, social care, children's services and public health to develop greater integrated working to make the best use of resources collectively available.

What does the Health and Wellbeing Board do?

As of April 2013, Havering's HWB is responsible for the following key functions:

- Championing the local vision for health improvement, prevention / early intervention, integration and system reform
- Tackling health inequalities
- Using the Joint Strategic Needs Assessment (JSNA)and other evidence to determine priorities
- Developing a Joint Health and Wellbeing Strategy (JHWS)
- Ensuring patients, service users and the public are engaged in improving health and wellbeing
- Monitoring the impact of its work on the local community by considering annual reports and performance information

1. CHAIRMAN'S ANNOUNCEMENTS

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

2. APOLOGIES FOR ABSENCE & SUBSTITUTE MEMBERS

(If any) – receive

3. DISCLOSURE OF PECUNIARY INTERESTS

Members are invited to disclose any pecuniary interest in any of the items on the agenda at this point of the meeting.

Members may still disclose any pecuniary interest in any item at any time prior to the consideration of the matter.

4. MINUTES (Pages 1 - 6)

To approve as a correct record the minutes of the Committee held on 13 March 2013 and to authorise the Chairman to sign them.

5. MATTERS ARISING/REVIEW OF ACTION LOG (Pages 7 - 8)

To consider the Board's Action Log

6. INTRODUCTION TO NEW MEMBERS

The Board to be introduced and welcome the following new members:

- Dr Mary Black, Director of Public Health, London Borough of Havering
- Anne-Marie Dean, Chairman, Havering Healthwatch

The Board also to welcome a representative of the national NHS Commissioning Board:

- Paul Bennett, Delivery Director (London), NHS Commissioning Board

PRESENTATION:

7. INTEGRATED CARE STRATEGY

To consider a presentation from the CCG Chief Operating Officer for Havering.

HEALTH & WELLBEING STRATEGY PROGRESS UPDATE:

8. PRIORITY 2: IMPROVED IDENTIFICATION AND SUPPORT FOR PEOPLE WITH DEMENTIA (Pages 9 - 14)

BUSINESS ITEMS:

9. HWB SUB STRUCTURE GOVERNANCE AND TERMS OF REFERENCE (Pages 15 - 26)

10. ANY OTHER BUSINESS

11. DATE OF NEXT MEETING

The Board is asked to note that the date of the next meeting of the Board is scheduled for 8th May 2013.

MINUTES OF A MEETING OF THE HAVERING SHADOW HEALTH & WELLBEING BOARD

13 March 2013, 1:30 pm – 3.30 pm
Havering Town Hall, Romford

Present

Cllr Steven Kelly (Chairman) Deputy Leader of the Council, LBH
Cllr Andrew Curtin, Cabinet Member, Town and Communities (Culture), LBH
Conor Burke, Accountable Officer, Havering CCG
Dr Gurdev Saini, Board Member, Havering CCG
Mark Ansell, Acting Director of Public Health, LBH

In Attendance

Kathy Bundred, Head of Children & Young People's Services, LBH (for item 129)
Dr Harpal Flora (and associates), Consultant, Barts Health NHS Trust
Dr Alex Tran, Board Member, Havering CCG
Sean Cable, Committee Officer, LBH (minutes)

Apologies

Councillor Paul Rochford, Cabinet Member, Children & Learning, LBH
Cllr Lesley Kelly, Cabinet Member, Housing, LBH
Dr Atul Aggarwal, Chair Havering CCG
Cheryl Coppell, Chief Executive, LBH
Joy Hollister, Group Director, Social Care and Learning, LBH
Alan Steward, Chief Operating Officer (non-voting), CCG
Julie Brown, HWB Business Manager, LBH

137. MINUTES OF LAST MEETING

The Board agreed the minutes of the meeting held on 13 January as a correct record.

138. MATTERS ARISING

Meeting in public

The Chairman informed the Board that meetings would be public starting with the Board's next meeting in April.

End of Life Training

Members were informed that Dr Saini had been meeting with the Board's Business Manager to agree a mutually acceptable position and the final report arising from those discussions would come to a future Board meeting.

Public Health Benchmarking

It was noted that benchmarking indicators for public health were not yet established and as such a further report on this would be coming to a future HWB meeting.

139. NORTH EAST LONDON ABDOMINAL AORTIC ANEURYSM SCREENING PROGRAMME

The Board received a presentation on a new national programme being established to offer screening for men over the age of 65 to detect Abdominal Aortic Aneurysm (AAA). It was explained that this condition was characterised by the widening of a vessel, specifically the aorta (the largest vessel in the body) and resulted in either the weakening or bursting of the vessel.

Members were informed that the chance of survival after a ruptured aneurysm was 20 out of a 100, however, when aneurysms were detected through screening the survival rate was 97-98%. There were approximately 6000 deaths from ruptured AAAs each year.

Most AAAs were detected whilst looking for other problems, therefore, the AAA screening programme was being rolled out to detect the condition in men aged 65 and over, who were said to be the group at the greatest risk. 2013 was the last phase of the roll out of the programme and Havering has a key area as it is the London borough with the highest number of men over the age of 65. It was suggested that some 6762 scans were anticipated.

The screening programme itself was described as non-evasive with the capacity for self-referral by patients. The screening team was flexible and the programme could be undertaken in a variety of health or community settings, without needing to be strictly medical facility. Typically, the team would hold three to five sessions in a week period.

The Board urged the delivery team to contact the local medical committee of GPs to raise awareness amongst clinicians of the service. It was further suggested that the team liaise with the new Director of Public Health for the borough once in place to ensure widespread awareness of the programme.

140. CANCER UROLOGY

The Board considered an update from Dr Alex Tran, CCG Board member, on proposals to remodel urological cancer services. The proposals centred on the idea of an integrated network of providers. For urological cancer plans were for a centre of excellence for complex surgery with satellite sites providing non-complex services.

The most likely site for this centre of excellence was to be University College Hospital. BHRUT was interested in bidding to be the centre of excellence but had since pulled out of contention leaving UCH the only centre in the running to offer the service. Non-complex sites would be focussed on one particular type of urological cancer, with one centre for bladder and prostate and one for kidney.

The intended plan for surgery and recovery at the centre of excellence was 1 day surgery for prostate cancer, 7 days for bladder, and 3 days for kidney with recovery for all such cancers taking place at the local satellite centres. The concern about the proposals was that teams were being dismantled, with opposition from local groups.

Board members expressed some concern that the proposals would impact financially on BHRUT, but CCG representatives informed the Board that complex surgery offered very little activity (or financially remuneration) relative to its total activity. Complex surgery was not a particularly lucrative practice. It was thought likely that overview and scrutiny would oppose the proposals and one problem that the model was being informed by data based on American patients. Travel into London would be problematic for patients requiring complex surgery and seemed to jar with the guiding principle for patient choice.

Members were keen that the Board should drive the response to proposals and expressed concern at the quality of information and its circulation. It was judged that much of the information that had been passed around was very misleading. The Board needed to know exactly what was being proposed and who was making the decision, as well as who needed to consulted. One Board member, it was confirmed, would be attending an event at which the issues would be explained to clinicians.

It was agreed that the Group Director, Social Care & Learning would attend the consultation event for clinicians to gain more information about the proposals and would report back to the Board.

141. FOLLOW-UP DISCUSSION ON PRIORITY 1 (EARLY HELP FOR VULNERABLE PEOPLE)

The Board considered a follow up verbal report from the Council's Head of Children & Young People's Services on services around early help for vulnerable people, which was one of the priorities in the Health and Wellbeing Strategy.

The Board was informed that early help for children was a particular kind of service tailored to children before they find themselves at risk of significant harm. The service was chiefly delivered through paired children's centres which operated on a 'hub and spoke' model, by which more services were offered through centralised units. Health partners were involved in the

children's centre offer, which also drew on the resources of the Troubled Families programme and had CAMHS support.

The Board was informed that domestic violence was the driver of the child protection plan and early help through children's centres was offered to those at the verge of becoming involved in social services. It was stated that the borough had been deemed to be less successful in terms of child protection plans by Ofsted.

The move towards a more integrated early help offer, through children's centres, was starting in the centre of the borough, to change the least challenging area, whilst the more challenging area (which would pose the greatest challenge to resources and management) would be tackled once the offer was firmly established.

The Board agreed that another paper should come to the Board in due course updating members on progress made and on comments from Ofsted.

142. HAVERING CCG – FINAL COMMISSIONING STRATEGY PLAN

The Board considered a report from Havering's CCG seeking approval for the CCG's CSP and QIPP plans to ensure that they were consistent and mutually supportive of the Health and Wellbeing Strategy 2012-14.

Since November 2012, Havering Clinical Commissioning Group had been developing its Commissioning Strategy Plan (CSP) and Quality, Innovation, Productivity and Prevention (QIPP) Plan in readiness for the financial year 2013/14.

This process had sought to identify and prepare to deliver a suite of projects that would:

- Meet the CCG's statutory responsibilities from 1st April 2013 under the Health and Social Care Act 2012
- Deliver priorities to improve the quality, safety, patient experience and outcomes of the health services that the CCG commission
- Support partners in the delivery of joint projects, services and wider Havering priorities
- Make £11 million of savings during 2013/14 to prevent a budget deficit

CSP and QIPP Plan development had involved heavy consultation with the CCG's key stakeholders, including the Health and Wellbeing Board, wider local authority, patient groups and voluntary sector. The CCG had ensured consistency of the CSP's priorities with the Health and Wellbeing Strategy (pages 2-3) and where appropriate, that the projects incorporated key Health and Wellbeing Strategy actions.

The CCG were now in a position to share the final draft CSP, within which the QIPP Plan was outlined (this report was submitted to the Board).

Additionally, Havering CCG was required by the NHS Commissioning Board (NHS CB) to produce and submit a 'Plan on a Page' to outline plans for 2013/14, which were also to be shared with the Board.

The next steps for CSP and QIPP Plan finalisation were:

- 20th March – Havering CCG Board sign off
- 5th April – submission to the NHS CB

The Board was informed that the CCG would be formally authorised from the 1 April 2013, with 6 conditions out of 119. Other areas had fared less well, with Waltham Forest having 25 conditions and Basildon 67. Havering's CCG was one of the best in London.

Responding to questions, the CCG representatives explained that the budget for the priorities contained within the CSP were still being finalised, with programme budgets due to be finalised imminently. A budget paper would be coming to the CCG Board within the next few weeks. It was felt that the CSP and the HWBS represented the best example of joint-working many members had ever seen between the NHS and local government.

Havering's CCG had a budget of £270 million with a target for 4-5% savings which was an average target compared to other CCGs. The CCG cluster (comprising Barking and Dagenham, Redbridge and Havering CCGs) had helped with the budget deficit at Queens to the amount of about £10 million, but there was no provision to assist Queens in the next financial year.

The Board noted the CSP.

143. ST GEORGES STRATEGIC OUTLINE CASE

The Board considered a report from Havering's CCG updating members on the St George's Strategic Outline Case (SOC) and to advise of progress in the development of the Outline Business Case (OBC).

Senior leaders from health and social care in Havering, along with senior leaders from Barking and Dagenham and Redbridge, had formally agreed to work together to improve integrated care and had agreed seven integrated care coalition principles. The integrated care strategy principles formed the foundations for developing the St George's SOC. The SOC built on and supported the strategy for integrated health and social care services in Barking and Dagenham, Havering and Redbridge. The integrated care SOC outlined the high-level direction for the development of integrated care and built on existing, successful examples of integrated care, such as integrated case management. Integrated case management (ICM) was currently being implemented in Havering, and formed the foundations for the transformation of delivery of care for people with long term conditions.

Working closely with our key partners the CCG had created a vision for a centre of excellence in Havering.

The Board noted the report.

144. ST GEORGES LEGIONELLA OUTBREAK

This item was deferred until further notice as the report had not yet been released from NELFT, the organisation which had conducted the investigation.

145. HWB DEVELOPMENT WORKSHOP FEEDBACK

Members stated that the workshop had been similar to many of the other events that had been organised and perhaps could have been more productive and informative.

146. FEEDBACK FROM 'CHALLENGE, LEARN, INSPIRE, CELEBRATE' EVENT

The member who attended the event stated that it had been useful.

147. DATE OF NEXT MEETING

The Board noted that the next meeting was due to take place on Wednesday 8th May 2013.

Health & Wellbeing Board

Action Log

Minute Ref	Meeting	Item for Discussion	Actions	Planned Completion date	HWB Lead	Actioning officer	future agenda item?	Date Completed	Issues Arising/ General updates
107	14-Dec-12	Emergency Hormonal Contraception	Scoping report to be produced	Jun-13	DPH	DPH	Yes - Jun-13		
118	09-Jan-2013	Minutes of previous meeting - ICS	Report from Jane Gately on the how rather than what and what she thinks the HWB needs to be doing to support this?	Mar-13	C Coppell / J Hollister	J Brown	Yes - Apr-13		
118	09-Jan-2013	Minutes of previous meeting - hospital performance sub group	Potential to disband sub group, given all other work going on at hospital to be discussed with Cllr S Kelly	Jan-13	C Burke	C Burke	No		
121	09-Jan-2013	End of Life Business Case	Further report required that sees costs shared and that looks at the delivery options.	Mar-13	Dr Saini / J Hollister	J Brown	Yes-May-13		
130	13-Feb-2013	Early Help for Vulnerable People	Further develop the indicators against each of the HWB Strategy priorities to increase partner accountability	Apr-13	C Coppell	J Brown	Yes-tbc		
tbc	13-Mar-2013	North East London Abdominal Aortic Aneurysm Screening Programme	Dr Durka and colleagues were asked to present details of the programme to the East London LMC to ensure clinicians were fully aware of the programme.		DPH	DPH	No		
tbc	13-Mar-2013	Cancer Urology	the Board wanted to clarify: 1) the process, i.e. who implements the decision, what consultation has taken place and who makes the decision 2) the content of the proposals. With this information, the HWB would develop a joint response. Attend an event at which clinicians and GPs were going to be briefed on the proposals and JOSC to gather more info.	Apr-13	J Hollister	J Hollister	Yes-Apr-13		

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Report to Health and Wellbeing Board – 10th April

Progress Update on Priority 2 – Improved identification and support for people with dementia

Introduction

The Dementia Partnership Board was formed in November 2012. It is accountable to the Health and Wellbeing Board. The Board is chaired by the Dr. Maurice Sanomi, the HCCG Clinical Director (Mental Health). Other members include:

- Group Director – Social Care & Learning
- Director of Public Health
- Assistant Director: Commissioning
- GP Clinical Lead (Adult Mental Health)
- HCCG Chief Operating Officer
- CSU Commissioning Lead for Dementia
- Transformation Programme Manager – Adults, Children's & Families

The Board is a strategic commissioning group but acknowledges the value of the provider perspective so will invite the Consultant Geriatrician/ BHRUT Dementia Lead to join the Board for some discussions.

The Board is the multi-agency mechanism which will develop and deliver Havering's Strategic plan aligned to the National Dementia Strategy, which will improve the quality of life and services available for people with dementia and their carers. Its key responsibilities are:

- Work collaboratively and in consultation with relevant partners to develop Havering's dementia strategy
- Provide executive advice and support to the Health and Wellbeing Board and ensure that the Board's strategic priorities are translated into action within the partner organisations
- Develop strategic oversight and priorities, ensuring that work is co-ordinated across all partner agencies.
- Work closely with other relevant partners around cross-cutting issues (such as medicines management)
- Ensure the delivery of these priorities via delegated actions to relevant sub-groups
- Monitor performance of sub-groups to ensure stated outcomes are achieved.

The Board has access to the funding remaining from that allocated to the Dementia projects funded by the NHS Support for Social Care 2011-13, which is approximately £200k.

Progress Against Action Plan

The Board met on 7th March to review progress and prepare this update for the HWB.

Objectives	Actions	Lead Partners	Progress Update – March 2013
1. De-stigmatise dementia and ensure sufferers and their carers receive the best possible support in managing their condition	Establish a multi-agency Dementia Partnership Board to implement a Havering Dementia Strategy, in line with the national strategic	LBH (Adults and Health) & HCCG	The Board is established and has reviewed the HWB Strategy actions in detail. It has agreed to fund a 1-year fixed term programme manager (funded from 2011-13 NHS Support for Social Care) to oversee the initiation of a programme of work to deliver the actions.
	Mainstream the application of assistive technologies to support people with dementia as part of a programme of purposeful walking	LBH (Adults and Health)	This pilot project has been running for approx 18 months. It has provided Vega "watch-style" assistive technologies to 51 people. An interim evaluation report indicated positive outcomes such as delay in entering residential care and increased peace of mind and quality of life for not only users of the devices but to their carers and families too. The final evaluation report on the Vega pilot is due in April and it is expected to provide more detail and analysis on outcomes and benefits that are being delivered. Evaluation of alternative assistive technologies was part of the project. The skyguard '"keyfob" device which is intended for clients with lower level dementia or early onset dementia has just commenced it's pilot in March 2013 and will be evaluated in summer 2013. It is anticipated that evaluation of all these technologies will be positive and they will be absorbed into the mainstream adult social care assistive technology offer in Havering during 2013.
2. Ensure high quality and accessible dementia information by improving data collection on the	System established to monitor GP recorded prevalence and practice (any reporting unusually low prevalence will be encouraged to participate in training to aid diagnosis)	HCCG	A resource within the CSU has been secured by the CCG to help review current patterns of referrals and activity against prevalence, scoring (dementia severity) etc

Objectives	Actions	Lead Partners	Progress Update – March 2013
prevalence of dementia and data sharing between organisations	Practice data to be shared to allow CCG to monitor and take accountability for quality assurance, enabling prioritisation of dementia strategy work targeted to practices	HCCG	The CCG's Clinical Director leading on dementia and the CCGs Practice Improvement Leads are working with the practices to share information around dementia and to target improvement activity.
	Link care for people with dementia to deliver seamless care across all agencies	LBH (Adults and Health) & HCCG	This is a significant action that will require commitment from the commissioning and provider, health and social care leadership in Havering. It is the cornerstone. Some mapping of the dementia pathways has already been completed by Dr J Rhodda of NELFT.
3. Clinically train professionals to recognise the symptoms of dementia leading to earlier diagnosis and improved outcomes for sufferers and their carers	Develop a new training strategy/pathway for professionals working with and supporting people with dementia	LBH (Adults and Health) & HCCG	Progress has been made in linking with the Joint Improvement Programme across London Councils, The aim is to have consistency of training strategies and implementation. Priority work is to develop an understanding of current training pathways/processes in all organisations, and complete a training needs analysis across organisations.
	Support the National Dementia and Antipsychotic Prescribing Audit and Reduction Exercise	HCCG	As a part of the medicine management part of Quality Outcomes Framework for 2012/13 all practices were asked to complete an antipsychotic audit devised by NHS London. This audit was focused on reducing antipsychotic prescribing in dementia patients. The audit deadline was Sept 12, and subsequently sent to NHSL for analysis. Medicines Mgt at the CSU are still awaiting the results from the submission.
	Review of assessed and diagnosed cases to assess success of early diagnosis and	HCCG	The resource secured by the CSU will be helping in this review.

Objectives	Actions	Lead Partners	Progress Update – March 2013
	performance against QOF/DES targets.		
	Training package to be developed for staff working with people with dementia, to include monitoring to record training sessions/people attending/feedback	HCCG	This has still to be developed but there is an opportunity to link with the Joint Improvement Programme across London Councils.
	Workforce development plans/appraisals programme embedded into Practice	HCCG	GP practices have been re-aligned into new GP practice clusters to aid the delivery of Integrated Case Management. This will facilitate the implementation of workforce development plans and the monitoring of how they are embedded into Practice.
	Mentoring support system to be available to key professionals including clinical supervision	HCCG	This still needs to be developed but there is an opportunity to link with the Joint Improvement Programme across London Councils
4. Deliver more universal services and better quality of care for people with dementia	Investigate the potential for a dementia centre of excellence community facility and progress plans for this accordingly	LBH (Adults and Health)	This action is part of the proposal for the redevelopment of the St Georges site, so is likely to take 3 to 5 years to fully deliver.
	Commission a rapid response service for people with dementia and their carers to provide support and medical assistance during times of crisis or escalation of symptoms/deterioration	HCCG	A rapid response service is provided by NEFLT and the CCG is using contract negotiations with NEFLT around the inclusion of dementia services to improve urgent care for people with dementia and to increase in the numbers of people with dementia remaining in their own homes with appropriate support
	Incorporate end of life planning into services for people with dementia, to enable them to have a dignified and painless death, and adequate	HCCG	22 GP practices have completed the Gold Standard Framework training

Objectives	Actions	Lead Partners	Progress Update – March 2013
	provision of support for their families		The opportunity for using the Gold Standard Framework for Care Homes is being discussed by the LBH and CCG as a vehicle for improving the quality of life for people with dementia and their carers through earlier end of life planning. A report will be brought to a future HWB.
	Develop education sessions for families about how to best support someone with dementia	LBH (Adults and Health) & HCCG	**Peer Support services** started in March 2012. In only eight months the service has facilitated a total of 991 opportunities for Havering residents to receive peer support (124 people per month). Eight groups were established but five have been discontinued as attendance at these locations was poor, however the remaining three are popular and well attended. **Singing for the Brain services** started in March 2012 and was immediately successful and has been operating weekly at full capacity of 30 service users ever since. Two further weekly sessions have been agreed replacing the peer support groups that were poorly attended. Feedback from service users and carers has been amazingly positive. Janet's story has been produced as a case study, picked up by the local media. The **Improved Information and Advice Outreach Service** provides information as widely as possible to the local community in Havering, complementing other local services. It seeks to improve knowledge and awareness of dementia and local services amongst residents through providing travelling information 'surgeries' across the borough. Between April 2012 and January 2012, 750 individual people have received information and in February 2013 the distribution of the Alzheimer's

Objectives	Actions	Lead Partners	Progress Update – March 2013
			Society local newsletter, which contained a complete list of all their factsheets, was increased to over 1300 per month.

Issues for Discussion

During discussions, the following issues were identified and it was agreed that these ought to be brought to the attention of the HWB in order to seek their views:

1. The need to ensure that Havering is aligned with government thinking and national best practice for example:
   - There is no specific Dementia Strategy for Havering
2. To flag the potential budget pressures arising from increased diagnosis of dementia, for example on the memory clinic
3. The Dementia Partnership Board recommends to the HWB :
   - that an additional action in objective 1 be added as follows : “Apply recommendations from the Innovations in Dementia report to embed a Dementia-Friendly Community”
   - alteration to the main objective 3 so that it becomes : “Development of health and social care workforce to recognise the symptoms of dementia leading to earlier diagnosis and improved outcomes for sufferers and their carers”
4. A position statement is needed on the Havering Dementia Care Pathway, as this action is the cornerstone which should drive other activity

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Health & Wellbeing Board Sub Structure Governance and Terms of Reference
Board Lead:	Cllr Steven Kelly
Report Author and contact details:	Sean Cable, Committee Officer sean.cable@havering.gov.uk

The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☒ Priority 1: Early help for vulnerable people
- ☒ Priority 2: Improved identification and support for people with dementia
- ☒ Priority 3: Earlier detection of cancer
- ☒ Priority 4: Tackling obesity
- ☒ Priority 5: Better integrated care for the 'frail elderly' population
- ☒ Priority 6: Better integrated care for vulnerable children
- ☒ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

This report and the accompanying document attached as Appendix 1 details the terms of reference and lines of reporting for the various sub-groups and bodies that will support the work of the Board. The Board is invited to consider how its business and operation has been managed to date and to discuss the possibility – in line with best practice – of holding a development session to cover business management and processes.

RECOMMENDATIONS

1. To agree the terms of reference for the various bodies that will make up the Board's sub structure.

2. To discuss and make a decision as to the possibility of holding a development session to cover the Board's business management.

REPORT DETAIL

1. Sub Structure

1.1 At its meeting in November 2012, the then Shadow Health and Wellbeing Board agreed to establish a series of bodies and sub-groups to take forward the operational aspects of Board decision-making. These bodies are listed in Appendix 2.

1.2 Further to this decision, at its meeting in February 2013, the Board agreed to formally constitute one of the bodies within the sub structure – the Health Protection Forum – as a sub-committee of the Board. The Health Protection Forum is therefore a formal Council committee and was constituted as such by Council at its meeting of 27 March 2013. The terms of reference and lines of reporting of the Forum are detailed in Appendix 1.

1.3 The other bodies listed in Appendix 2 are considered as informal working or task and finish groups. However, to ensure that each contributes to the delivery of Board decisions and objectives, these bodies have been assigned specific and detailed terms of reference and lines of reporting, although specific membership has yet to be finalised. The terms of reference of each body is listed in Appendix 1.

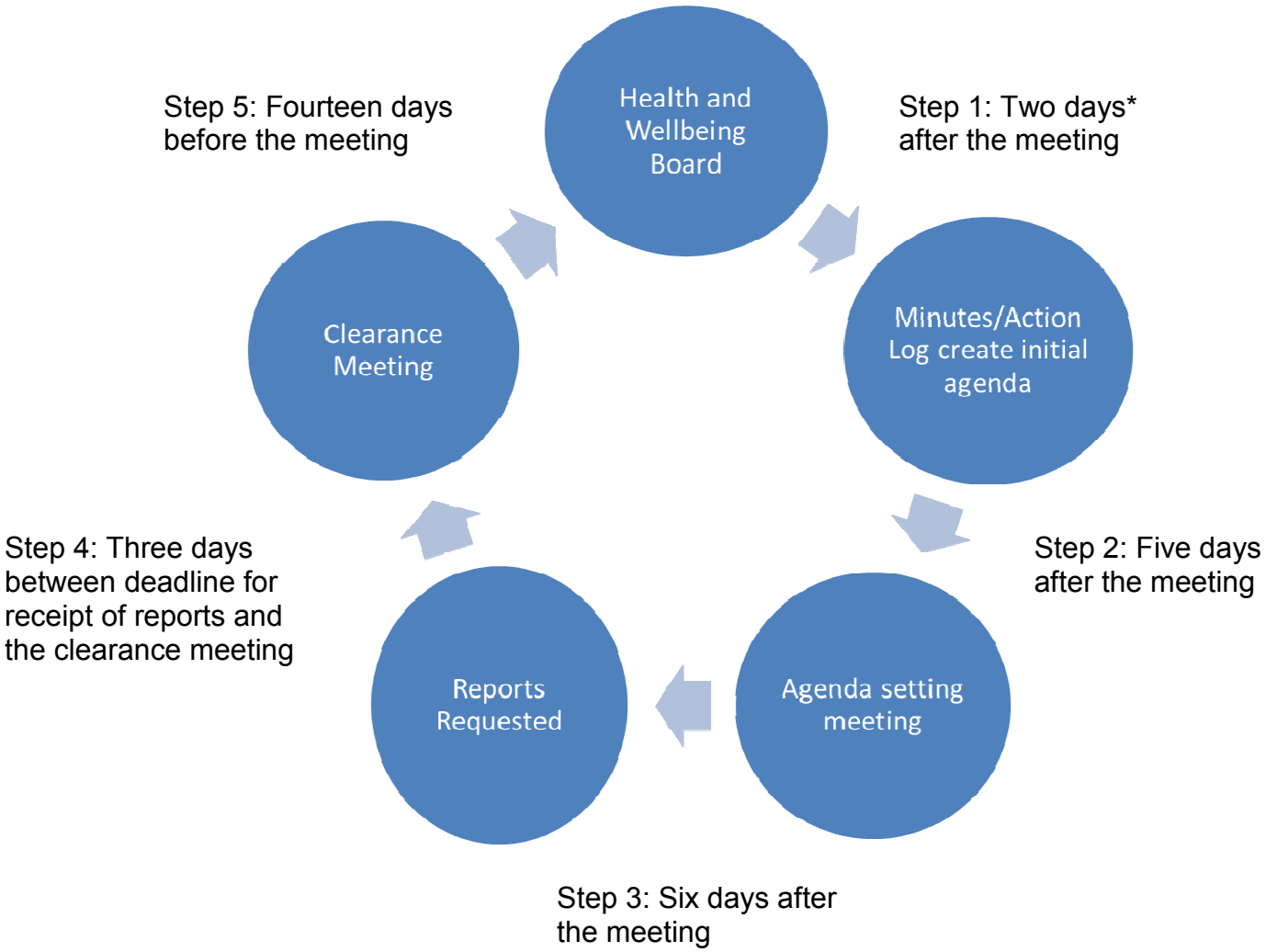
1.4 A distinction has been made between 'working groups', which are permanent bodies and 'task-and-finish groups' which are time limited and established to fulfil a specific function. The Board is asked to consider and approve the attached terms of reference.

2. Business Management & Development Session

2.1 On 27 March 2013 the Board's powers and membership were formally codified into the Council's Constitution. To enable Board members to ensure that the Board is making full use of its powers and meeting its responsibilities, members are asked to consider the possibility of conducting a development session examining decision-making and the process associated with it, including: agenda-setting, chairman's briefings and the Board's action log.

2.2 Currently, the agenda is managed by the Council's Transformation Programme Manager acting as the Board's Business Manager, supported by the clerk to the Board. Agenda are planned around decisions taken at Board meetings, monitored through minutes of meetings and through the action log. Initial items for consideration are taken from the action log and the agenda is then finalised through agenda pre-meetings. The Chairman of the Board is then briefed on the proposed agenda and amends or adds to it as appropriate.

2.3 Board meetings are monthly and, given that the Board is a formal Council committee, strict timings and deadlines are required to ensure that the agenda-planning cycle works efficiently. Moving forward, it is proposed that pre-agenda 'clearance meetings' act as the means by which agenda are agreed upon, through a meeting of some Board members acting on behalf of their respective organisations. The flowchart below details the intended process moving forward:



*In each case 'days' refers to working days.

2.4 The above charts the timescales between each Board meeting and the compiling of agendas. The Chairman is briefed and amends/adds to the agenda between the requesting of reports and the agenda setting meeting, the latter of which is supervised by the Council's Chief Executive. The 'clearance meeting' is a means of tackling inaccuracies or issues before reports or items are discussed at Board meetings. This allows Board meetings to retain a strategic focus without becoming burdened with detail, which is dealt with by the sub structure. The clearance meetings will be attended by:

- Chairman of the Board
- Chief Executive of the Council and/or the Group Director Social Care & Learning from the Council
- Chief Operating Officer from the Havering CCG
- The Director of Public Health from the Council.

2.5 Requests for items to be included onto an agenda for Board meetings must be made at least by the time of the clearance meeting, or fourteen days prior to the Board meeting. Requests for items to be included onto the agenda must be made to the Board's Business Manager, so that Board business can be coordinated effectively.

2.6 Requests for reports to Board meetings will be made following the agenda setting meeting and final reports will be required no later than six working days before the Board meeting. Reports must be submitted within this timescale in order to allow the Council to meet statutory deadlines around publication of meeting papers as stipulated by the Local Government Act 1972. If reports are not received within this timescale the agenda will be published without the reports attached.

2.5 The Board is asked to consider the current process and discuss the value of a development session through which best practice around agenda management and process can be discussed.

IMPLICATIONS AND RISKS

Financial implications and risks:

There are no obvious financial implications or risks.

Legal implications and risks:

Human Resources implications and risks:

There are no obvious human resource implications or risks.

Equalities implications and risks:

There are no obvious equalities implications or risks.

BACKGROUND PAPERS

- Governance reports to the Health and Wellbeing Board: November 2012 and February 2013.
- Minutes of the Health and Wellbeing Board meetings held on 7 November 2012 and 13 February 2013.

HEALTH & WELLBEING BOARD

Sub-structure

The Health and Wellbeing Board agreed to establish a series of bodies to deliver the strategic decisions taken at Board level. This document summarises how these various bodies will operate.

In establishing the sub-structure, the Health and Wellbeing Board stipulated that each body must have a clear purpose and make a direct contribution to:

- Delivering the outcomes of the JHWS
- Developing and monitoring local commissioning plans
- Facilitating two way communication between the HWB and local groups/representatives, individuals and key stakeholders

Further, the Board required that each group within the sub structure must have:

- A written and agreed work plan, terms of reference and frequency of progress reporting to the HWB
- Written records of decisions and key actions
- An agreed membership
- Each group should be "sponsored" (though not necessarily chaired) by a Board member who would be accountable for the group, support its work and present progress reports to the HWB at the agreed frequency.

This document details the arrangements, as required above, for all of the bodies in the Health and Wellbeing Board's sub-structure.

HEALTH & WELLBEING BOARD SUB-STRUCTURE				
Body	**Type**	**Board Sponsor**	**Permanent**	**Public or Private**
Health Protection Forum	Sub-Committee	Director of Public Health	Yes	Public
Operational Partnership Group	Working Group	Group Director, Social Care & Learning	Yes	Private
User Patient Community Forum	Working Group		Yes	Private
Provider Forum	Working Group		Yes	Private
Integrated Care Group	Task & Finish Group		No	Private
Hospital Performance Group	Task & Finish Group		No	Private
JSNA Group	Task & Finish Group		No	Private

1. SUB-COMMITTEE

HEALTH PROTECTION FORUM

1.1 Function

(a) The Health Protection Forum is responsible for providing assurance on behalf of the local population about the adequacy of prevention, surveillance, planning and response with regard to health protection issues, including but not limited to communicable disease control, infection prevention and control, Emergency planning, sexual health, environmental health and immunisation and screening programmes.

(b) The specific duties of the Forum are as follows:

(i) To provide strategic health protection input to local health strategies, including the Joint Strategic Needs Assessments and Health and Well-being strategies.
(ii) To receive short reports from partner members for discussion at Committee meetings to plan and agree processes for improvement.
(iii) To review all significant incidents / outbreaks to identify and share lessons learnt and make recommendations to commissioners / providers / partners regarding necessary changes.
(iv) To develop and review local risks register, and make recommendations to partners regarding mitigating actions and to commissioners where appropriate.
(v) To provide a forum for professional discussion of health protection plans, risks and opportunities for joint actions.
(vi) To encourage quality improvement through receiving and reviewing suggestions from partner members regarding process improvements.
(vii) To challenge emergency planning &business continuity plans of CCGs, Acute Trusts and Community & Mental Health Trusts

(b) The Health Protection Forum is a Sub-Committee of the Board. This means that it will be a formally constituted body in the Council's Constitution. It will report formally to the Health and Wellbeing Board and will be a public meeting.

(c) As a formal body, the Forum will be subject to the following requirements:

- Meeting dates to be published on the Council website;
- publication of meeting papers on the Council website at least five working days prior to each meeting;
- members of the public will be permitted to attend, and;
- minutes and a record of all decisions taken by the Board are to be published on the Council website within ten working days of the meeting.

1.2 Chairman

(a) The Chairman of the Forum will be the Director of Public Health and the Vice-Chairman will be nominated by the Forum at the start of each year.

(b) Where two or more forums meet to fulfil the functions of Havering's Forum, then the chairman will be the Director of Public Health for one of those authorities represented on the Forum as determined by the Forum.

1.3 Meetings

(a) The Forum will meet bi-monthly, but the Chairman will be able to hold additional meetings or cancel meetings as appropriate.

(b) The Forum will be subject to the Committee Procedure Rules outlined in Part 4 of the Constitution, with the exception of rules 5 and 7(d).

1.4 Membership

(a) The membership of the Forum will consist of the following officers:

- Director of Public Health
- Emergency Planning Lead
- Infection Control Lead
- Consultant in communicable disease (Public Health England)
- Environmental Health
- Immunisations Commissioner (National Commissioning Board)
- Screening Commissioner (National Commissioning Board)
- Emergency Planning Officer
- Emergency Planning Officer (BHRUT)
- Emergency Planning Officer (NELFT)
- Emergency Planning Officer (CCGs)

(b) Should a joint-Forum be established between two or more forums, then the above membership will include the above officers from each constituent council.

1.5 Reporting

The Forum will report annually to the Health and Wellbeing Board, summarising its work and achievements.

1.6 Support

The Forum will be supported by a Committee Officer from Committee Administration who will provide administrative and agenda management support.

2. WORKING GROUPS

2.1 OPERATIONAL PARTNERSHIP GROUP

2.1.1 Function

(a) The Operational Partnership Group (OPG) is the lead partnership body, established to ensure that the strategic decisions of the Health and Wellbeing Board are realised in delivery. The Board is comprised of senior officers from the NHS and the Council. Its functions are as follows:

- To take forward and implement Board decisions.
- To oversee and ensure that agreed work plans are delivered.
- Oversee reports, including budgetary and performance information, to be presented to the HWB.
- To have operational oversight of activity relevant to the delivery of the health and wellbeing strategy and joint activity and commissioning such as the NHS Support for Social Care programme funding.
- Generally manage operational services so the HWB retains a strategic commissioning focus and is not drawn into operational detail.

2.1.2 Chairman

The Chairman will alternate between the most senior member of the Board from the Council and from the NHS.

2.1.3 Meetings

The Group will meet bi-monthly.

2.1.4 Membership

(list) to be added

2.1.5 Reporting

(a) The Group will be accountable to the Health and Wellbeing Board through the Board members present and officers representing those members.

(b) The Group will be able to propose HWB agenda items based on the annual work programme for approval by the HWB Chair.

(c) Officers forming the membership of the Group will report back to the HWB monthly (is this frequency appropriate) on progress made with implementing Board decisions.

(d) The HWB Chairman will be able to attend meetings of the Group.

(e) The Group will have four sub-groups that will report to it on an alternating basis at each meeting, these sub-groups are:

- Strategic Drug and Alcohol Group
- Dementia Partnership Board
- LD (Learning & Disability) Partnership Group
- Mental Health Partnership Board

2.1.6 Support

The Group will be supported by [to be added but not Committee Admin]

2.2 USER PATIENT COMMUNITY FORUM

2.2.1 Function

(a) The User Patient Community Forum will be responsible for ensuring that patients and service users have their concerns addressed and are the Board's strategic focus.

(b) The Board will achieve this by bringing together representatives from existing patient/user groups along with relevant representatives from the voluntary/community sector and Healthwatch and seeking input into the key questions arising from health and social care commissioning.

2.2.2 Chairman

The Chairman of the Forum will be the Healthwatch representative on the Health and Wellbeing Board.

2.2.3 Meetings

The Forum will meet bi-monthly.

2.2.4 Membership

(list)

2.2.5 Reporting

(a) The Forum will report to the Board on an annual basis (more regularly?).

(b) The Forum will work closely with the Operational Partnership Group to ensure that the delivery of services is patient/service–user focussed.

(c) The Forum will work with any groups or bodies to ensure that patients/service users remain at the centre of the strategic direction of the HWB and its partners.

2.2.6 Support

The Group will be supported by [to be added but not Committee Admin]

2.3 PROVIDER FORUM

2.3.1 Function

(a) The Forum will be responsible for supporting the delivery of the JHWS and improving two way communication between commissioners and providers, in order to promote greater collaborative and partnership working.

(b) The Forum will not be a venue for raising fee levels or contract disputes.

2.3.2 Chairman

The Chairman of the Forum will be…(to be added)

2.3.3 Meetings

(a) The Forum will meet quarterly.

2.3.4 Membership

(a) Membership shall be open to all Heath, Adult and Children's Social Care and pharmacy providers who have current contracts in Havering, ensuring that the range of voluntary sector partners is well represented.

(b) Nominations to the Provider Forum could be made for a two year term, through the Operational Partnership Group making recommendations to the Board.

(c) The following categories of providers would be eligible to attend the Forum:

- Larger acute and community Health organisations
- Smaller local Health providers
- Larger children's service providers
- Smaller local children's service providers
- Larger adult social care providers
- Smaller local adult social care providers
- Local pharmacy provider
- Housing provider supporting vulnerable adults and children
- HAVCO
- Voluntary sector provider representative not covered within the other groups

2.3.5 Reporting

The Forum will report to the Board on an annual basis or earlier as appropriate. (to be determined)

2.3.6 Support

The Group will be supported by [to be added but not Committee Admin]

3. TASK & FINISH GROUPS

(a) All task and finish groups will be time-limited working parties established to undertake specific pieces of work.

(b) Any Board member can join a task and finish group.

(b) The Board, upon establishing such a group, will nominate a Board member or officer to lead the work of the Group. This person will return to the Board with suggestions for the Group's terms of reference, membership and project plan. These arrangements will be ratified by the Board.

(c) Upon the completion of the work of a task and finish group, the group will present a final report to the Board.

(d) Support for task and finish groups will be the responsibility of the Board member or officer nominated to carry out the work.

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