

HEALTH & WELLBEING BOARD

AGENDA

Wednesday, 8th May, 2013
1.30 - 3.30 pm

Committee Room 2 - Town Hall

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 10 April 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. PRIORITY 2: IMPROVED IDENTIFICATION AND SUPPORT FOR PEOPLE WITH DEMENTIA

Report to follow.

7. JOINT STRATEGIC NEEDS ASSESSMENT (Pages 9 - 22)
8. HWB GOVERNANCE AND SUB STRUCTURES (Pages 23 - 34)
9. JOINT COMMISSIONING REVIEW OF NHS SUPPORT FOR SOCIAL CARE PROGRAMME

Report to follow.

10. HEALTHWATCH UPDATE
11. ANY OTHER BUSINESS
12. DATE OF NEXT MEETING

The Board is asked to note that the date of the next meeting of the Board is scheduled for 12th June 2013.

Public Document Pack Agenda Item 4

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

10 April 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
Councillor Paul Rochford, Cabinet Member, Children & Learning, LBH
Dr Atul Aggarwal, Chair, Havering CCG
Mary Black, Director of Public Health, LBH
Conor Burke, Accountable Officer, Havering CCG
Cheryl Coppell, Chief Executive, LBH
Anne-Marie Dean, Chairman, Healthwatch Havering
Joy Hollister, Group Director, Social Care and Learning, LBH
Alan Steward, Chief Operating Officer (non-voting), Havering CCG

In Attendance

John Atherton, Head of Assurance, NHS England (London)
Julie Brown, HWB Business Manager, LBH
Sean Cable, Committee Officer, LBH (minutes)

Apologies

Cllr Lesley Kelly, Cabinet Member, Housing, LBH
Dr Gurdev Saini, Board Member, Havering CCG

1 CHAIRMAN'S ANNOUNCEMENTS

The Chairman welcomed all those present to the first 'live' and public meeting of Havering's Health and Wellbeing Board.

2 MINUTES

The Board agreed the minutes of the meeting held on 13 March 2013 as a correct record, subject to amendment to Minute number 141.

Replace the existing text with the following:

The Board was informed that domestic violence features in many child protection cases and therefore agencies have agreed that some of the government funding for Troubled Families should be directed towards earlier specialist support and intervention to tackle domestic violence in families.

The Early Help service will be borough wide by September, starting now in the centre of the borough, based on the areas served by St Kilda and Collier Row children's centres. The Board was informed that Ofsted had commented positively on the recent work and plans for Early Help. The report will be available in early April.

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

3 MATTERS ARISING/REVIEW OF ACTION LOG

Abdominal Aortic Aneurysm Screening Programme

Areas of work around this screening programme were being picked up outside the Board meetings, but it was noted that the programme was nationally funded and would be rolled out later in the year.

Cancer Urology

Further to the previous meeting, members were informed that the reform to cancer urology services was a process of specialisation, by which key cancers were to be operated on in a training centre (UCH) in London. Consultation was underway and the Board would be updated on this, further, a briefing on the whole proposals would be completed and circulated to members outside of the meeting.

CCG Commissioning Strategy Plan

The Board noted that work towards finalising the CCG's CSP and the Board offered its congratulations to the CCG for its successful authorisation, in particular to Conor Burke, Accountable Officer for the CCG.

St Georges Business Case

Consultation was underway regarding the proposed changes to St Georges; these proposals had been circulated to the Board previously. The Board was updated about the capital receipt from the sale of the St Georges site. Previous commitments had been made under the H4NEL programme that any such capital receipts should be returned to local commissioners. The CCG was awaiting the final verdict on this and was striving to ensure that this principle was upheld.

St Georges Legionella Report

The Board was updated that NELFT, the organisation which had undertaken the investigation of the legionella outbreak, had not yet released the report.

Action Log

- Emergency Hormonal Contraception – a final scoping/feasibility report was still outstanding, which was to be carried forward by the Director of Public Health.
- Queens Hospital Sub-Group – this group had been disbanded with the agreement of the Chairman, but there would be regular reports on BHRUT and the Group Director of Social Care & Learning would attend regular CCG performance meetings relating to the hospital.

4 INTRODUCTION TO NEW MEMBERS

The Board welcomed the two new members to the Board, the new Director of Public Health for the borough, Mary Black and the Chairman of Havering's Healthwatch organisation. Both were statutory members and introduced themselves and the work underway to date within their respective fields.

The Board was also introduced to the representative from NHS England (London regional office), which had previously been called the NHS Commissioning Board. The representative was the Head of Assurance for the North East and Central Branch of NHS England and had a wide range of experience within the Health sector. The representative explained that he was part of a small team which focussed on operation and delivery. His particular expertise, assurance, fulfilled the performance function that had previously been conducted by the Strategic Health Authority, but with an emphasis of much less direct control. NHS England would, unlike its predecessors, be commissioning directly, it was to be one organisation with four regional arms.

Board members welcomed the representative from NHS England, and sought reassurance that the unique health and wellbeing needs of Havering would be considered as NHS England moves forward. It was explained that Havering had an Essex demographic but, as a London borough, was typically treated as though its health needs were the same as a London borough. Therefore, members were concerned that the representative from NHS England, as part of a small team in one regional office, may not appreciate and be able to offer the influence that the Board was seeking.

Members further expressed the vital importance of BHRUT as a local, regional and national issue. Havering CCG is the lead commissioner on behalf of the BHR CCG cluster. Support from NHS England to work with partners through the HWB and Integrated Care Coalition to improve the position at BHRUT would be really useful. It was suggested that a working group might be set up looking at BHRUT and commissioning of local NHS services.

A key priority was to enable BHRUT to attain foundation trust status but not at the cost of commissioning good local health and wellbeing services. For example, an urgent care board had been established comprised of strategic

local partners which would build on the recommendations of the mid-Staffordshire report. Commissioning of primary care by NHS England was a crucial local issue for which partners locally were keen to feed into.

The NHS England representative explained that all the regional teams of NHS England were small but they fed into decision-making virtually and if specific issues needed to be looked at then specialist support would be brought in.

5 INTEGRATED CARE STRATEGY

The Board considered a presentation from the Chief Operating Officer (Havering) from the CCG regarding progress to date with the Integrated Care Strategy.

Members were informed that since the establishment of the Integrated Care Coalition in December 2011 (which sought to enable senior leaders across health and social care in Barking and Dagenham, Havering and Redbridge to work together to develop a joint approach to integrated care to build a sustainable health and social care system) much progress had been made. In December 2012, the Integrated Care Strategy had been completed, followed by priority-setting in January 2013 and a work plan in February 2013.

The Board were updated on the Integrated Care Strategy work plan. The plan focussed on three areas: Integrated Case Management (ICM), development of community services and joint assessment and discharge (JAD). Specific targets and areas of work around each of these areas were provided at the meeting and through the presentation.

Board members expressed their commitment to the work underway and were positive about the activity of the Integrated Care Coalition, but stressed the need to ensure that partners across all three boroughs and the local acute and community health services providers are equally committed to the Strategy and the work being undertaken. It is vitally important the three authorities remained committed and unified in their approach.

There is the need to make significant progress with the Strategy in the next three months and the involvement of NHS England in continually stressing the need to commit to the strategy to each of the three health and wellbeing boards would be very helpful. The CCG explained that any lack of delivery from the acute trust would result in improvement notices being issued. Members commented on the urgent need for evidence regarding current performance and what the partners sought to achieve.

The role that partners have in working with Queens to address the challenges was highlighted.

The Board agreed that a total place cost modelling be undertaken for one strand of work arising from the Integrated Care Strategy, as a means of demonstrating what would be required from all partners and the resources involved.

6 PRIORITY 2: IMPROVED IDENTIFICATION AND SUPPORT FOR PEOPLE WITH DEMENTIA

The Board considered a report outlining the work that had been taking place to date around priority two of the Health and Wellbeing Strategy, which focussed on improved identification and support for people with dementia.

The Board was informed that a Dementia Partnership Board (DPB) had been formed in November 2012, which reported directly to the Board. The DPB was chaired by a CCG Board member and clinical director for mental health, Dr Maurice Sanomi. The DPB was a strategic commissioning group which acknowledged the value of provider input.

The DPB was further described as a multi-agency mechanism established to develop and deliver Havering's Strategic Plan aligned to the National Dementia Strategy. The Strategy sought to improve the quality of life and services available for people with dementia and their carers. The DPB, it was explained, had access to the funding remaining from that allocated to the Dementia projects funded by the NHS Support for Social Care 2011-13, which was said to amount to approx. £200,000.

The Board reviewed the action taken to date.

In discussion, the Board heard that Havering would be one of the biggest areas in the country for dementia and it was argued that Havering therefore needed a stronger priority for dementia in the Health and Wellbeing Strategy. The need to establish a dedicated pathway for dementia was debated with members expressing a desire that the work be implemented immediately. Officers explained that setting up a pathway would take some time, as a diagnostic would need to be undertaken and plotted against gaps in the service.

The Board agreed that the Chairman, Group Director, Social Care & Learning and the CCG's Chief Operating Officer for Havering meet to discuss how quickly the pathway might be implemented.

7 HWB SUB STRUCTURE GOVERNANCE AND TERMS OF REFERENCE

The Board deferred this item until its next meeting.

8 ANY OTHER BUSINESS

The Chairman asked that the CCG and the Director of Public Health meet to discuss the measles outbreak in Wales and its implications for Havering. Members were told that Havering had 88% take-up of the MMR inoculation.

9 **DATE OF NEXT MEETING**

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

Chairman

Health & Wellbeing Board

Action Log

Minute Ref	Meeting	Item for Discussion	Actions	Estimated Completion by	HWB Lead / Actioning Officer	on future agenda?	Date Complete
S107	14-Dec-12	Emergency Hormonal Contraception	Scoping report to be produced	Jun-13	M Black	Yes Jun-13	
S121	09-Jan-13	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	
S130	13-Feb-13	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	
S139	13-Mar-13	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. A proposal due back to a future HWB.	tbc	Dr Aggarwal	Yes tbc	
S140	13-Mar-13	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.	Apr-13	Dr Aggarwal / Dr Tran	No though report to be drafted & circulated	
5	10-Apr-13	Integrated Care Strategy	ICM Review to be undertaken in Oct-13 and outcome to be reported to HWB	Nov-13	A Steward & J Hollister	Yes Nov-13	
5	10-Apr-13	Integrated Care Strategy	Total Place Cost Modelling to be undertaken for one theme under ICS	Nov-13	A Steward & J Hollister	Yes Nov-13	
6	10-Apr-13	HWB Strategy - Priority 2 Dementia	Prepare position statement on Dementia Care Pathway in Havering	May-13	J Hollister, M Black & A Steward	Yes tbc	
8	10-Apr-13	AOB	To discuss measles outbreak in neighbouring borough	May-13	M Black & A Steward	No	

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HEALTH & WELLBEING BOARD

Subject Heading:	Future development of the Joint Strategic Needs Assessment (JSNA)
Board Lead:	<i>Mary Black, Director of Public Health</i>
Report Author and contact details:	<i>Gemma Andrews, JSNA Officer 01708 432103, gemma.andrews@havering.gov.uk</i>

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

Government policy has strengthened the role of the JSNA from April 2013 and the Council is continuing its rolling programme of development. Moving forward local authorities and Clinical Commissioning Groups share joint responsibility for preparing and demonstrating the use of the JSNA to inform commissioning decisions. In March 2013 Statutory Guidance on JSNA and Joint Health and Wellbeing Strategies was released that emphasised the importance of ensuring that views fed in through the community participation process are captured within the JSNA and JHWS. The guidance recommended the establishment of strong working partnerships with the local Healthwatch organisation to achieve this. The report was taken to CMT on 12th February 2013 and recommendations have been followed and applied.

The report is brought before the board to request **approval for the proposed JSNA developments** (adding commentary to JSNA datasets and new deep dive chapters) as well as **discussion and decision on topics for the next in-depth needs assessments or 'deep dives'**. The report also discusses accessibility and the Pharmaceutical Needs Assessment in the context of the JSNA.

RECOMMENDATIONS

- 1) To work towards **ensuring that commissioning plans and decisions are supported** by evidence from the JSNA by:
 - a) Selecting a HWB member to chair the JSNA subgroup
 - b) Requesting that all papers brought to the HWB for policy and commissioning decision demonstrate links to needs identified in the JSNA.
- 2) To **agree the approach** outlined for developing the JSNA, including data commentary and 'deep dive' chapters.
- 3) To **discuss and agree topics** for the next in-depth needs assessments or 'deep dives'. Please note chapter specific recommendations in this section.

REPORT DETAIL

1.0. BACKGROUND

1.1. National Policy

Since 2008 there has been a statutory requirement for PCTs and Local Authorities to co-produce a Joint Strategic Needs Assessment (JSNA) for their local area. The JSNA is an on-going process of assessment of the health and wellbeing needs of local people, and provides an evidence base to inform commissioning of services that improve health and wellbeing outcomes, reduce health inequalities and support social inclusion.

Government policy has strengthened the role of the JSNA going forwards. Public health responsibility will transfer from PCTs to local authorities in April 2013. From this point forward, local authorities and Clinical Commissioning Groups will have a joint responsibility to prepare the JSNA and use it as the basis for the Joint Health and Wellbeing Strategy and subsequent commissioning decisions. Specifically, the Health and Wellbeing Board (HWB) will be the statutory mechanism through which these duties are fulfilled. There is a requirement to work closely with the local Healthwatch organisation to incorporate vital qualitative information on service user views. The JSNA must be published, since other key bodies, such as NHS England and voluntary sector bodies will also be obliged to have regard to the JSNA.

The JSNA has the potential to develop the whole health and social care response to more closely meet the needs of local people. It also presents an opportunity for the HWB to demonstrate action on their duty to promote and encourage integrated working across the wider determinants of health.

New requirements for the production and use of the JSNA:

- Statutory duty on Local Authorities (including Public Health) and NHS Clinical Commissioning Groups, fulfilled through Health and Wellbeing Board
- Relatively high **organisational significance**
- Integral to new-decision making forums
- More involvement of the local community in development of the JSNA through the Health and Wellbeing board (Health Watch representative)
- Robust link to commissioning
- Resource mapping to complement integrated planning and commissioning agendas
- Focus on community 'assets' and "deficits"
- A wide range of partner engagement
- Moving from 'snapshot' to 'trend' data, using both quantitative and qualitative data

Hudson and Henwood, 2012, The London Health and Wellbeing Partnership Support Programme

1.2. To meet the new requirements, the HWB should demonstrate:

- Active participation in the development of the JSNA, via the JSNA subgroup
- Documented use of the JSNA to a) assist in planning for future service provision within the borough and b) build a case for pooling of resources where integrated working is necessary to tackle major health issues
- Efforts to raise the profile of the JSNA's enhanced role in decision making and promote its use as the evidence base for all policy and commissioning decisions in the borough
- Direct support of the project management approach by ensuring **staff resources** from all partners are committed to the development of the JSNA as and when required

1.3. Making it happen

One way that the HWB could demonstrate action on their duty of active participation in the JSNA could be to select a HWB member to chair the JSNA subgroup. Their role would be to provide strategic steer and hold partners to account around the agreed programme of JSNA development. It is also recommended that the HWB request that all papers brought to the board for policy and commissioning decision demonstrate links to needs identified in the JSNA. CMT agreed that the Director of Public Health would be appropriate for this role.

1.4. Havering's JSNA

The Havering JSNA was initially produced in 2008, and has followed a rolling programme of development. The JSNA is hosted on the Havering Data Intelligence Hub and comprises of a suite of information including:

- 1) Datasets (presented in tables)
- 2) Chapters (pdf files)
- 3) Other independent Needs Assessments (pdf files)

Chapter topics to date include: Local Demographics, Cancer, Domestic violence, Cardiovascular disease, Breastfeeding, Smoking, Obesity, Dementia and most recently - Supporting vulnerable children and young people, Supporting vulnerable adults and older people and Keeping people out of hospital. Chapters provide additional information on local views, service provision and gaps etc.

2.0. FUTURE DEVELOPMENT

Going forwards we propose to develop the JSNA resource by:

2.1. Adding data commentary to JSNA datasets on the Data Intelligence Hub

The JSNA datasets on the hub are periodically updated - monthly, quarterly, annually, 2 yearly and 10 yearly. The proposal is to provide interpretative commentary, piloted on the Health theme. For example, when new data is released on dementia prevalence in Havering, commentary could include implications for health and social care services.

Members, internal/external commissioners and officers will be able to view and lift accurate interpretation of these datasets directly into their own business cases and reports. The JSNA commentary will be aligned with new data releases to ensure the latest possible information is presented and accessible. The pilot will be evaluated and if successful will be rolled out across the remaining 7 themes (Housing, Education, Economy, Environment, Equalities, Population and Crime). This commentary will serve as ongoing surveillance to identify indicators where performance is poor and highlight topics that need to be addressed through more in-depth needs assessments ('deep dive' chapters).

2.2. A series of 'deep dive' chapters to help inform Health and Wellbeing Strategy

'Deep dive' chapters aim to provide enhanced detail around a particular topic, with consideration of the impact of interacting factors, for example the toxic trio (substance misuse, domestic violence and mental health).

'Deep dive' chapters will inform the Health and Wellbeing Strategy by providing the HWB with valuable information to set direction and prioritise commissioning decisions within limited resources.

Through consultation with partners and staff the following potential JSNA 'deep dive' topics have emerged:

a) Queens Hospital research project

CMT felt that this topic represents an issue that the National Commissioning Board, CCG and Council can make a real impact on through the new collaborative working arrangements.

Recommendation: CCG take lead on this joint project and co-author chapter to ensure that the research questions match clinical commissioning information needs. Healthwatch must also be engaged in the planning and development of this project to ensure patient experience research is imbedded into the process.

b) Children's services

It has been agreed that the independent Children and Young People baseline needs assessment will be included in the Havering JSNA moving forward. There is strong opinion that further needs assessment is required particularly around troubled families, the toxic trio and public health early years prevention areas.

Recommendation: The Children and Young People needs assessment is recommended as the first chapter for refresh as it is required to influence new commissioning post June 2013.

c) Sexual health

Monitoring of access to sexual health services is within the public health transition mandate to local authorities. To date, a short paragraph on teenage conceptions and sexually transmitted infection rates (including Chlamydia) has been included in the 'Supporting vulnerable children and young people' chapter. This needs assessment revealed that although Havering has lower under-18 conception rates than the England/London averages more young people who conceive go on to have abortions than the England average. Further work could look at why and how this will impact on service demand and provision.

d) Mental health (adults and children)

Incorporation of the independent Mental Health needs assessment into the JSNA is under discussion, since currently mental health is predominantly assessed within the chapters 'Supporting vulnerable adults and older people' and 'Dementia'. Although Havering Child and Adolescent Mental Health Services (CAMHS) is mentioned in the 'Supporting vulnerable children and young people' chapter, there are some gaps in recorded data around mental health issues in vulnerable young people, including information on transitional issues from childhood to adulthood.

e) Drugs and Alcohol misuse

Some information is included within the 'Supporting vulnerable children and young people' chapter. Incorporation of the Drugs and Alcohol Action Team (DAAT) needs assessment into the JSNA is recommended. Further needs assessments around adult issues are recommended, including:

- Long-term conditions and alcohol
- Drug related deaths
- Acute sector and blood-borne virus data (driving commissioning of 'Payment by Results')

f) Wider determinants of health, including Housing (Environmental Health & Public Protection) and Education

With the transfer of the Public Health function into local authority, there is enhanced scope for collaborative working between Public Health, Public Protection (legislation) and Housing to look at health inequalities and improve wellbeing. Air pollution is a current issue of interest following the proposal of imposing fines on councils for failing to meet the EU limit values.

g) Autism

In line with 'Statutory guidance to Local Authorities and NHS organisations to support the implementation of the Autism Act (2010)', Havering Adult Autism Strategy has highlighted that more intelligence is required to inform future commissioning of services for people with Autism. Data is not currently collected on the number of school leavers or adults with autism and the impact of this on housing and employment in the borough. In partnership with the National Autistic Society, Adult Social Care is undertaking an asset mapping project to produce a directory of existing services for people with autism. The directory could be included in the chapter and made accessible to the public in an autism friendly/easy read format.

h) Havering Demographics update (Census 2011)

The Office of National Statistics (ONS) carried out the Census in March 2011 and are now in the process of releasing the data. The ONS have produced a prospectus regarding release dates and new geographies; both are published on

the Havering Data Intelligence Hub and can be viewed here:
<http://www.haveringdata.net/research/census2011.htm>

This list is not exhaustive. **The HWB is asked to discuss and put forward topics for consideration before agreeing which to take forward, with what priority, over the next 12 months.**

2.3. Clarifying where the Pharmaceutical Needs Assessment (PNA) responsibility will sit and whether it can be included in the JSNA

Draft regulations suggest that in light of the transfer of the PNA responsibility to the HWB in April, the next compulsory refresh will be postponed to 2015. NHS North East London & City Pharmacy Commissioning states that the PNA takes 6 months to complete, therefore 18 months is available to build understanding and plan. There may be potential to incorporate elements of the PNA into the JSNA in future, however no commitment will be given to this until further legislative detail is released and there is clarification of any financial risk. Risk is managed at this time since any financial implications will be charged to the 2014-2015 budget.

2.4. Improving JSNA accessibility

There is on-going commitment to enhancing the look and improving accessibility of the JSNA, drawing on experience of other local authorities, to make it more user-friendly and interactive.

2.5. Using a project management approach

The JSNA will be delivered through a project management approach, which requires commitment of staff resources from all partners as and when required. 'Deep dive' chapters will be developed subject to commitment of resources from allocated leads, with technical data analysis support and advice from Public Health and Corporate Policy and Partnerships. The JSNA will incorporate information from existing service strategies and the project group will work with service directors to input intelligence around current provision/ plans for change (**see Appendix 1**). The JSNA Officer will marry needs assessment requirements with resources available from within the council and external partners. The Havering JSNA Data model outlines the operational approach (**see Appendix 2**). Major operational issues will be raised through the JSNA subgroup. This approach reduces duplication of work, improves quality and optimises existing expertise within partner organisations. The JSNA will be continually reviewed and aligned with the timescales of the HWB priority deadlines, such as the Health and Wellbeing Strategy interim review and 2014 refresh, CCG Commissioning Strategy Plan and NHS England key publications.

IMPLICATIONS AND RISKS

Financial implications and risks:

The existing JSNA Officer post will carry out this work via a project management approach, utilising the skills and expertise of the existing workforce. In the event that the PNA is considered for inclusion in the JSNA, a cost of between £40-60K has been estimated by existing NELC staff, which includes seeking specialist pharmaceutical expertise.

Legal implications and risks:

Production and evidenced use of the JSNA is a mandatory requirement for Local Authorities, Clinical Commissioning Groups and NHS England.

Human Resources implications and risks:

Staff actively involved in the JSNA project will be required to honour a small time commitment to attend one of two project groups: the JSNA steering group (strategic) or the JSNA project team (operational). The JSNA project team will have rolling membership dependent on the 'deep dive' chapters selected. Members of the JSNA project team will be required to attend meetings and arrange for the provision of service specific data and commentary to be incorporated into the chapter at set intervals.

Equalities implications and risks:

The current JSNA Equalities Assessment (EA) is available upon request. The data commentary would improve access and, therefore, optimise the positive impact of the JSNA products without negatively impacting any protected characteristics groups.

BACKGROUND PAPERS

[Appendix 1](#) – Relationship between JSNA and Health and Wellbeing Strategy and wider Commissioning Plans

[Appendix 2](#) - Havering JSNA data model (operational).

Policy Briefing –Statutory Guidance on JSNA & HWBS 2013[1] (attached).

Statutory guidance published on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies - <http://healthandcare.dh.gov.uk/jsnas-jhwss-guidance-published/>

JSNA Equality Assessment (available upon request).

No further papers are provided as all Havering JSNA documents are available in the public domains as “published papers” on the Havering Data Intelligence Hub JSNA tab at: <http://www.haveringdata.net/research/jsna.htm> .




Appendix 1

Relationship between JSNA and Health and Wellbeing Strategy and wider Commissioning Plans



Appendix 2

 Havering JSNA data model	
1. Set timing	<ul style="list-style-type: none">• Triggers• Implementation 'when & whys'
2. Who is involved?	<ul style="list-style-type: none">• Local Authority (all services, including Public Health)• CCG• Healthwatch• Health & Wellbeing Board overview
3. Build a joint picture of scope	<ul style="list-style-type: none">• Partnership working with HWB members and further local organisations
4. Define resources	<ul style="list-style-type: none">• Can it be done in-house? If so, by whom?• What else do we need?• What assets do we already have?
5. Workplan	<ul style="list-style-type: none">• JSNA HWB subgroup chaired by Mary Black, Director of Public Health
6. Assign roles	<ul style="list-style-type: none">• Governance arrangements• Comments
7. Writing development, consulting & review	<ul style="list-style-type: none">• Addressing Equality and Diversity requirements for publishing
8. Publishing	<ul style="list-style-type: none">• Website testing and communication plan consolidation
9. Launch	<ul style="list-style-type: none">• Maximising impact through effective communication• Link with Communications Team/ Public Health Campaigns
10. Evaluation	<ul style="list-style-type: none">• Was the data used? How?• What learning is there to inform future development?



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POLICY BRIEFING: Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies - Summary of Key Points

CORPORATE POLICY & PARTNERSHIPS
APRIL 2013

BACKGROUND

- The Government published [Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies](#) on 26th March 2013, which further clarifies the Government's expectations for these areas.
 - This statutory guidance explains the duties and powers relating to JSNAs and JHWSs. This guidance does not cover the wider membership of health and wellbeing boards, or detail regarding which services should be commissioned in response to local JSNA findings and JHWS priorities.
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KEY CONTENT GUIDANCE FOR JSNAs / JOINT HEALTH & WELLBEING STRATEGIES

- Consider assets rather than just deficits (e.g. community strengths).
 - Consider inequalities/wider determinants of health and areas such as mental health, carers and health protection.
 - Include a range of quantitative and qualitative evidence. Qualitative information used could include views collected by the local Healthwatch organisation or local voluntary sector organisations.
 - There is no formal template or format that must be used and no mandatory data set to be included – JSNA content is entirely locally decided.
 - Evidence of service outcomes from local commissioners, providers or service users could also inform JSNAs. Boards will need to ensure that staff involved in the JSNA project have easy access to the evidence they need to undertake any analysis required to support the board's decision making.
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CHANGES TO JSNA REQUIREMENTS

- New focus on areas that require partnership working between organisations represented on the HWB.
- JSNA must consider "current and future local health and social care needs – needs which are capable of being met or affected to a significant extent, by the local authority, Clinical Commissioning Group (CCG) or NHS Commissioning Board functions".
- CCGs, NHS Commissioning Board and local authorities must now "have regard to" findings of JSNA, not just produce JSNA.

- There is now a requirement to involve people living/working in the local area and a requirement to involve local Healthwatch. An emphasis is placed on ensuring that views fed in through the community participation process are captured within the JSNA and JHWS. Arrangements for this process will be locally determined.
- As strategic tools both JSNA and JHWS should cover the whole local population across the life course (not just GP registered population) and must meet public sector equality duty. Locally this may involve reviewing and agreeing a standardised local population calculation across partners (residential vs. GP population).
- JSNAs provide the objective assessment of the local needs, but Joint Health & Wellbeing Strategies are where decisions and opinion become involved.
- JSNAs can also be informed by more detailed local needs assessments that research specific groups (such as those likely to have poor health outcomes), or investigate wider issues that affect health such as employment, crime, community safety, transport, planning or housing. There is no longer a requirement for a separate Children & Young People's Plan or Needs Assessment, so areas will want to ensure info about children and young people is incorporated in JSNA / Joint Health & Wellbeing Strategy.
- JSNAs should build on and align to other strategies/assessments. This is a two-way process with JSNAs and Joint Health & Wellbeing Strategies both informing other local assessments, and also using their findings.
- Health and wellbeing boards are also required to undertake Pharmaceutical Needs Assessments (PNAs). Although many may choose to combine the process with JSNAs, the duties for these are separate, and distinct PNAs need to be produced to inform the NHS CB's decisions on commissioning pharmaceutical services for the area.

JOINT HEALTH & WELLBEING STRATEGY REQUIREMENTS

- CCG's must involve the Health & Wellbeing Board in development of their commissioning plans and must have regard to JSNA and Joint Health & Wellbeing Strategy.
- Joint Health & Wellbeing Strategy is the mechanism for local authorities and CCGs to address the needs identified in JSNAs, setting out agreed priorities for collective action by commissioners, and identifying where more integrated commissioning can take place.
- The aim of the Joint Health & Wellbeing Strategy is to jointly agree what the greatest issues are for the local community based on evidence in JSNAs, what can be done to address them; and what outcomes are intended to be achieved.

TIMINGS

- Full JSNAs and Joint Health & Wellbeing Strategies do **not** necessarily need to be undertaken annually, but Health & Wellbeing Boards will want to agree how they will refresh or update them to inform annual commissioning plans.

WHO IS RESPONSIBLE?

- The statutory members of Health & Wellbeing Boards are jointly responsible for the preparation and sign-off of JSNAs and Joint Health & Wellbeing Strategies – therefore there is an equal responsibility between the CCG representatives, the Director of Public Health, Director of Adult Social services and the Director of Children’s Services, elected representatives, local Healthwatch representatives; and other members. Although the NHS Commissioning Board (NHS CB) is not a core statutory member of health and wellbeing boards, prescribed by the Act, it must also participate in JSNAs and JHWSs.
- As the duties apply across the health and wellbeing board as a whole, boards must discuss and agree their own arrangements for signing off the process and outputs. It is important that duties are discharged by the board as a whole.
- The Health & Wellbeing Board has the power to request the local authority, CCGs, local Healthwatch, NHS Commissioning Board or other Health & Wellbeing Board members to supply information for the purpose of undertaking JSNAs and Joint Health & Wellbeing Strategies; and these partners must supply the information as requested.
- Local authorities and health and wellbeing boards can decide to include additional members on the board beyond the core members. Additional members, such as service providers (NHS, private or voluntary and community sector), health and care professionals, representatives of criminal justice agencies, fire and rescue services, local voluntary and community sector organisations, universities, or representatives of military populations, can bring expert knowledge of the local community to enhance JSNAs and JHWSs.
- The board is required to work with a wide range of local partners and the community beyond the board’s membership to a) ensure a thorough and robust needs assessment is produced and b) provide an opportunity to influence the work of partners.

CONTACT FOR FURTHER INFORMATION

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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

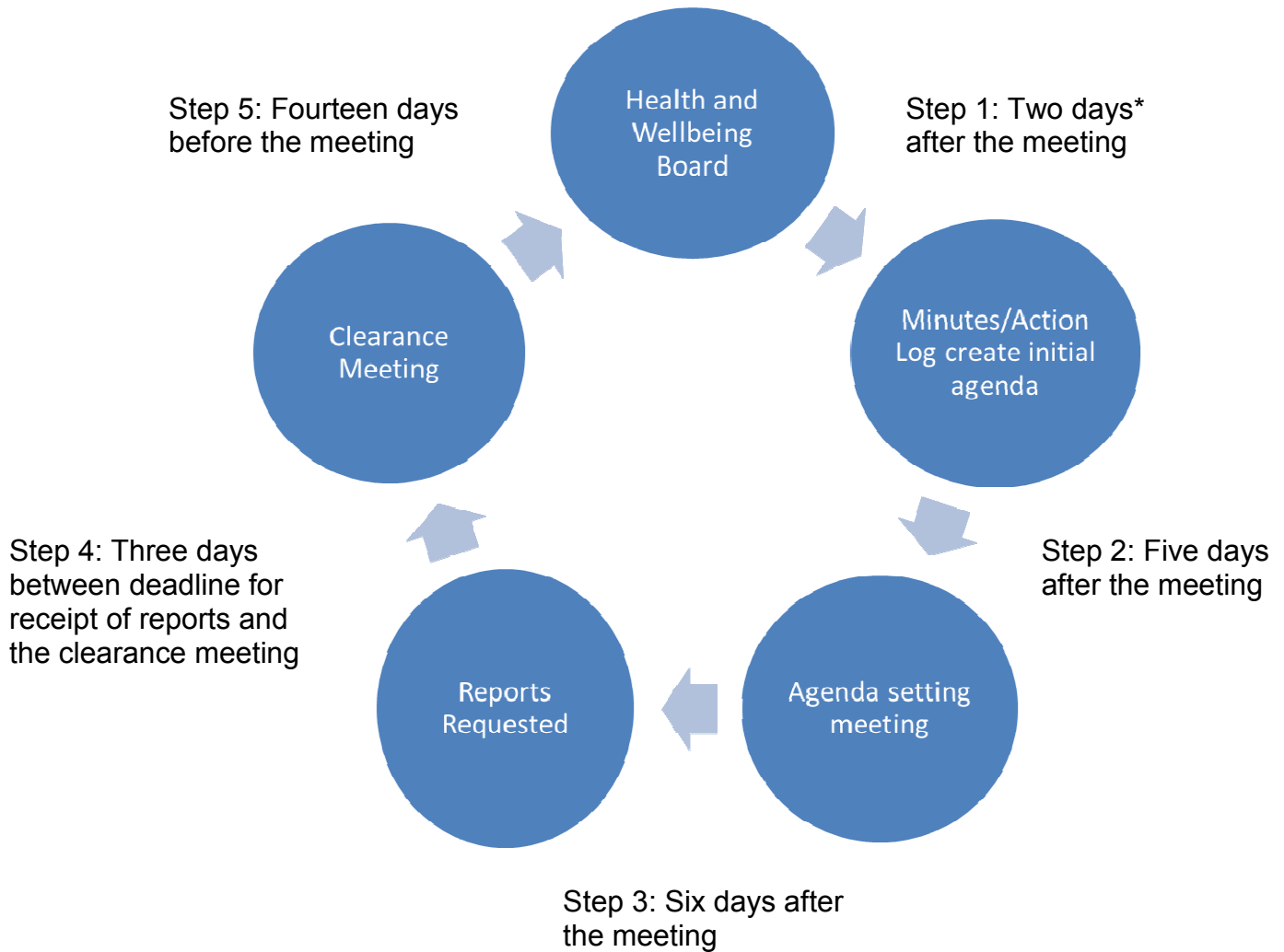
1. Sub Structure

- 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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