TOWER HAMLETS

Meeting of the

HEALTH SCRUTINY PANEL

Tuesday, 21 June 2011 at 6.30 p.m.

A G E N D A

VENUE
Room M72, Seventh Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

Members:	**Deputies (if any):**
Chair: Councillor Rachael Saunders **Vice-Chair:**	
Councillor Abdul Asad **Councillor Lesley Pavitt** **Councillor Denise Jones** **Councillor David Edgar** **Councillor Dr. Emma Jones** **1 Vacancy**	Councillor Tim Archer, (Designated Deputy representing Councillor Dr. Emma Jones) Councillor Mizan Chaudhury, (Designated Deputy representing Councillors Rachael Saunders, Abdul Asad, Lesley Pavitt, Denise Jones and David Edgar) Councillor Anna Lynch, (Designated Deputy representing Councillors Rachael Saunders, Abdul Asad, Lesley Pavitt, Denise Jones and David Edgar) Councillor Helal Uddin, (Designated Deputy representing Councillors Rachael Saunders, Abdul Asad, Lesley Pavitt, Denise Jones and David Edgar)

[Note: The quorum for this body is 3 Members].

Co-opted Members:		
David Burbridge	–	(THINk)
Dr Amjad Rahi	–	(THINk)

If you require any further information relating to this meeting, would like to request a large print, Braille or audio version of this document, or would like to discuss access arrangements or any other special requirements, please contact: Amanda Thompson, Democratic Services, Tel: 020 7364 4651, E-mail: amanda.thompson@towerhamlets.gov.uk

LONDON BOROUGH OF TOWER HAMLETS

HEALTH SCRUTINY PANEL

Tuesday, 21 June 2011

6.30 p.m.

1. ELECTION OF VICE-CHAIR

At the meeting of the Overview & Scrutiny Committee held on 7th June 2011, Councillor Rachael Saunders was appointed Chair of the Health Scrutiny Panel for the Municipal Year 2011/2012.

However, it is necessary to elect a Vice-Chair of the Health Scrutiny Panel for the Municipal Year 2011/2012.

2. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

3. DECLARATIONS OF INTEREST

To note any declarations of interest made by Members, including those restricting Members from voting on the questions detailed in Section 106 of the Local Government Finance Act, 1992. See attached note from the Chief Executive.

		PAGE NUMBER	WARD(S) AFFECTED
4.	**UNRESTRICTED MINUTES**	3 - 12	

To confirm as a correct record of the proceedings the unrestricted minutes of the ordinary meeting of Health Scrutiny Panel held on 19th April 2011.

5. REPORTS FOR CONSIDERATION

5.1 Health Sector Horizon Scanning: The Perspective of NHS East London and the City, Tower Hamlets GP Consortium and Tower Hamlets Involvement Network

To receive presentations from key stakeholders.

5.2 Health Sector Horizon Scanning: Establishing the Health and Wellbeing Board and the Perspective of Public Health — **13 - 20**

To receive presentations from key stakeholders.

6. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

DECLARATIONS OF INTERESTS - NOTE FROM THE CHIEF EXECUTIVE

This note is guidance only. Members should consult the Council's Code of Conduct for further details. Note: Only Members can decide if they have an interest therefore they must make their own decision. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending at a meeting.

Declaration of interests for Members

Where Members have a personal interest in any business of the authority as described in paragraph 4 of the Council's Code of Conduct (contained in part 5 of the Council's Constitution) then s/he must disclose this personal interest as in accordance with paragraph 5 of the Code. Members must disclose the existence and nature of the interest at the start of the meeting and certainly no later than the commencement of the item or where the interest becomes apparent.

You have a **personal interest** in any business of your authority where it relates to or is likely to affect:

(a) An interest that you must **register**

(b) An interest that is not on the register, but where the well-being or financial position of you, members of your family, or people with whom you have a close association, is likely to be affected by the business of your authority more than it would affect the majority of inhabitants of the ward affected by the decision.

Where a personal interest is declared a Member may stay and take part in the debate and decision on that item.

What constitutes a prejudicial interest? - Please refer to paragraph 6 of the adopted Code of Conduct.

Your personal interest will also be a prejudicial interest in a matter if (a), (b) and either (c) or (d) below apply:-

(a) A member of the public, who knows the relevant facts, would reasonably think that your personal interests are so significant that it is likely to prejudice your judgment of the public interests; AND
(b) The matter does not fall within one of the exempt categories of decision listed in paragraph 6.2 of the Code; AND EITHER
(c) The matter affects your financial position or the financial interest of a body with which you are associated; or
(d) The matter relates to the determination of a licensing or regulatory application

The key points to remember if you have a prejudicial interest in a matter being discussed at a meeting:-

i. You must declare that you have a prejudicial interest, and the nature of that interest, as soon as that interest becomes apparent to you; and

ii. You must leave the room for the duration of consideration and decision on the item and not seek to influence the debate or decision unless (iv) below applies; and

iii. You must not seek to improperly influence a decision in which you have a prejudicial interest.

iv. If Members of the public are allowed to speak or make representations at the meeting, give evidence or answer questions about the matter, by statutory right or otherwise (e.g. planning or licensing committees), you can declare your prejudicial interest but make representations. However, you must immediately leave the room once you have finished your representations and answered questions (if any). You cannot remain in the meeting or in the public gallery during the debate or decision on the matter.

LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE HEALTH SCRUTINY PANEL

HELD AT 6.30 P.M. ON TUESDAY, 19 APRIL 2011

M72, 7TH FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Tim Archer (Chair)

Councillor Abdul Asad
Councillor Lutfa Begum
Councillor Anna Lynch

Co-opted Members Present:

Myra Garrett	–	(THINk)
Dr Amjad Rahi	–	(THINk)

Guests Present:

Judith Bottriel	–	Barts and the London NHS Trust
Richard Fradgley	–	East London Foundation Trust
Paul James	–	East London Foundation Trust
Vaughan Jones	–	Praxis
Jane Milligan	–	Praxis
Kay Riley	–	Barts and the London NHS Trust
Dr Steve Ryan	–	Barts and the London NHS Trust
Alex Sutton	–	Praxis
Dr Mohit Venkataram	–	East London Foundation Trust
Susan Wright	–	Doctors of the World UK/ Project London

Officers Present:

Michael Keating	–	(Service Head, One Tower Hamlets)
Jebin Syeda	–	(Scrutiny Policy Officer)
Helen Taylor	–	(Acting Corporate Director Adults Health & Wellbeing)
Amanda Thompson	–	(Team Leader - Democratic Services)

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Lesley Pavitt and Kosru Uddin.

2. DECLARATIONS OF INTEREST

Councillor Lutfa Begum declared a personal interest in all agenda items as she was an employee of Tower Hamlets PCT.

Councillor Anna Lynch declared a personal interest in agenda item 5.4 as she was an employee of Barts and the London Trust.

3. UNRESTRICTED MINUTES

The minutes of the meeting of the Panel held on 25 January 2011 were agreed as a correct record and signed by the Chair.

4. REPORTS FOR CONSIDERATION

4.1 Excellence in Quality Strategy

In addition to a written report detailing the headline objective and quality improvement priorities for 20011/12, Mr Steve Ryan, Medical Director, and Kay Riley (Chief Nurse), from Barts and the London NHS Trust, were present to give an overview of the Trust's performance against 2009/10 objectives.

The presentation focussed on the following points:

Quality and Operational Delivery Progress 2009-2011

Quality, safety and standards:

- Top 20 Trusts for HSMR in last 3 years
- Achieved Level 3 NHSLA in 2010
- Infection control fewer MRSA & C Dif cases 2 years running
- Selected as lead education provider
- Designated an stroke centre (quintupling service size)
- Forefront of London wide trauma system

National targets and KPIs:

- Rated by DH 'performing' for last 3 quarters
- Turnaround on 18 weeks
- Met emergency care standard 09-10 & 10-11
- Hitting maternity, cancer & cardiac standards
- Challenged in T&O, 6hr waits and cancelled operations
- Single sex compliance – RLH from April 2012

Building capacity and capability:

- Appraisal rates of 90%+

- Staff Survey progress
- Talent management and operational 'top 50' externally appraised / coached
- Barts Phase 1 delivered April 2010
- RLH Phase 1 (Dec 11 - Mar 12)
- Renewing CRS ICT products in 2011

Expenditure controls and £36m cost reduction:

- £2.5m+ programme for drugs (use and price)
- 90% of contracts externally tendered
- End to end processes reviewed for better control
- Driving out temporary staffing, halved in Q3-4
- Low sickness absence rates (3-4%)
- Vacancy rates reduced to below 8%

Quality Account our stated priorities going forward

Improving the patient's experience

- Keeping wards and public areas clean
- Staff always being kind and compassionate
- Improving the quality and availability of patient information
- Build on the improvements we have achieved in maternity services
- Continued focus on food and nutrition and help with feeding
- Not cancelling - operations and clinics
- Make the OP appointments booking, and scheduling processes more reliable

Improving safety and delivering harm free care

- Intentional rounding - hourly comfort checks for all patients
- Reducing pressure ulcers by a further 30%
- Implement safety alerts within the specified time
- Continue to exert zero tolerance on poor infection control standards
- Prevent risk for people with known allergies
- Better nutrition and hydration campaign

Effective care and treatment

- To implement six new enhanced recovery surgical pathways
- Normalise birth to ensure comparable caesarean section rates and higher satisfaction
- Continue to deliver improved national access and waiting time standards
- Maintain our excellence in stroke, cardiac and trauma care
- Develop integrated pathways and services with community care teams and specialist services to benefit patients and promote better health

Committee Members then asked detailed questions on a number of issues including budget cuts and the impact of PFI, the availability of drug support and rehabilitation for drug users, the need to improve the appointments process and the outpatient experience overall, the number of jobs at risk and which areas would be most affected, patient entertainment and provision of internet access, and the need to try and improve links between different clinics so patients only needed one set of tests etc.

The Chair thanked Mr Ryan and Ms Riley for their presentation, the contents of which were noted by the Panel.

4.2 Focus on Dementia

Received a report from Richard Fradgley, Head of Mental Health Commissioning (NHS TH) and Barbara Disney, Service Manager, Strategic Commissioning (LBTH), outlining the actions the Tower Hamlets Partnership would take forward to improve services for people with dementia, and detailing the development of the Commissioning Strategy.

The Panel noted that the strategy had been developed with the involvement of a range of stakeholders across the Tower Hamlets Partnership, including service users and carers, NHS Tower Hamlets, East London NHS Foundation Trust (ELNHSFT) as well as the Council and voluntary sector.

Since the publication of the Strategy, the partnership had made considerable progress with its delivery:

- Commissioned a new Memory Service to be provided by ELNHSFT with substantial additional capacity and new, clearer pathways in and out for service users and their carers.

- Commissioned ELNHSFT to sub-contract a new Dementia Adviser Service, the aim of which was to provide a point of contact and support for service users with a diagnosis of dementia but who have low to moderate associated needs.

- Commissioned a new Dementia Liaison Service at the Royal London Hospital to provide rapid specialist assessment to in-patients with dementia or possible dementia.

- Commissioned an extra care supported accommodation scheme at the Shipton Street site specifically for service users, which would hopefully be ready to open by the end of 2011.

- Developed and started to implement a 3 year Dementia Awareness Strategy, with a focus on improving both local knowledge on dementia as a condition and access to local services.

- Included within the annual GP Practice Prescribing Audit, questions regarding prescription of anti-psychotic drugs to service users with dementia.

- Promoted better end of life care for people with dementia.

The Partnership was continuing to work on the following priorities:

- Residential Care
- Respite for both service users and carers
- Development of interface between the Memory Service and GP practices
- Reconfiguration of in-patient beds for people with dementia
- Personalised Care
- Extra Care – sheltered housing

In response to questions Mr Fradgley advised that the issue of language barriers would be addressed by both the Dementia Awareness Strategy and outreach work, and support for carers was the number one priority of the Commissioning Strategy.

4.3 New Residents and Refugee Forum - Access to Healthcare

Received a presentation from Vaughan Jones, Vice-Chair of the New Residents and Refugee Forum, providing detailed findings of the seminar on the issues of accessing healthcare faced by new migrants in Tower Hamlets.

The presentation focussed on the following points:

- Since opening in 2006 Project: London had seen growing numbers of patients unable to access NHS services
- From 2006 -2010 Project: London saw 3,008 service users and provided 2,370 consultations
- In 2010 Project: London saw 180 service users from Tower Hamlets – of these, 102 service users eligible for care were effectively barred from being registered with the majority of surgeries because of restrictive practice policies requiring them to (a) prove their immigration status or (b) show original photo ID in order to register
- The most prevalent countries of origin for service users in 2009 were India, China, Philippines, Eritrea, Bangladesh, Uganda, Brazil, Romania, Pakistan and the Ukraine
- A recent Freedom of Information request revealed the number admitted to A&E at The Royal London Hospital who were not registered with an NHS GP was 18,847 in the year 2008 and 17,075 in 2009

Barriers which prevent new communities from accessing healthcare included:

- Language barriers which led to further problems in diagnosing and prescribing
- Barriers caused by inhospitable and sometimes hostile GP surgery staff
- Barriers caused by surgery staffs lack of knowledge and understanding of regulations
- Barriers caused by new communities not having knowledge of NHS systems and rights

Specific reasons given for refusing registration in Tower Hamlets included:

- Lack of sufficient proof of ID (either none available, and the surgery insists on photo ID in order to register a patient; or photocopy of passport not sufficient – surgery insists on seeing original passport, even when this is not available)
- Lack of sufficient proof of address (needed 1-2 'official' pieces of PoA from within the last 3 months in order to register. Only accepted bank statements, tenancy agreement, utility bills, etc)
- Lack of proof of immigration/residency status, when surgery insists on seeing this 'to prove entitlement to NHS services'

Tower Hamlets NRRF Recommendations:

1. Guidelines and Training for front-line staff - this should be complemented by the provision of training to all front line staff as part of their induction and become a regular feature of any ongoing training programmes.

2. Enforcement of written confirmation of refusal to register - a further concern is in relation to community members being refused GP registration without a letter being issued to confirm the reason addressing why they could not register. This should be standard practice, otherwise we are unable to keep track of the number of people who are being refused primary healthcare access.

3. Support for NRPF clients receiving treatment for TB - Barriers exist in relation to providing daily treatment for TB to community members that have NRPF and street homeless. Accommodation and support needs to be provided to ensure full treatment can be dispensed.

Members of the Panel raised the following points:

- The cost of emergency treatment could be avoided if GP's could be accessed sooner

- Was there a formal complaints procedure?

- Some communities, for example travellers, were very difficult to access, and language skills and interpreters were also very important

- Some clinics provided advocacy services which were useful in helping register people sooner.

- The need to clarify the registration service defining those with automatic rights to services and those whose eligibility needed to be determined.

Jane Mulligan, NHS East London, welcomed the comments made and advised that there was a need to clarify the process and make sure it was carried out appropriately. Contractual arrangements with GP surgeries could be enforced and those in breach could be named and shamed. 'Navigators' were available at some surgeries and A and E departments.

The Chair thanked Mr Vaughan for his presentation and assured him that the Health Scrutiny Panel would continue to raise these issues in the future and put pressure on GPs.

4.4 Visit to Barts and the London Trust - Verbal update

The Chair gave a verbal report of the Panel's meeting with Peter Morris, Chief Executive, and Ali Mohammed, Director of Human Resources, at Barts and the London Hospital.

The outcome of the discussion had been:

- Barts and the London were looking to make 6.5%-7% (approx. 41m) budget buts in 2011 which included a 1% (6m) surplus as an aim

- It would not to be carrying forward any deficits by 2012 – a good position to be in as part of the merger plans

- Proposals included looking at the use of property and community services, not just staff and service costs

- The media talked of 635 redundancies – however there were 405 live vacancies and only 178 at risk

- The consultation process was due to end on 13 May 2011

A numbers of other issues were highlighted by the Panel, including:

- The loss of patient engagement and involvement during the transition/change period

- The quality of care and compassion demonstrated by night staff was considered to be unsatisfactory

- The appointment system at the dental institute wasn't working – people were left waiting for long periods of time and then told to go home.

- Patients often didn't see the named consultant on their referral letters

4.5 Cancer - the Development of Early Diagnosis and Preventative Services - Scrutiny Challenge Session

The Chair asked Jebin Syeda, Scrutiny Policy Officer, to present the report detailing the outcome of the Scrutiny Challenge Session on the Development of Early Diagnosis and Preventative Services held on 18 January 2011.

The session had taken place at the Mile End Hospital to enable local residents and patients to attend, and was structured to enable an exchange of information about the local approach to addressing cancer issues and an opportunity to hear stories from residents and patients about their experience of using local health services.

The recommendations had previously been considered and agreed by the Overview and Scrutiny Committee.

The Panel noted the report.

4.6 Health Scrutiny Panel response to Health Lives Healthy People White paper

The Chair advised that following the discussion held at the last meeting, a letter was submitted to Andrew Lansley, Health Secretary, outlining the issues raised by the Health Scrutiny Panel in their response to the White Paper – Healthy Lives Healthy People.

Helen Taylor, Corporate Director, Adults Health and Well Being (LBTH), advised that the Council had applied to be an 'early implementer' of the proposed Health and Well Being Board, and an introductory meeting had been arranged for early July when the membership and terms of reference would be determined. The need to establish a link to scrutiny and establish what each would be responsible for would also need to be agreed.

5. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT

As it was the last meeting of the municipal year the Chair expressed his thanks to all those present for their valuable contributions to the work of the Health Scrutiny Panel.

The meeting ended at 9.30 p.m.

Chair, Councillor Tim Archer
Health Scrutiny Panel

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Committee *Health Scrutiny Panel*	Date 21st June 2011	*Classification* **Unrestricted**	Report No.	Agenda Item No. **2**
Report of: Deborah Cohen, Service Head Commissioning and Strategy, Adults Health and Wellbeing Directorate.		**Title:** Development of Tower Hamlets Statutory Health and Wellbeing Board **Ward(s) affected:** *All*		

1. Summary

1.1 The NHS White Paper 'Equity and Excellence: Liberating the NHS' and the accompanying consultation paper 'Local democratic legitimacy in health' outlined significant changes to local health and wellbeing structures, including the creation of a statutory Health and Wellbeing Board. This paper sets out proposals for the development of the Health and Wellbeing Board in Tower Hamlets.

2. Recommendations

2.1 The Health Scrutiny Panel is asked to consider the proposals in this paper and provide comments and feedback. One particular area for consideration is how to manage the relationship between Health Scrutiny Panel and the Health and Wellbeing Board.

BRIEFING PAPER FOR HEALTH SCRUTINY PANEL

TITLE	AUTHOR
Development of Tower Hamlets Statutory Health and Wellbeing Board	Deborah Cohen - Service Head for Commissioning and Strategy

1. INTRODUCTION/SUMMARY

1.1 The NHS White Paper *'Equity and Excellence –Liberating the NHS'* was published in July 2010. This document and the accompanying consultation paper 'Local democratic legitimacy in health' outlined significant changes to local health and wellbeing governance structures, including the creation of a statutory 'Health and Wellbeing Board' (HWBB). This presents a major opportunity for the Borough to strategically address health inequalities by steering the commissioning of services through the work of the Board.

1.2 '*Healthy lives, healthy people; Our strategy for public health in England'* (the Public Health White Paper) confirmed the government's intention to establish statutory boards in each unitary/upper tier local authority. The government's response to the NHS White Paper consultation process reiterated this point, indeed there were no objections, and outlined that the Health and Social Care Bill would include a specification that 'all health and wellbeing boards should have to develop a high level joint health and wellbeing strategy.'

1.3 The statutory requirement to establish a Health and Wellbeing Board is now in the Health and Social Care Bill that is currently going through the parliamentary process. There is currently a pause in the legislative process whilst further consideration is given particularly to more controversial aspects of the Bill. It is not believed that there is likely to be significant change in relation to the establishment of HWBBs, but a key area of concern that is to be resolved is the level of accountability that GP consortia will have to the HWBB.

1.4 LBTH was successful in its application to become an early implementer and establish a local shadow Health & Wellbeing Board during 2011/12. The GP Commissioning Consortium in Tower Hamlets (now known as NHS TH Consortium) has been successful in obtaining pathfinder status and THINk are also likely to achieve pathfinder status in their transition to Local HealthWatch. We believe that it is important that the HWBB is established over the next few months in order to maximise the opportunities for shared learning and development regarding the new arrangements. Another key factor is to inform the next round of commissioning. For this reason Cabinet is being asked to agree many of the proposals for the development of the Health and Wellbeing Board in August and discussions with MAB are happening between now and then. It is likely that the first formal meeting of the

HWBB will be held in September, with an earlier informal meeting in the summer.

1.5 Health Scrutiny is invited to consider the proposals within this paper and to provide comments and feedback. This will then be fed into the appropriate MAB and Cabinet reports. One particular area for consideration will be how the relationship between Health Scrutiny and the HWBB is managed, to ensure complementary working and synergies are maximised, but also recognising the distinct roles and responsibilities.

2. BACKGROUND

2.1. The NHS White Paper 'Equity and Excellence - Liberating the NHS' outlined the Government's intention to establish local statutory Health and Wellbeing Boards to support joint working on health and wellbeing. The primary function of the board is described as concentrating on joining up the commissioning of local NHS services, social care and health improvement: **'allowing local authorities to take a strategic approach and promote integration across health, adult social care, children's services, and the wider local authority agenda'**. The subsequent consultation document 'Local democratic legitimacy in health' further defined the role around four key functions:

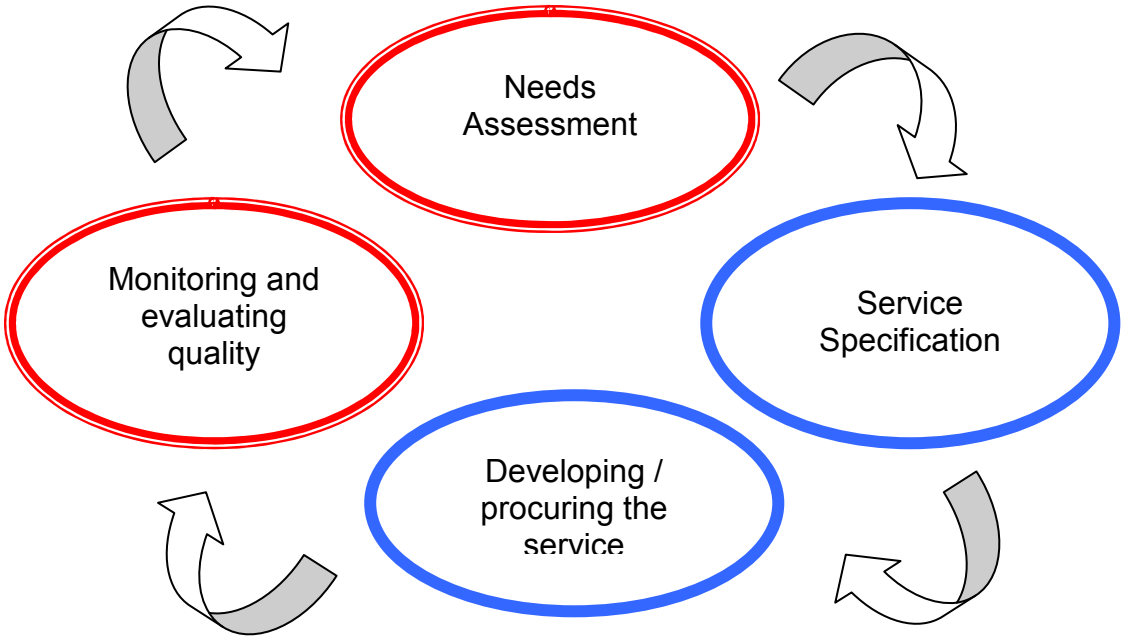
- To assess the needs of the local population and lead the statutory joint needs assessment.
- To promote integration and partnership across areas, including through promoting joined up commissioning plans across the NHS, social care and public health
- To support joint commissioning and pooled budgets where all parties agree it makes sense
- To undertake the statutory scrutiny functions currently undertaken by health overview and scrutiny committee (N.B. this was later amended in response to consultation in the DH document 'Legislative Framework and next steps' and the expectation is that current health overview and scrutiny arrangements will continue).

2.2 The board is designed to help facilitate effective engagement between local government and NHS commissioners within the new system of NHS commissioning with GP consortia at its heart. It is proposed that it is the mechanism through which joint commissioning and pooled budgets are taken forward and the board would have a lead role in determining how any place budgets for health are used.

2.3 The role outlined for local government in leading this board is significant and the opportunity to influence and steer the effective use of local health and social care resources is an important one for the Council to grasp. The potential influence of the board on the commissioning cycle of the JSNA and joint Health and Wellbeing Strategy is significant. This is illustrated in the sections highlighted in

red in the diagram below. The Council's leadership of these functions will help to ensure services meet local need and are of good quality.

Commissioning cycle for Social Care, Health and Health Improvement



2.4 The White Paper timescale for implementing HWBBs was that they should assume their statutory responsibilities from April 2013. This timescale may be affected by the current delay in the legislation however as noted in the introduction MAB is recommended that the Borough establishes its shadow Health and Wellbeing Board in the over the summer 2011 to provide a critical senior level to engage with NHS East London and the City, NHS TH Consortium, and local HealthWatch. Developing the Board during 2011/12 will enable Tower Hamlets to test out the model and the respective roles of key stakeholders within it.

3. Draft Terms of Reference

3.1 **Structure:**
It is suggested that consideration is given to establishing an operational group to support the HWBB with sub-groups such as the JSNA and Integrated Care Board reporting in. Further work is needed on the overall governance and will require detailed discussion with partners.

3.2 **Healthy Communities CPDG:**
As the Health and Wellbeing Board will be the statutory board leading on all aspects of health and wellbeing in Tower Hamlets, including health inequalities, there would be considerable overlap between it and the CPDG. It is therefore proposed that the Healthy Communities Community Plan Delivery Group's role and remit are handed over to

the Health and Wellbeing Board and that the CPDG is stood down. This has been discussed with the CPDG at a recent meeting who supported this view.

3.3 **Children's Trust Board (CTB):**
There are clear linkages and also potential duplication between the CTB Be Healthy subgroup and areas to be overseen by the HWBB; it is proposed that the Corporate Directors for Adults Health and Wellbeing and Children's Schools and Families discuss this as part of the development of an overall governance structure and recommend the way forward to the Health and Wellbeing Board.

3.4 **Membership:**
As the key objectives are for genuine strategic and practical collaboration between commissioning organisations with clear elected member leadership and to give the populations that they serve a greater say, membership of the HWBB must comprise the following:

- Councillors
- Directors of Public Health
- Adult and Children's Services
- GP Consortia
- HealthWatch

Detailed membership however is left to local decision and agreement. The boards may also choose to invite participation from relevant professionals, community groups and the voluntary sector.

3.5 Based on this, the suggested executive membership of the Tower Hamlets Health and Wellbeing Board is outlined below:

- Mayor (Chair)
- Chief Executive – LBTH
- DASS – LBTH **
- DCS – LBTH **
- Lead Members for Adults and Children's Services
- Chief Executive – NHS East London and the City
- Borough Director - Tower Hamlets (NHS East London and the City)
- Chair – NHS Tower Hamlets Consortium
- Director of Public Health – Tower Hamlets
- Corporate Directors whose services contribute to health and wellbeing such as CLC ?
- Tower Hamlets CVS

** These statutory roles will be fulfilled by the new Executive Director for Education, Social Care and Wellbeing when appointed. The postholder will be the Chief Operating Officer for the HWBB.

3.6 **Frequency of Meetings:**
In order for the Board to oversee the commissioning cycles of key strategies connecting NHS and local government, specifically the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy, it is proposed that the Board meets each quarter commencing in September 2011. Further meetings would therefore be scheduled in December 2011 and March 2012.

3.7. In addition, an initial development meeting is proposed in July 2011 for the Board to give consideration to the business issues listed above such as Terms of Reference, objectives of the Board, meeting dates, and importantly, for the matters covered by the Healthier Communities CPDG to be handed over. Tower Hamlets is in advance of many authorities in that it already has a JSNA and a joint Health and Wellbeing Strategy that was refreshed during 2009, both of which have been commended as models of good practice and so the Health and Wellbeing Board will have strong foundations on which to build. It is likely that the Health and Wellbeing Board will want to commission a review of the strategy to reflect the latest JSNA and the current organisational and financial context.

4. Issues to clarify going forward

4.1 **Establishing shared priorities:**
There needs to be 'buy-in' to the purpose and priorities of the board from all its members. A key activity in establishing the new board will be agreeing joint priorities that adequately cover the concerns of all partners and form a basis on which progress across the health and wellbeing sector can be tracked. Priorities could include:

- Allocation of the ring fenced Public Health budget
- Major service change such as the transfer of community health services to BLT/development of Community Virtual wards
- Reducing unacceptable variations in health
- Integrated commissioning
- Joint arrangements for future operational services
- Prevention e.g. early intervention measures, reducing premature deaths
- Reducing emergency admissions
- Oversight of the borough's health and social care sector's financial position
- Decommissioning to meet financial challenges in a way that will minimise harm

4.2 **Relationship to Health Scrutiny:**
Although health scrutiny was outlined as a specific role of the Board in the white paper the subsequent Department of Health response has clarified that this will be a separate function. We await any further changes in the passage of the Health and Social Care Bill which already provides for strengthened scrutiny powers for local authorities.

A protocol will need to be developed covering the roles and relationship between health scrutiny and the HWBB. The views of Health Scrutiny are specifically sought on this point.

4.3 **Relationship to the Tower Hamlets Partnership:**
It is proposed that the new statutory Board takes over the functions of the existing CPDG. Consideration will need to be given to how the HWBB relates to the Partnership overall related structures.

5. CONCLUSIONS

5.1 The establishment of the Health and Wellbeing Board is a major opportunity for the Council to strategically lead health and wellbeing in Tower Hamlets by steering the commissioning of a wide range of health and social care services, including Public Health services and ring-fenced funding. It provides the opportunity to develop strong partnerships with the NHS and GP Consortia locally through effective engagement led by local government. The new Tower Hamlets Health and Wellbeing Board will build on the strong foundations in place from the existing JSNA and Joint Health and Wellbeing Strategy to develop high quality services that are responsive to local need.

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