h&f the low tax borough	**London Borough of Hammersmith & Fulham** **HEALTH & WELLBEING BOARD** **13 January 2014**
TITLE OF REPORT Joint Strategic Needs Assessment (JSNA) Update	
Report of the Interim Director of Public Health	
Open Report	
Classification - For Decision and Information **Key Decision: Yes**	
Wards Affected: All	
Accountable Executive Director: Interim Director of Public Health	
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1. EXECUTIVE SUMMARY

1.1. As agreed at the meeting of the Health and Wellbeing Board on 17 June 2013 the JSNA will be a standing item on the HWB agenda.

1.2. This report provides a further update on progress with the 2013/14 JSNA work programme, presents the Tuberculosis JSNA for consideration and approval, and describes the next steps for developing the 2014/15 work programme.

2. RECOMMENDATIONS

2.1. The Health and Wellbeing Board are requested to consider the progress being made against the 2013/14 JSNA programme

2.2. Review and agree to publish the findings and recommendations of the Tuberculosis JSNA

2.3. Consider and approve the approach to developing the 2014/15 work programme

3. JSNA UPDATE

3.1. Due to a large number of apologies the 2nd meeting of the JSNA Steering Group scheduled for 28 November was cancelled. The next meeting will take place on 21st January 2014 and will begin the process of setting the work programme for 2014/15.

3.2. Interviews have taken place for the JSNA Manager post and the successful candidate, Dan Lewer, will start early April 2014.

3.3. At the November meeting the JSNA Highlights report for Hammersmith and Fulham was approved. Final edits are being made and the report will be published on the JSNA website in the New Year.

4. CURRENT JSNA WORK PROGRAMME

4.1. The following deep dive JSNAs are in progress:

- The Learning Disabilities JSNA has now been completed and will come to the Health and Wellbeing Board along with the Tri-borough Learning Disabilities Plan

- Physical Activity JSNA. The final recommendations have been sent for approval by the Community Sport & Physical Activity Networks (CSPAN) and JSNA Steering group. These will come to the Health and Wellbeing Board in March 2014.

- Child Poverty JSNA. A well attended Engagement Summit was held on 12 November which informed key priority areas and recommendations for the final JSNA. These recommendations are being finalised and will come to the Health and Wellbeing Board in March 2014.

5. 2014/15 WORK PROGRAMME

5.1 One of the key responsibilities of the JSNA Steering Group is to establish the priorities for the JSNA work programme. Priorities may be identified from:

- the Joint Health and Wellbeing Strategies
- existing summary JSNA reports
- local and national policy drivers
- commissioning intentions and re-procurement plans
- specific requests for a JSNA

5.2 A meeting of the JSNA Steering Group will be dedicated to setting the priorities for the 2014/15 work programme. This will be held in early Spring 2014 to ensure alignment with the commissioning cycle and will be expanded to include key stakeholders to assist in identifying potential topics for deep dive JSNAs and developing the work programme.

5.3 No new applications have been submitted to the JSNA Steering Group for consideration, however the following topics are on the radar and may contribute to the 2014/15 work programme:

- Impact of parental mental health on children
- Female Genital Mutilation (FGM)
- Working population
- Rickets (Vitamin D)
- Housing (focussing on Older People)
- Bullying (including cyberbullying)
- Population and ward profiles
- Homeless with no recourse to public funds
- Co-morbidites among homeless

5.4 Any topic to be considered as part of the JSNA work programme will need to be fully scoped and each may require a different level of work

6. TUBERCULOSIS (TB) JSNA

6.1 This JSNA was commissioned in response to an identified need for a systematic programme for TB services and for new entrant identification and screening in primary care. It is also intended to inform a robust service specification for TB services commissioning in the future.

6.2 The JSNA reports on the prevalence and characteristics of TB across the Tri-borough, describes current service provision and makes recommendations to ensure services meet the needs of the local population.

6.3 TB is an airborne disease caused by a bacterium which usually affects the lungs but can develop in any part of the body. Pulmonary TB (affecting the lungs) can spread the disease to others. TB is curable in almost every case if the full treatment is taken (usually 6 months involving up to 4 drugs), otherwise the disease can return in a drug-resistant form (which

can take up to 2 years to treat and is associated with a higher mortality). TB is fatal in about 3% of cases.

6.4 The risk of TB and particularly drug resistant TB is increased in individuals who have one or more social risk factors such as homelessness, drug use, alcohol misuse, imprisonment associated with a high risk of non-adherence. Often a number of risk factors co-exist.

6.5 The prevalence of TB in London (41 per100,000 in 2012) is significantly higher than the national prevalence (13.9 per 100,000 in 2012). While lower than London, the prevalence in Hammersmith & Fulham is 26 (per 100,000), higher than the national prevalence. Royal Borough of Kensington and Chelsea is 21 (per 100,000) and Westminster is 23 (per 100,000).

6.6 TB presents a particular challenge for the tri-borough area because of its central London location with high levels of homelessness, high density of schools, colleges, universities, work places and neighbouring boroughs with very high TB prevalence, making TB prevention particularly resource intensive for the tri borough due to large scale and complex contact tracing exercises

6.7 Key findings of the TB JSNA:

a) Lack of clarity on the overall strategic planning and management of services, particularly since the demise of the TB Action Group. Now that the responsibility for commissioning sits with Clinical Commissioning Groups with input from the Health and Wellbeing Board, there are opportunities for CCGs, Adult Social Care, Public Health and other agencies to work together to address local issues and operate across boundaries

b) Management of services for active TB. There are four centres providing TB services with a large input of specialists for a small service. This current model does not offer economies of scale required for the provision of specialist clinics or adequate staffing levels to respond to increased demand. In addition, there are tensions and gaps in service provision arising from the fragmentation of services and funding arrangements. The latter means that aspects of TB prevention and treatment are not sufficiently ring-fenced.

6.8 Based on the findings of the JSNA a number of recommendations are highlighted:

a) Pooling staff, clinics and resources where appropriate. At present there are Trusts close together providing similar expertise for a relatively small workload which is unlikely to be cost efficient. A single service model has been shown to work in North Central London and a proposed model for Tri-borough could comprise two hubs with additional provision of community

services. Capacity could be mapped across the four sites in terms of accessibility.

b) Consider how hospital and community services can be provided more effectively. To prevent TB transmission efforts should be concentrated on new migrants to the UK in the last 5 years with primary care and community services playing a key role. One proposed solution is for the hospital services to lead on index case and latent TB infection (LTBI) case management. The community service would lead on the screening element of TB control and management such as new entrant screening and active case finding as well as providing support for hospital and primary care services.

c) Review current commissioning arrangements and establish service specification and service level agreement for TB. Currently TB payments are bundled into the acute respiratory block contract or respiratory services for CLCH. However, the TB service is different from the respiratory or infectious disease services in that an effective TB service is equally about prevention of TB, rather than just acute treatment. The Payments By Result (PBR) method does not allow for flexible allocation of the funds across all the various elements of TB care such as screening activities, data entry, cohort review, contact tracing and incident management. Commissioners should consider agreeing a service specification with the hospital services and unbundling the TB contract from the acute contract. Attaching costs to the various elements of the service may help hold back funds when they are needed for contact-tracing and incidence control.

d) Establish a local pathway for the management of TB. A joint pathway with local authorities for the management of patients with no recourse to public funds (e.g. some recent immigrants, homeless, drug users) would improve prevention of TB cases in high risk patients, particularly with regards to drug resistant TB. A dedicated social worker could make the service more effective and efficient by establishing good links between the housing department in the councils, the TB teams, and the third sector providers.

6.9 A briefing describing these key recommendations and implications for contractual arrangements has been sent to Central London Clinical Commissioning Group with a view that this will be shared across the three CCGs.

6.10 Since this JSNA has been written a London TB Control Board has been co-sponsored by Public Health England and NHS England. The objectives of this board are:

- Achieve a 50% reduction in TB rates by 2018
- Provide strategic oversight and direction to the control, commissioning, quality assurance and performance management of TB services across London
- Promote service specific improvements and a whole systems approach that address TB incidence of TB

- Ensure pan-London resources targeted at TB are commissioned and utilised effectively, provide value for money and improve health outcomes

6.11 The London TB Control Board will provide future strategic direction for TB services across London and recommendations will need to be considered in the context of this development. We envisage that the TB JSNA will feed into this London wide process.

7. CONSULTATION

7.1. Consultation with key stakeholders is undertaken for each JSNA as an integral part of the JSNA Rolling Programme

8. EQUALITY IMPLICATIONS

8.1. JSNAs must consider the health, wellbeing and social care needs for the local area addressing the whole local population from pre-conception to end of life.

8.2. The “local area” is that of the borough, and the population living in or accessing services within the area, and those people residing out of the area for whom CCGs and the local authority are responsible for commissioning services

8.3. The “whole local population” includes people in the most vulnerable circumstances or at risk of social exclusion (for example carers, disabled people, offenders, homeless people, people with mental health needs, Travellers etc.)

9. LEGAL IMPLICATIONS

9.1. The Joint Strategic Needs Assessment (JSNA) was introduced in the Local Government and Public Involvement in Health Act 2007

9.2. The Health and Social Care Act 2012 placed the duty to prepare a JSNA equally and explicitly on local authorities (LAs), Clinical Commissioning Groups (CCGs) and the Health and Wellbeing Boards (HWB).

10. FINANCIAL AND RESOURCES IMPLICATION

10.1. Dependent on the findings of individual JSNA reports

11. RISK MANAGEMENT

11.1. Dependent on the findings of individual JSNA reports

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1. Dependent on the findings of individual JSNA reports

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	TB JSNA draft version_3Dec13	Colin Brodie, Tel: 02076414632	Tri-Borough Public Health