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Brent

Brent Clinical Commissioning Group

Health and Wellbeing Board

Thursday 19 March 2015 at 7.00 pm
Sudbury Primary School, Watford Road, Wembley, Middlesex, HA0 3EY

Membership:

Members		Substitute Members
Councillor Pavey (Chair)	Brent Council	Councillors:
Councillor Crane	Brent Council	Butt, Denselow, Mashari and McLennan
Councillor Hirani	Brent Council	
Councillor Moher	Brent Council	
Councillor Warren	Brent Council	
Christine Gilbert	Brent Council	
Sue Harper	Brent Council	
Phil Porter	Brent Council	
Dr Melanie Smith	Brent Council	
Gail Tolley	Brent Council	
Dr Sarah Basham	Brent CCG	
Rob Larkman	Brent CCG	
Dr Ethie Kong	Brent CCG	
Sarah Mansuralli	Brent CCG	
Ann O'Neill	Brent Health Watch	

For further information contact: Bryony Gibbs, Democratic Services Officer
0208 937 1358

For electronic copies of minutes, reports and agendas, and to be alerted when the minutes of this meeting have been published visit:
democracy.brent.gov.uk

The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members.

Item Page

PART A

Facilitated Workshop: Improving mental wellbeing throughout life

PART B

1 Declarations of interests

Members are invited to declare at this stage of the meeting, any relevant financial or other interest in the items on this agenda.

2 Minutes of the previous meeting

The minutes of the previous meeting were not available at the time of publishing and will be circulated separately prior to the meeting. To Follow

3 Matters arising

4 Arrangements for keeping the Pharmaceutical Needs Assessment up to date 1 - 6

The Health and Social Care Act 2012 conferred the duty for publishing and keeping up to date a statement of the population needs for pharmaceutical services in their area, referred to as a Pharmaceutical Needs Assessment (PNA), onto Health and Wellbeing Boards (HWBs). This paper proposes a process for keeping the PNA up to date and determining if a revision of the PNA is needed within the next three years.

Ward Affected:
All Wards

Contact Officer*:* Dr Melanie Smith, Director Public Health
Tel: 0208 937 6227
melanie.smith@brent.gov.uk

5 Primary Care Co-commissioning in North West London 7 - 18

This paper serves to update Brent HWBB on developments in primary care co-commissioning in North West (NW) London up to the end of February 2015, plus next steps for March to April and beyond. Furthermore, this paper is intended to initiate and progress conversations between Brent HWBB and Brent Clinical Commissioning Group on the future role of the HWBB in primary care co-commissioning, to ensure a

timely and transparent dialogue as decisions are made about whether to enter into formal co-commissioning arrangements from April 2015.

Ward Affected: All Wards	***Contact Officer**:* Sarah Mansuralli, Brent Clinical Commissioning Group

6 Better Care Fund Update 19 - 30

This report provides an update on progress with the Better Care Fund since the last Health and Wellbeing Board. It notes the final assurance letter from NHS England at the end of January, outlines the approach and timescales for implementation planning, and sets out proposals for a revised governance structure which has a clear focus on accountability for delivery.

Ward Affected: All Wards	***Contact Officer**:* Phil Porter, Strategic Director, Adults, Sarah Mansuralli, Brent Clinical Commissioning Group Tel: 020 8937 5937, phil.porter@brent.gov.uk,

7 Progress update on workshop outcomes

A verbal update will be presented to the Board on the outcomes from the Brent Dementia Action Alliance workshop and Brent Children's Trust workshop.

Ward Affected: All Wards	***Contact Officer**:* Phil Porter, Strategic Director, Adults, Gail Tolley, Strategic Director, Children and Young People Tel: 020 8937 5937, Tel: 020 8937 6422 phil.porter@brent.gov.uk, gail.tolley@brent.gov.uk

8 Date and topic of next meeting

9 Any other urgent business

Notice of items to be raised under this heading must be given in writing to the Democratic Services Manager or his representative before the meeting in accordance with Standing Order 64.

Date of the next meeting: To be confirmed following the annual Council meeting.

Please remember to switch your mobile phone to silent during the meeting.

- The meeting room is accessible by lift and seats will be provided for members of the public.

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Brent	**Health and Wellbeing Board** 19 March 2015 **Report from the Director of Public Health**
For decision	Wards Affected: ALL

Arrangements for keeping the Pharmaceutical Needs Assessment up to date

1.0. Summary

1.1. The Health and Social Care Act 2012 conferred the duty for publishing and keeping up to date a statement of the population needs for pharmaceutical services in their area, referred to as a Pharmaceutical Needs Assessment (PNA), onto Health and Wellbeing Boards (HWBs).

1.2. The Brent HWB has previously agreed to establish a PNA Steering Group. The HWB has delegated to the PNA Steering Group the authority to conduct, consult on and publish a revised Brent PNA. The HWB has also delegated to the PNA Steering Group the task of reviewing PNAs from neighbouring boroughs and responding to consultation as required

1.3 A draft PNA has been published and consulted on. The PNA Steering Group will consider responses to consultation at its meeting on 16th March 2015, with a view to agreeing a final PNA. It is anticipated this will be published on the Brent Council Website in advance of the 1st April and in accordance with the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the Regulations).

1.4 The Regulations require that HWBs produce a statement of its revised assessment within three years of its previous publication of a PNA, or sooner should the HWB determine there has been a significant change in pharmaceutical needs in the area. This paper proposes a process for keeping the PNA up to date and determining if a revision of the PNA is needed within the next three years.

2.0. Recommendations

The Board is asked to

- Note that the Brent PNA has been published in draft form and consulted upon
- Note that the Brent PNA Steering Group intend to publish the final Brent PNA before 1st April 2015
- Note the roles of NHS England, the CCG and Brent Council in maintaining the PNA
- Agree the process for keeping the Brent PNA up to date by:
    - Delegating to the Director of Public Health ("DPH"), or the DPH's nominee, the decision as to whether a revision of the PNA is required
    - Delegating to the DPH, or the DPH's nominee, the publication of Supplementary Statements to the PNA

3.0. Detail

3.1. From April 2013, Health and Wellbeing Board have been responsible for producing, consulting on and publishing the PNA for their area. In Brent the HWB has delegated these responsibilities to the PNA Steering Group.

3.2. PNAs are used by the NHS to make decisions on which NHS funded services need to be provided by local community pharmacies. PNAs are also used in decisions as to whether new pharmacies are needed in response to applications by businesses.

3.3 The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 ("the Regulations") require PNAs must be revised within three years of its first publication and reviewed thereafter to take into account any significant events/changes that will impact on the need for pharmaceutical services in the Brent area. The Regulations stipulate the circumstances under which revision will be required earlier and the requirements for keeping the PNA up to date between revisions. Appendix one contains the relevant extract from the Regulations.

3.4 In summary, a revision of the PNA may be required should there be a significant change to the need for pharmaceutical services, for example,as a result of demographic change, or should the current provision of pharmaceutical services change, for example a pharmacy closes. However a full revision of the PNA is only required should this be a proportionate response to those changes.

3.5. Changes in pharmaceutical services may result from a pharmacy changing its opening hours, ownership or location. Such changes would be agreed by NHS England and should be notified to the HWB. Changes may also result from commissioning decisions by the CCG, the local authority or NHS England.

3.6 If a change in the provision of pharmaceutical services occurs which is not deemed to merit a full revision of the PNA, the HWB may publish a Supplementary Statement, pending the publication of statement of revised PNA

3.7 In order that the PNA is kept up to date the arrangements referred to in paragraphs 3.8 – 3.9 below will be put into place.

3.8 NHS England will provide information on a monthly basis on any changes to the pharmaceutical list for Brent. NHS England, Brent CCG and Brent Council public health provide information on any changes to their commissioning that may result in a change in the need for pharmaceutical services.

3.9 The DPH or the DPH's nominee will determine if a revision of the PNA should be considered or if the publication of a Supplementary Statement will suffice. If the former, the Brent PNA Steering Group will be reconvened with the revised Terms of Reference contained in Appendix Two. If the latter, the Supplementary Statement will be published on the Brent Council Website

3.10 The JSNA process will be used to determine if there is a significant change to the need for pharmaceutical services. In this event, Brent Council will reconvene the PNA Steering Group.

Director

Melanie Smith

Director Public Health

Melanie.smith@brent.gov.uk

Appendix One

Extract from The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013

Part 2 Regulation 6: Subsequent assessments

6. (1) After it has published its first pharmaceutical needs assessment, each HWB must publish a statement of its revised assessment within 3 years of its previous publication of a pharmaceutical needs assessment.

(2) A HWB must make a revised assessment as soon as is reasonably practicable after identifying changes since the previous assessment, which are of a significant extent, to the need for pharmaceutical services in its area, having regard in particular to changes to

(a) the number of people in its area who require pharmaceutical services;
(b) the demography of its area; and
(c) the risks to the health or well-being of people in its area,

unless it is satisfied that making a revised assessment would be a disproportionate response to those changes.

(3) Pending the publication of a statement of a revised assessment, a HWB may publish a supplementary statement explaining changes to the availability of pharmaceutical services since the publication of its or a Primary Care Trust's pharmaceutical needs assessment (and any such supplementary statement becomes part of that assessment), where

(a) the changes are relevant to the granting of applications referred to in section 129(2)(c)(i) or (ii) of the 2006 Act; and
(b) the HWB
(i) is satisfied that making its first or a revised assessment would be a disproportionate response to those changes, or
(ii) is in the course of making its first or a revised assessment and is satisfied that immediate modification of its pharmaceutical needs assessment is essential in order to prevent significant detriment to the provision of pharmaceutical services in its area.

Appendix Two

Brent Pharmaceutical Needs Assessment Steering Group Terms of Reference

Purpose

To provide advice to the DPH, or the DPH's nominee, on the need to revise the Brent Pharmaceutical Needs Assessment (PNA) in order to comply with The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, Part 2 Regulation 6: Subsequent assessments

Responsibilities

The Steering Group will consider the need to revise the PNA in advance of 2017/18 in the light of

- Changes in the provision of pharmaceutical services – as advised by NHS England
- And / or changes in the need for pharmaceutical services as a result of changes in the local population's demographics or health status or as a result of changes in the commissioning of health services

Membership

DPH or the DPH's nominee: Chair

Brent Council public health analyst

LPC nominee

CCG nominee

Healthwatch representative

NHS E representative

Meeting frequency

Brent Council public health will be responsible for determining when consideration of a revision of the PNA requires the Steering Group to convene. The Group may conduct its business through the exchange of email at the decision of the Chair

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Brent	**Health and Wellbeing Board** Thursday 19 March 2015 **Report from Brent Clinical Commissioning Group**
For noting/approval	
Primary Care Co-commissioning in North West London	

1.0 Summary

1. Executive Summary

Through its letter to Local Authority CEOs and Health and Wellbeing Board (HWBB) Chairs issued on 18th December,[1] NHS England encouraged HWBBs to have a conversation with their local commissioners of primary care, both Clinical Commissioning Groups (CCGs) and NHS England.

This paper serves to update Brent HWBB on developments in primary care co-commissioning in North West (NW) London up to the end of February 2015, plus next steps for March to April and beyond. Furthermore, this paper is intended to initiate and progress conversations between Brent HWBB and Brent Clinical Commissioning Group on the future role of the HWBB in primary care co-commissioning, to ensure a timely and transparent dialogue as decisions are made about whether to enter into formal co-commissioning arrangements from April 2015.

[1] Update on primary care co-commissioning. 18 December 2014. Gateway reference: 02776.

2. Key Matters for the Board's Consideration

The HWBB is asked to support the initiation of a conversation between it and local commissioners of primary care for Brent Clinical Commissioning Group on the future role of the HWBB in primary care co-commissioning.
Furthermore the HWBB is asked to consider:

- How to ensure a timely and transparent dialogue as decisions are made about whether to enter into formal co-commissioning arrangements from April 2015; and
- Further stakeholder organisations that they may need to engage with over the coming months and how Brent CCG can support in this.

3. Introduction and national context

3.1. In June 2014 NHS England invited CCGs to submit an Expression of Interest in an increased role in the commissioning of primary care services. The intention was to enable CCGs to improve primary care services locally for the benefit of patients and local communities.

3.2. Currently NHS England commission primary care services, including primary medical care services, ophthalmology, dentistry and pharmacy. NHS England also commissions specialised services, offender healthcare, and healthcare for people in the military.

3.3. At this stage primary care co-commissioning refers to the commissioning of primary medical care services only, either jointly between CCGs and NHS England or though NHS England delegating their commissioning functions to a CCG.

3.4. Brent CCG submitted an Expression of Interest in primary care co-commissioning to NHS England in June 2014, and a further submission of draft proposals on 9 January 2015.

3.5. On 10 November 2014, NHS England published Next steps towards primary care co-commissioning.[2] This document sets out three possible models for primary care co-commissioning (greater involvement, joint

[2] *Next steps towards primary care co-commissioning*. NHS England and NHS Clinical Commissioners. 10 November 2014. Publications Gateway Reference 02501.

commissioning and delegated commissioning) and the next steps towards implementation.

3.6. The approach has been developed by the joint CCG and NHS England Primary Care Co-commissioning Programme Oversight Group, which includes two local authority representatives: Ged Curran (Chief Executive, Merton Council) and Merran McRae (Chief Executive, Calderdale Council).

3.7. Through the letter to Local Authority CEOs and HWBB chairs issued on 18 December,[3] NHS England encouraged HWWBs to have a conversation with their local commissioners of primary care, both CCGs and NHS England.

3.8. This paper serves as an update Brent HWBB on developments in primary care co-commissioning in Brent and across North West London. Furthermore, this paper is intended to initiate conversations between Brent HWBB and Brent CCG on the future role of the HWBB in primary care co-commissioning to ensure a timely and transparent dialogue as decisions are made about whether to enter into formal co-commissioning arrangements from April 2015.

4. The vision for care in North West London for sustainable, integrated and high quality services

4.1. There is a vision to improve the quality of care for individuals, carers and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community.

4.2. This vision is supported by three principles:

- People will be empowered to direct their care and support and to receive the care they need in their homes or local community;
- GPs will be at the centre of organising and coordinating people's care; and
- Systems will enable and not hinder the provision of integrated care.

4.3. The vision for Brent and across NWL is focused on integrated whole systems delivering population-based care, co-ordinated around the needs of the patient.

[3] Update on primary care co-commissioning. 18 December 2014. Gateway reference: 02776.

4.4. General Practice will be the cornerstone for this new model of care delivery, with the majority of patient care being delivered in the primary care setting and with General Practice delivering more accessible, co-ordinated services with a focus on prevention.

4.5. Therefore in Brent and across NWL there is an ambition of achieving sustainable General Practice that is supported to deliver the services and high quality care that local people need.

5. Challenges faced in General Practice nationally and locally in North West London

5.1. Today General Practice undertakes 90 per cent of NHS activity for 7.5 per cent of the cost, seeing more than 320million patients nationally per year.

5.2. The vision of whole systems integrated care for Brent CCG describes General Practice at the core of coordinating and delivering services.

5.3. However, the model of General Practice that has served Londoners well in the past is now under unprecedented strain.

5.4. Primary care nationally and in North West London is facing a number of challenges in the evolving health and care landscape:

- A growing and aging population with increasingly complex health and care needs;
- Variable levels of accessibility and quality of primary care services that patients can access;
- Workforce challenges with an increasing proportion of General Practitioners (GPs) nearing retirement age and with limited number of clinicians coming into the system; and
- A significant fall in investment in General Practice as a percentage of total health spend with minimal investment into developing and maintaining primary care estates and facilities.

5.5. Given these challenges, there is an ambition to enable a shift in investment into primary care to achieve supported and sustainable General Practice.

5.6. As patients' needs are changing the systems that are currently in place need to evolve to ensure that they are still fit for purpose.

5.7. However, new ways of working that GPs would be asked to deliver for the Brent and NWL vision are above and beyond that expected in the current primary medical services contracts. Furthermore, while some expectations are within the remit of the core contracts, there is a lack of clarity in the specification.

5.8. In addition, current contractual forms for General Practice cannot be readily changed.

6. Primary care co-commissioning in North West London to promote sustainable and integrated high quality services to deliver patient benefits

6.1. Since May 2014, NWL CCG Chairs, Londonwide LMCs, NHS England and Brent Clinical Commissioning Group representatives have been involved in a discussion about the place primary care co-commissioning could have in ensuring that General Practice is supported in its role as the core for the new model of care for Brent and across NWL.

6.2. Alongside this, the NWL CCGs have been involved in an extensive period of stakeholder engagement with the NHS England local area team, CCG Governing Bodies, CCG constituent members, the Londonwide LMCs, local NWL LMC borough Chairs, patient and public representative groups and other stakeholder groups.

6.3. Primary care co-commissioning will be an enabler to helping Brent CCG to achieve this vision, by enabling local commissioners and stakeholders the ability to:

- Influence local decision making in primary care to align with wider local strategies for integrated and coordinated care;
- Commission for a new contractual offer for General Practice to sustainably deliver the necessary enhanced services for it to act as the foundation for the new model of care and to limit current variations in quality and access; and
- Influence the necessary investment in the supporting primary care estates and workforce to enable the delivery of the enhanced role of General Practice.

6.4. Ultimately, through primary care co-commissioning, the ambition is to achieve the right benefits for patients:

- Improved access to primary care and wider out-of-hospitals services, with more services available closer to home;
- High quality out-of-hospitals care;
- Improved health outcomes, equity of access, reduced inequalities;
- Services that are joined up, coordinated and easy for users to navigate around;
- A better patient experience through more joined up services; and
- A greater focus on prevention, staying healthy and patient empowerment.

6.5. Although primary care co-commissioning is seen as an opportunity for local clinicians and people to gain more influence over the commissioning of primary care to achieve the right benefits for patients, through stakeholder engagement it has been agreed that in Brent CCG and across the other seven NWL CCGs that co-commissioning will not be about:

- CCGs taking on the role of performance or contract managing practices or GPs which would introduce potential conflicts of interest;
- Losing local influence in decision-making on out of hospital services to NHS England; or
- Taking away core primary care contracts from practices.

6.6. As member-led organisations, the decision to enter into primary care co-commissioning arrangements will be determined through the support of each CCG's constituent member practices. Although the method and level of support varies between each CCG, according to their constitutional agreements in place, generally this support must be achieved through a majority vote. For Brent this is 75% as noted in the Brent CCG constitution.

6.7. Through engagement over the last few months, Brent CCG has achieved support from CCG constituent members and the Governing Body to enter

into a shadow period in which joint commissioning arrangements may be trialled in order to test how arrangements could work. Through these arrangements, Brent CCG can explore and determine how to achieve the flexibility to enable the required benefits as well as defining streamlined and efficient governance arrangements that allow for effective and consistent decision-making with localisation.

6.8. As the establishment of shadow arrangements do not affect the CCG constitutional arrangements in place, all decisions continue to be ratified by individual CCG Governing Bodies and NHS England.

6.9. Any decision to enter into formal primary care co-commissioning arrangements will be following full engagement with each CCG's constituent member practices to gain the support to make the necessary constitutional amendments. This support is being sought in March 2015.

7. National Guidance has influenced how Primary Care Co-commissioning can be taken forward

7.1. On 10 November 2014, NHS England published Next steps towards primary care co-commissioning[4] (which can be found by clicking here). This document sets out three possible models for primary care co-commissioning (greater involvement, joint commissioning and delegated commissioning) and the next steps towards implementation.

7.2. Further statutory guidance on the management of conflicts of interest was issued on 18 December (and can be found here).

7.3. The new guidance does not change what have been agreed as priorities for Brent Clinical Commissioning Group, though it will impact how Brent CCG can take co-commissioning plans forward in practice.

7.4. Brent CCG initially expressed an interest in *joint commissioning* arrangements. In light of new guidance from NHS England, it became apparent that *delegated commissioning* arrangements may align best with what has been described for Brent CCG, as this would enable:

- Greater local influence in primary care commissioning decisions without giving up influence to NHS England on decisions relating to out of hospital services;

[4] *Next steps towards primary care co-commissioning*. NHS England and NHS Clinical Commissioners. 10 November 2014. Publications Gateway Reference 02501.

- The commissioning of a full new offer for General Practice;
- Streamlined and efficient governance arrangements that allow for effective and consistent decision-making with localisation; and
- More appropriate management resource to carry out assumed functions.

7.5. Ultimately, future arrangements must be designed around the required benefits and the boundaries that have been agreed upon through stakeholder engagement.

7.6. NHS England requested that applications for delegated commissioning arrangements be submitted by 9 January. Brent CCG did this. The application was reviewed by a regional moderation panel on 16 January. The feedback from the panel was that:

- The governance arrangements proposed did not align with NHS England legislation as NHS England cannot delegate functions directly to a joint committee. Therefore the CCG would have to look at a different approach, for example a 'Committee in Common'; and
- As Harrow CCG is not meeting its financial targets, NHS England would need assurance that Harrow CCG had a robust action plan in place and that the other seven CCGs would be willing to underwrite Harrow CCG's financial deficit.

7.7. Neither of these points is necessarily a stumbling block for Brent, but both will require a well-considered approach. Therefore, considering the tight timescales that NHS England has set out for making a final decision, the NWL CCG Chairs, jointly with NHS England (London Region) local area team, have deferred the current application for delegated arrangements and are now pursuing joint arrangements initially for 2015/16. This is with a view to re-applying for delegated arrangements after an appropriate process of due diligence has been completed and with support of constituent member practices.

7.8. As member-led organisations, any alterations to CCG governance arrangements are subject to full consultation with members in due course at the appropriate forums. Therefore, submissions to NHS England have so far been in draft form.

7.9. As such, Brent CCG reserve the right to withdraw their application and not proceed into co-commissioning arrangements in April 2015.

8. Health and Wellbeing Board involvement in Primary Care Co-commissioning

8.1. Under the National Health Service Act 2006 (as amended by the Health and Social Act 2012), CCGs have the following statutory requirements in relation to CCG commissioning plans and Health and Wellbeing Boards:

- CCGs must give each relevant Health and Wellbeing Board a draft of the plan and consult each such Board on whether the draft takes proper account of each Joint Health and Wellbeing Strategy published by it, which relates to the period that the plan relates to (section 14Z13(4));
- Where a Health and Wellbeing Board is consulted, it must give the CCG its opinion on whether the plan takes proper account of each relevant Joint Health and Wellbeing Strategy;
- CCGs must include a statement of the final opinion of each relevant Health and Wellbeing Board consulted in relation to the commissioning plan in the final plan as published (section 14Z13(8)); and
- Where a significant revision is made to an existing commissioning plan, CCGs must consult with the Health and Wellbeing Board as per section 14Z13, before finalising the revised plan (section 14Z12). They must also give a copy of the document to each relevant Health and Wellbeing Board.

8.2. National guidance on Health and Wellbeing Board involvement in primary care co-commissioning states that:

- In both joint and delegated commissioning arrangements, CCGs must issue a standing invitation to the local Health and Wellbeing Board to appoint representatives to attend commissioning committee meetings, including, where appropriate, for items where the public is excluded from a particular item or meeting for reasons of confidentiality. These representatives would not form part of the membership of the committee;

- Where there is more than one local Health and Wellbeing Board for a CCG's area, the CCG should agree with them which should be invited to attend the committee; and
- Health and Wellbeing Boards are under no obligation to nominate a representative, but we believe there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

8.3 The CCGs of North West London all believe that co-commissioning will be made stronger through the close involvement of their local Health and Wellbeing Boards. For NWL, the statutory guidance regarding the role of Healthwatch and HWBBs means sixteen representatives who, practically, could each have only a very limited role on any co-commissioning committee. The CCGs have therefore suggested that a representative from each Health and Wellbeing Board in North West London, alongside Healthwatch, form an additional group to steer and review the work of the CCGs and NHS England in the co-commissioning of primary care. This group would then nominate four of its members, two from the HWBBs and two from Healthwatch, to attend the commissioning committee as non-voting advisors. One HWBB advisor would be from CWHHE and one would be from BHH. The group would be serviced by the co-commissioning secretariat.

9. Next steps in terms of Health and Wellbeing Board involvement in Primary Care Co-commissioning for North West London

9.1. This paper serves as an update for HWBBs on developments in primary care co-commissioning in North West (NW) London. Furthermore, this paper is intended to initiate conversations between local commissioners and HWBB in Brent on the future role of the HWBB in primary care co-commissioning to ensure a timely and transparent dialogue as decisions are made about whether to enter into formal co-commissioning arrangements from April 2015.

9.2. Particularly in light of national guidance, it may now be prudent to begin a conversation between Brent CCG and Brent HWBB on HWBB involvement in formal primary care co-commissioning arrangements in the future. These conversations will enable the joint identification of local

authority representation for future co-commissioning arrangements in Brent.

9.3. The HWBB is asked to support a conversation between the HWBB and local commissioners of primary care for Brent CCG on the future role of the HWBB in primary care co-commissioning. Furthermore the HWBB is asked to consider:

- How to ensure a timely and transparent dialogue as decisions are made about whether to enter into formal co-commissioning arrangements from April 2015; and
- Further stakeholder organisations that they may need to engage with over the coming months and how Brent CCG can support in this.

2.0 Recommendations

2.1 See above report.

3.0 Detail

3.1 See above report.

4.0 Financial Implications

4.1 N/A

5.0 Legal Implications

5.1 N/A

6.0 Diversity Implications

6.1 N/A

7.0 Staffing/Accommodation Implications (if appropriate)

7.1 N/A

8.0 Background papers
See above report.

Contact Officers

- Ethie Kong, Chair, Brent CCG
- Rob Larkman, BHH Chief Officer
- Sarah Mansuralli, Acting Chief Operating Officer, Brent CCG
- Matthew Walker, Deputy Director Primary Care Transformation, Strategy and Transformation, North West London CCGs
- Julie Sands, Deputy Head of Primary Care, NHS England (NW London)

Brent	**Health and Wellbeing Board** 19 March 2015 **Report from the Chief Operating Officer, Brent Clinical Commissioning Group, and Strategic Director, Adults, Brent Council**
For Action	Wards Affected: ALL

Better Care Fund Update

1. Summary

1.1 This report provides an update on progress with the Better Care Fund since the last Health and Wellbeing Board. It notes the final assurance letter from NHS England at the end of January, outlines the approach and timescales for implementation planning, and sets out proposals for a revised governance structure which has a clear focus on accountability for delivery.

2. Recommendations

2.1 The Health and Wellbeing Board is recommended to:

(i). Note and comment on the on the assurance letter received from NHS England subsequent to the Nationally Consistent Assurance Review (NCAR) process

(ii). Comment on and approve the revised governance arrangements for implementation (set out in 4.5).

3. Background – Better Care Fund Brent

3.1 As the last report to the Health and Well Being Board set out:

- Brent Clinical Commissioning Group and Brent Council have been leading work with key partners including service users, patients and carers to integrate services to improve the quality of life for people in Brent
- A key part of this work is the Better Care Fund plan. This is a national programme for health and social care integration – draft visions and plans for Brent's Better Care fund plan were discussed as early as April 2014
- The national programme was reviewed last summer, which led to a need to revise and re-submit the Brent Better Care Fund plan in September. This was

followed by a regional and national assurance process with the draft (October 2014) assurance letter presented to the Health and Well Being Board in November 2014

- As the last update to the Health and Well Being Board set out, the vision for health and social care integration and the plans have not changed significantly and are still focused on five key areas:
    - *Scheme 1* – Keeping the most vulnerable well in the community
    - *Scheme 2* – If there is a crisis, ensuring we have the services and support to avoid unnecessary hospital admissions
    - *Scheme 3* – If someone is admitted to hospital, ensuring we have an integrated hospital discharge scheme which ensure a safe and sustainable discharge
    - *Scheme 4* – Improving urgent mental health care
    - *Enabling projects* which underpin all of the above, for example and Integrated Health and Social Care Rehabilitation and Reablement service. This service could be accessed by staff working in the services in any of the other schemes.

4. Brent Better Care Fund – Update since the last Board

4.1 Since the last Health and Wellbeing Board work has continued on the assurance process. The October 2014 assurance letter stated that the Brent BCF was 'Approved with Support' and outlined a range of issues with the plan at that time. Subsequently, additional work has been done to clarify the detail of the project concepts, the performance measurements and the finances, and the final assurance letter (attached at Appendix 1) was received on 23 January 2015, which states that the BCF plan is now 'Approved'.

4.2 Work has also continued to develop the detailed implementation plans for each of the schemes, building on the project concepts detailed in the Brent Better Care Fund plan as submitted to NHS England and circulated as part of the paper to the last Health and Wellbeing Board. The deadline for these plans to be agreed at the Brent BCF Implementation Board is the end of April so that the schemes can go live from June 2015 and through 2015/16.

4.3 The detailed plans are being co-produced, building on the methodology that has been developed through the North West London Whole Systems Integrated Care (WSIC) programme. This ensures that there is already, or there will be service user, patient and carer involvement in the development of all plans. The co-production work is being led by Brent Healthwatch and Brent CVS, as key partners on the Brent BCF Implementation Board, to ensure we take the best from the NWL methodology, ensure it is firmly embedded in the Brent and provide a strong user voice and clear independent challenge.

4.4 All plans will also include a clear plan for what needs to be done to re-confirm the commitment from all organisations, in particular health providers, and for the decisions to go through the Council and Clinical Commissioning Group governance structures as required.

4.4 The April deadline for implementation plans does reflect slippage of 2 months on the original schedule. There are a number of reasons for this delay. The capacity

required to deal with both the regional and national assurance process and the development of the implementation plans was underestimated. The capacity issue was reinforced by the fact that we were seeking to develop the plans during winter, a time of significant challenge for the health and social care economy, the challenges of which should have been foreseen. It has also become clear that the governance arrangements are not fit for purpose. Therefore, a revised governance structure has been put together and is attached at Appendix 2, and revised terms of reference are attached at Appendix 3.

4.5 Previously there was a single Brent Integration Board, which was conflating a number of functions - commissioning, programme board and operational project detail. Therefore, these functions have been separated out in the following groups:

- *Better Care Fund Executive Group* – meeting of key commissioners from Brent Clinical Commissioning Group and Brent Council
- *Brent BCF Implementation Board* – jointly chaired by COO, Brent Clinical Commissioning Group and the Strategic Director, Adults, Brent Council. This is where senior representatives of all stakeholders will meet on a monthly basis to provide leadership and commitment across all health and social care partners, and will include service user and carer representation
- *Brent BCF Operational Group* – chaired by the BCF Programme Manager, this is where the project management capacity responsible for developing the implementation plans and then overseeing their delivery meet to ensure the detail of the interdependencies between the schemes are identified and worked through.

4.6 This governance structure is designed to clarify responsibility and accountability across the health and social care system and reflects the complexity of delivering this programme of change. The structure does not replace the decision making procedures in place in the individual organisations and in particular in Brent Clinical Commissioning Group and Brent Council. In fact, one of the key challenges for the coming months is how we can work together and get the relevant decisions from individual organisations given the different timescales and procedures that we all work to. This will require all partners not only to fully participate in the governance structures set out in the paper, but also to be proactively working within their own organisations to ensure people understand the proposed changes, the impact of those changes and the decisions required by which decision making body to deliver them successfully.

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Appendix 1 – Final Assurance Letter

NHS England

Publications Gateway Ref. No. 02396

Quarry House
Quarry Hill
Leeds
LS2 7UE

E-mail: england.coo@nhs.net

To:
Cllr Michael Pavey – Brent Health and Wellbeing Board
Rob Larkman – Brent CCG
Copy to:
Phil Porter – Brent Local Authority

23rd January 2015

Dear colleague,

Thank you for submitting further evidence to move your Better Care Fund plan to a fully approved status. We know that the BCF is an ambitious programme and preparing the plans at pace has proved an immensely challenging task. However, your plan is now part of an ongoing process to transform local services and improve the lives of people in your community.

It is clear that your team and partners have worked very hard over the last year, making valuable changes to your plan in order to improve people's care.

NHS England is now able to formally approve plans following the publication of the 2015/16 Mandate. I am delighted to let you know that, following the subsequent Nationally Consistent Assurance Review (NCAR) process, your plan has been classified as **'Approved'**. Essentially, your plan is clear and ambitious and we support your ambitions. This puts you in a strong position for delivering the change outlined above.

Your BCF funding will be made available to you subject to the following standard conditions which apply to all BCF plans:

- The Fund being used in accordance with your final approved plan and through a section 75 pooled fund agreement;
- The full value of the element of the Fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year. However, CCGs may only release the full value of this funding into the pool if the admissions reduction target is met as detailed in the BCF Technical Guidance[1]. If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. Any part of this funding that is not released into the pool due to the target not being met must be dealt with in accordance with NHS England requirements. Full details are set out in the BCF Technical Guidance

The conditions are being imposed through NHS England's powers under

sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These allow NHS England to make payment of the BCF allocation subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG that it be spent in a particular way.

We are confident that there are no areas of high risk in your plan and as such you should progress with your plans for implementation.

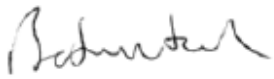
Any ongoing support and oversight with your BCF plan will be led by your NHS England Regional/Area Team along with your Local Government Regional peer rather than the BCF Taskforce from this point onwards.

Non-elective (general and acute) admissions reductions ambition

We recognise that some areas may want to revisit their ambitions for the level of reduction of non-elective admissions, in light of their experience of actual performance over the winter, and as they become more confident of the 2014/15 outturn, and firm-up their plans to inform the 2015/16 contracting round. Any such review should include appropriate involvement from local authorities and be approved by HWBs. NHS England will assess the extent to which any proposed change has been locally agreed in line with BCF requirements, as well as the risk to delivery of the ambition, as part of its assurance of CCGs' operational plans.

Once again, thank you for your work and we look forward to the next stage.

Yours sincerely,

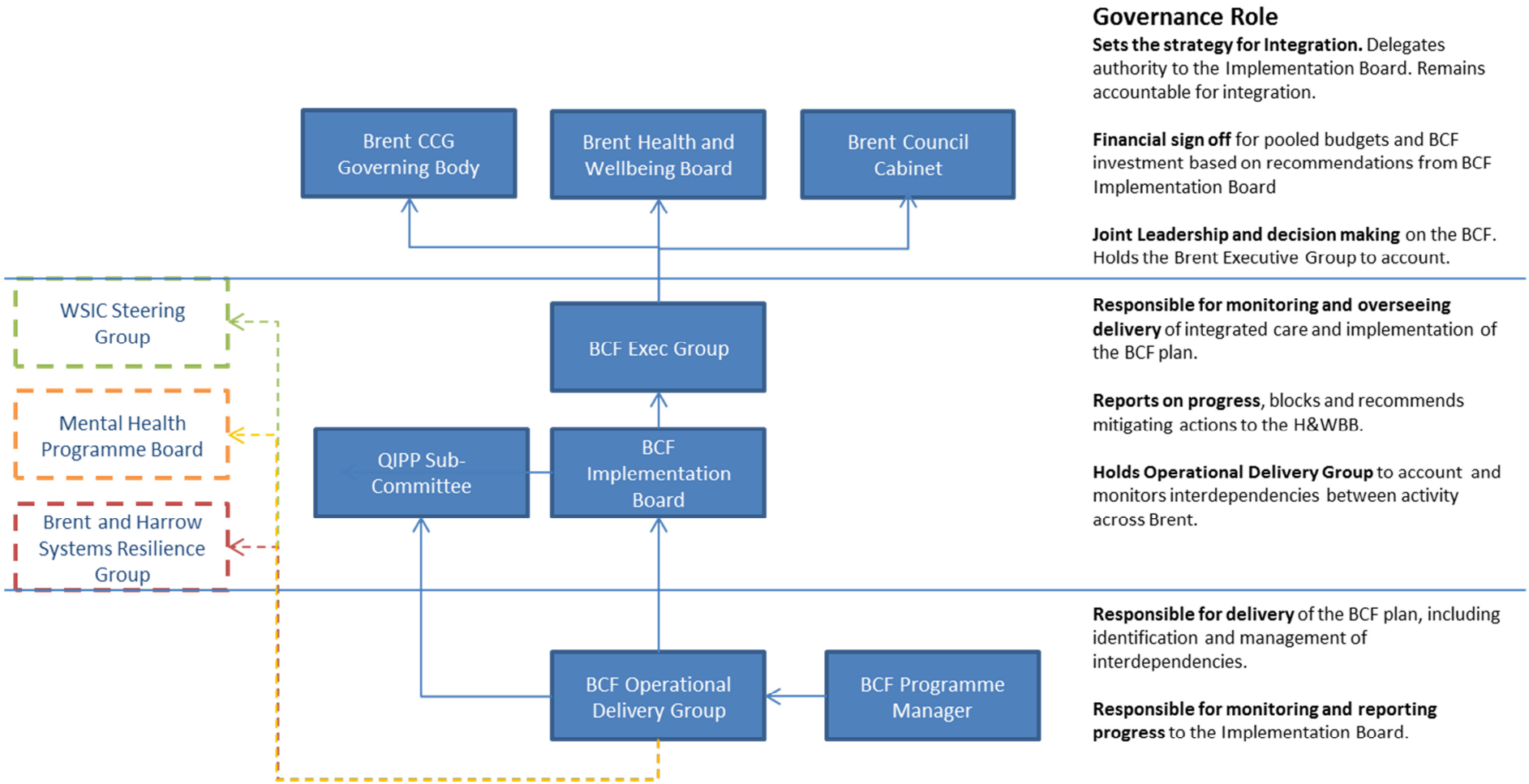


Dame Barbara Hakin
National Director: Commissioning Operations
NHS England

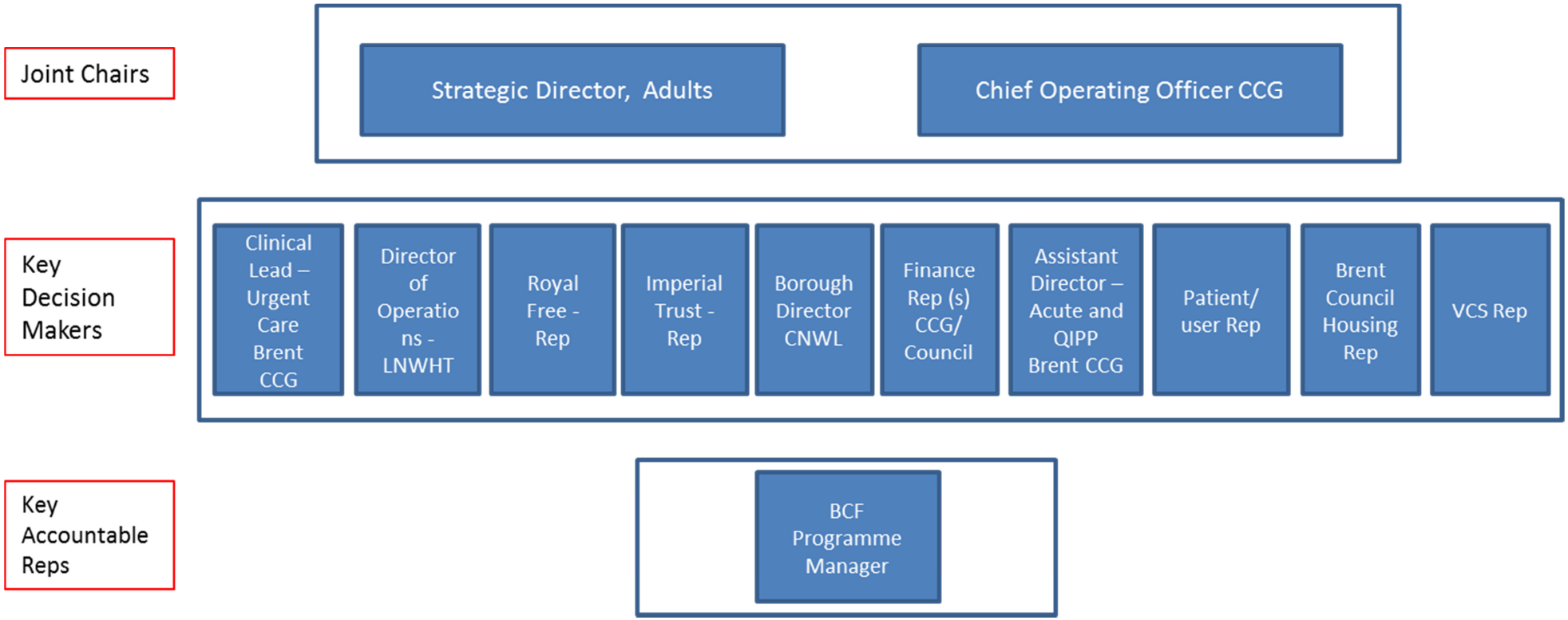
[1] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

Appendix 2

Proposed Brent BCF Governance Structure



Proposed membership of BCF Implementation Board



Appendix 3

DRAFT TERMS OF REFERENCE: BRENT BCF IMPLEMENTATION BOARD

1. Purpose

The purpose of the Brent Implementation Board is to provide system wide leadership and accountability for the delivery of Brent's Better Care Plan – as set out in the joint CCG/LBB submission to NHSE.

The primary purpose of the Better Care Plan is to achieve a 3.5% reduction in non-elective hospital admissions for the population of Brent; predicated on a step-change in the provision of integrated care services for those at risk in the local population.

2. Key schemes

The following are the key schemes within the Brent Better Care Plan that the Brent Integration Board is responsible for:

1. Keeping the most vulnerable well in the community
2. Avoiding unnecessary hospital admissions
3. Integrated Rehab and Reablement Service
4. Effective multi agency hospital discharge
5. Mental health improvement

3. Responsibilities

3.1 To own the delivery of the BCF vision for a step change in integrated health and social care services in Brent reducing unnecessary hospital admissions and residential and nursing care and ensuring improved quality of life as people live independently in the community

3.2 To monitor and support the delivery of the agreed BCF plan

3.3 To oversee and challenge progress and pace of delivery of all BCF schemes

3.4 To receive progress updates, including risks and issues, from scheme leads and to support the resolution of barriers and issues

3.5 To monitor the achievement of agreed benefits and to lead corrective actions where benefits are not being achieved against the plan

3.6 To oversee the development of a health and social care system which commissions and provides different models of integration through innovation and transformation to deliver more co-ordinated care in the community to enable people to live longer and live better

3.7 To escalate as appropriate risks, issues and barriers which are preventing timely delivery of agreed schemes. Escalation may be within member organisations or collectively to relevant governing boards.

3.8 To oversee the development of a system of care which co–ordinates in hospital and out of hospital services, including 7 day availability, across Brent to achieve better outcomes which will enable people to live longer and live better

3.9 To take an economy wide approach to managing difficult issues and where appropriate to use freedoms and flexibilities available to maximum advantage locally and challenge the system where barriers exist and seek solutions at the necessary level

3.10 To understand the total NHS and Local Authority resources and direct those resources to support integration as required. This will include advising and informing the Health and Wellbeing Board on the targeting of transferred NHS resources to social care (including the Integration and Transformation Fund) and creating opportunities for supporting integration

3.11 To support the move to towards a joint health and social care information system and joined up information technologies, maximising the benefits of a single shared record users of services and staff

3.12 To support the Health and Wellbeing Board and develop a two way relationship to inform and support the delivery of integrated health and care.

3.13 To quality assure communications and engagement activity across the schemes and to assure itself that any changes to the system reflect the views and experience of local people and users of services

3.14 To develop a financial model which supports the spectrum of integration, including risk and benefit sharing, proposing changes to existing payment mechanisms and contractual arrangements where necessary

3.15 Promote learning that could be shared with other programmes and/or applied to different client groups

3.16 To oversee service development and a culture change to deliver integration, innovation and transformation

4. Values

We will work to the following principles:

- Working better together is first and foremost about what is best to add value for the people we care for
- Improving the quality of care and support available
- Looking for improvement through the eyes of the people we care for and the staff providing the care

We will ensure collective ownership by:

- Continuing to create a culture of trust, openness and transparency, including demonstrating a collective stewardship of resources

- Putting the interests of the people we serve ahead those of our individual organisations

We will ensure learning and development by...

- Sharing our learning from working together with one another, and others as well as learning from elsewhere and will share our learning more widely

- Building on existing work that has established strong foundations for integration e.g. NWL WSIC

- Ensuring our clinicians, social care professionals, managers and others will work together to make change happen

- Collectively agreeing our future priorities as a whole system

- Adopting a positive mind-set – 'we can, we will'

- Committing to working at pace, to achieve rapid progress, make decisions and see them through

5. Membership

- Chief Operating Officer, Brent CCG (Joint Chair)
- Strategic Director - Adults, Brent Council (Joint Chair)
- Clinical Lead – Urgent Care, Brent CCG
- Adult Social Care – BCF Head of Service Lead
- Director of Operations, LNWHT
- Director of Strategy, Imperial
- Director of Strategy, Royal Free
- Borough Director, CNWL
- Finance Reps (CCG and Council)
- Assistant Director Acute and QIPP, Brent CCG
- Patient/Service User rep
- Brent Council Housing
- Chief Executive, Brent CVS

6. Frequency of meetings

The meetings to be held monthly

7. Conflicts of interest

a. As commissioners and providers will be jointly developing new models of integration, careful consideration will need to be given to potential conflicts of interest.

b. Members of the Implementation Board are expected to conduct themselves in an appropriate manner. They must refrain from actions that are likely to

create any real or perceived conflict of interest, save those that are inherent in the institutional interests of the organisations that members represent.

c. Members are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the Board. Where items are deemed to be privileged or particularly sensitive in nature, these should be identified and agreed by the Chair.

8. Reporting

a. The Brent Implementation Board is collectively accountable to the Brent Health and Wellbeing Board. It will report to the Brent Health and Wellbeing Board through its Chair and will develop a two way relationship and feedback from the Health and Wellbeing Board.

b. The minutes of the Brent Implementation Board will be made available to the Health and Wellbeing Board and to constituent organisations.

c. Minutes with clear sets of actions will be received at each Brent Implementation Board Meeting.

d. The Chairs of the BCF Implementation Board are individually accountable to their own organisations and their decision making processes.

9. Review

a. The Brent Implementation Board Terms of Reference will be formally reviewed in October 2015.

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