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Brent

NHS
Brent Clinical Commissioning Group

Health and Wellbeing Board

Tuesday 2 June 2015 at 7.00 pm
Chalkhill Community Centre, 113 Chalkhill Road, Wembley, Middlesex HA9 9FX

Membership:

Members		Substitute Members
Councillor Butt (Chair)	Brent Council	Councillors:
Councillor Pavey	Brent Council	Denselow, Mashari, McLennan and Southwood
Councillor Hirani	Brent Council	
Councillor Moher	Brent Council	
Vacancy	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

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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: Social Isolation

	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**	1 - 6
3	**Matters arising**	
4	**NHS Brent CCG: Quality Premium 2015/2016** The Quality Premium is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities. The quality premium 2015/2016 is paid to CCGs in 2016/17 to reflect the quality of the health services commissioned by them in 2015/16. In considering the report, the Health and Wellbeing Board is asked to approve the Quality Premium 2015/16 measures for Brent for 2015/16.	7 - 8
5	**Brent CCG London Ambulance Service (LAS) - performance diagnostic and transformation business case** This report presents performance information regarding the London Ambulance Service and details a transformation business case. In considering the report, the Health and Wellbeing Board is asked to note the increased investment into LAS services to improve performance.	9 - 12
6	**Progress update on workshop outcomes** A progress update will be provided on the outcomes of the improving mental wellbeing across the life course workshop.	

7 Health Visiting Transfer (verbal update)

Dr Melanie Smith (Director of Public Health, Brent Council) will provide a verbal update to the Board on the Health Visiting Transfer.

8 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: 7 July 2015

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

MINUTES OF THE HEALTH AND WELLBEING BOARD
Thursday 19 March 2015 at 7.00 pm

PRESENT: Councillor Pavey (Chair and Deputy Leader of Brent Council), Councillor Crane (Lead Member for Environment, Brent Council), Councillor Hirani (Lead Member for Adults and Health and Wellbeing, Brent Council), Dr Ethie Kong (Chair, Brent Clinical Commissioning Group), Rob Larkman (Chief Officer, Brent, Harrow and Hillingdon Clinical Commissioning Groups), Sarah Mansuralli (Deputy Chief Operating Officer, Brent Clinical Commissioning Group, Ann O'Neill (Director, Healthwatch Brent), Phil Porter (Strategic Director, Adult Social Services, Brent Council), Dr Melanie Smith (Director of Public Health, Brent Council) and Gail Tolley (Strategic Director, Children and Young People, Brent Council)

Also Present: Councillors Conneely and Miller.

Apologies were received from: Councillor Moher (Lead Member for Children and Young People, Brent Council), Councillor Warren (Brent Council), Christine Gilbert (Chief Executive, Brent Council), Sue Harper (Strategic Director, Environment and Neighbourhoods, Brent Council) and Dr Sarah Basham (Assistant Chair, Brent Clinical Commissioning Group)

PART A

The for the first part of the meeting, members of the board took part in a facilitated workshop on improving mental wellbeing throughout life. In addition to the board members, the workshop was attended by a further 53 individuals including representatives of a variety of related organisations.

The board then briefly adjourned and reconvened at 8.25pm to consider the remaining business on the agenda.

PART B

1. **Declarations of interests**

None declared.

2. **Minutes of the previous meeting**

RESOLVED:-

that the minutes of the previous meeting held on 22 January 2015 be approved as an accurate record of the meeting.

3. **Matters arising**

Phil Porter (Strategic Director Adults) provided an update to the board regarding the opportunity to place a bid for the Health and Wellbeing Board (HWB) to work with the Leadership Centre for Local Government. He advised that he and Sarah Mansuralli (Deputy Chief Operating Officer, Clinical Commissioning Group) were in early discussions regarding the proposal. It was intended that two additional meetings of the HWB would be scheduled to review the board's current ways of working and explore examples of good practice.

4. **Progress update on workshop outcomes**

Danny Maher (Chair, Community Action on Dementia – Brent (CAD-Brent)) provided an update to the meeting on the progress achieved regarding the development of CAD–Brent, following the related workshop held at the meeting of the Health and Wellbeing Board in November 2014. Members of the board were reminded that CAD–Brent had been established to challenge and empower people from local communities, businesses, voluntary sector organisations and the council to support people with dementia; it would act as a central point for information and support and was not intended to be a service provider.

Outlining some of the successes achieved, Danny Maher reported that CAD–Brent was now a registered charity and this broadened the range of funding opportunities available to the organisation. Work had begun to link CAD–Brent to local business networks, with an initial meeting resulting in a local business agreeing to design a logo for the organisation free of charge. One aim of working with local businesses was to help people with dementia have positive shopping experiences by championing measures such as slow payment lanes and staff awareness training. Ethnographic research was shortly due to commence and this would encompass the training of twenty people in ethnographic research techniques. These individuals would be representative of Brent's diverse community and would be a valuable resource, enabling additional research to be conducted in Brent's BAME and faith communities. It was acknowledged that issues of awareness and willingness to talk about dementia could affect support offered to those with the condition in some BAME or faith communities. Attendance at a recent meeting of the Multi Faith Forum had resulted in some very positive outcomes including the intention to develop dementia champions across faith groups.

Danny Maher further advised that CAD-Brent was now represented on the Brent Clinical Commissioning Group Dementia Steering Group. This group took a primarily clinical view of supporting people with dementia and for this reason, CAD-Brent's efforts to highlight the importance of the community perspective in this work had been well received. CAD-Brent was also working with Brent Council's Geographical Information System to plot incidences of diagnoses of dementia against service provision to identify areas of need. Moving forward it was intended to obtain funding to support a CAD-Brent Development worker to further assist the charity in achieving its aims.

The board discussed the progress achieved in the development of CAD-Brent and thanked Danny Maher for his contribution to the meeting. Danny Maher noted the importance of the role of the HWB in the achievements made. Fiona Kivett (Senior Policy Officer, Brent Council) advised that a letter providing an update on some of the key projects underway had been sent to those who had attended the original workshop; CAD-Brent would facilitate further feedback. Dr Ethie Kong (Chair, Brent

Clinical Commissioning Group) noted that the CCG had undertaken significant data cleansing, as a result of which the prevalence of dementia diagnoses had increased, and suggested that this information could be used to assist with identifying hotspots of service need.

Gail Tolley (Strategic Director, Children and Young People) then provided an update on the health and wellbeing for under 5s workshop held at the previous meeting of the board. Three key actions had been identified as a result of the feedback from the workshop; developing a role for parent champions; establishing an early years voluntary sector network; and, driving forward improvements for health and wellbeing for under 5s via a children's centres partnership. Work was already underway to implement these actions. The Early Years Public Health Officer was currently working with the Maternity and Child Health Partnership Group to extend the existing and successful Parent Champion model; a mapping exercise was underway to identify community voluntary groups that offered early years services; and, the Head of Early Years and Family Support was leading on embedding the requirement for driving forward improvements for health and wellbeing in under 5s in the tender for the Children's Centres Partnership.

RESOLVED:

That the progress achieved following the Community Action on Dementia workshop and the health and wellbeing for under 5s workshop be noted.

5. **Arrangements for keeping the Pharmaceutical Needs Assessment up to date**

Dr Melanie Smith (Director of Public Health, Brent Council) introduced a report to the committee regarding the duty held by Health and Wellbeing Boards (HWBs) to publish and keep up to date a statement of the population needs for pharmaceutical services, known as the Pharmaceutical Needs Assessment (PNA). Brent HWB had previously established a PNA Steering Group, to which authority had been delegated 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.

Updating the Board on the progress achieved by the PNA Steering Group, Dr Melanie Smith advised that a draft PNA had been published and consulted on, with the final PNA due to be published to Brent Council's website before 1 April 2015. The board's attention was then drawn to the requirement for HWBs to produce a statement of its revised assessment within three years of publishing a PNA, or sooner should the HWB determine there has been a significant change in pharmaceutical needs in the area. Dr Melanie Smith advised that the proposed process for keeping the PNA up to date was set out in the report for board members' consideration.

RESOLVED:

(i) That the publication of a draft Brent Pharmaceutical Needs Assessment be noted;

(ii) That the consultation held on the draft Brent Pharmaceutical Needs Assessment be noted;

(iii) That the role of NHS England, the Clinical Commissioning Group and Brent Council in maintaining the Pharmaceutical Needs Assessment be noted;

(iv) That the process for the keeping the Brent Pharmaceutical Needs Assessment up to date, as set out in the report from the Director of Public Health, be agreed;

(v) That authority be delegated to the Director of Public Health, or the Director of Public Health's nominee, to decide whether a revision of the Pharmaceutical Needs Assessment is required.

(vi) That authority be delegated to the Director of Public Health, or the Director of Public Health's nominee, to publish Supplementary Statements to the Pharmaceutical Needs Assessment.

6. **Primary Care Co-commissioning in North West London**

Rob Larkman (Chief Officer, Brent, Harrow and Hillingdon Clinical Commissioning Group) introduced a report on primary care commissioning in North West London (NWL). It was explained that NHS England currently held sole responsibility for primary care commissioning but had invited CCGs to submit expressions of interest in assuming a heightened role. NHS England had published proposals detailing three potential models for primary care co-commissioning with CCGs; greater involvement, joint commissioning and delegated commissioning. Brent CCG had initially pursued the option of delegated commissioning; however, having identified issues that required further consideration, the NWL CCG Chairs jointly with NHS England (London Region) local area team had deferred the application in favour of a joint co-commissioning arrangement for 2015/16. It was emphasised that, as member led organisations, CCGs would be required to seek the support of their constituent member practices with regard to any decisions to enter into primary care co-commissioning arrangements.

Dr Chris Cotton (NWL CCGs) explained that the proposed joint commissioning of primary care services in Brent would be conducted via a joint committee between Brent CCG and NHS England. In order to align services across NWL, it was intended that all NWL joint committees would meet in common; this would allow discussions to encompass issues of importance across NWL but ensure that each CCG made an individual decision with NHS England for its respective area. It was intended that the new co-commissioning arrangements would enable Brent CCG to shape primary care in Brent in line with local strategies for integrated and coordinated care. A new contractual offer for General Practice would be pursued to create a foundation for a new model of primary care in Brent; this enhanced role for General Practice would be supported by influencing necessary investment in primary care estates.

In the subsequent discussion, the board sought further details regarding the proposed arrangements for ensuring HWBs and Healthwatch groups were appropriately represented at the joint committee with NHS England. Further queries were raised regarding the frequency of the joint committee meetings, the publication of work programmes and when the views of the Brent CCG members would be known.

Dr Chris Cotton advised that statutory guidance permitted each HWB and Healthwatch to nominate a representative to attend meetings of the joint committee as a non-voting observer. As there was a potential eight CCGs across NWL who could engage in the joint commissioning arrangements, this could result in there being a total of sixteen HWB and Healthwatch representatives. It was currently proposed that this group nominate two of its number to attend meetings of the joint committee; it had been suggested that the nominations comprise one representative for Inner London and one for Outer London. Rob Larkman confirmed that the joint committee would meet monthly and would publish a forward work programme. The views of Brent's CCG members would be known by 31 March 2015.

During discussion, members of the board emphasised that Brent was demographically very different from neighbouring boroughs; it was therefore essential that there be an appropriate means for HWBs and Healthwatch groups to submit their views to the joint committees, where they would not be directly represented at the meetings. It was acknowledged that a key challenge for the board lay in developing a shared view of the priorities for primary care in Brent to enable that view to be clearly communicated to the joint committee. The board subsequently agreed that the planned additional HWB meetings encompass discussion on the strategic commissioning priorities for primary care in Brent.

RESOLVED:

(i) That the approach pursued by the Brent Clinical Commissioning Group (Brent CCG) regarding primary care commissioning in Brent, as detailed in the report from Brent CCG, be endorsed;

(ii) That Brent Clinical Commissioning Group note the board's view regarding the need to develop an appropriate medium through which Health and Wellbeing Boards and Healthwatch groups could submit views to the joint committee when their representatives would not be in attendance at a meeting.

(iii) That the proposed additional Health and Wellbeing Board meetings encompass discussion on the strategic commissioning priorities for primary care in Brent.

7. **Better Care Fund Update**

Sarah Mansuralli (Chief Operating Officer, Brent Clinical Commissioning Group) presented an update report regarding the Better Care Fund. Members of the board were asked to note the assurance letter received from NHS England subsequent to the Nationally Consistent Assurance Review (NCAR) process and approve proposed revised governance arrangements for implementation.

Drawing the board's attention the report, Sarah Mansuralli advised that the Better Care Fund plan, a national programme for health and social care integration, had been reviewed in the summer of 2014 and this had lead to the need to revise and re-submit the Brent Better Care Fund plan in September 2014. This had been followed by a regional and national assurance process with the draft assurance

letter presented to the HWB in November 2014. Following continued work on the assurance process, the final assurance letter, attached at appendix 1 to the report, had been issued on 23 January 2015. Sarah Mansuralli further explained that the vision for health and social care integration had not changed significantly since the last update to the HWB and still focussed on four key themes which aimed to reduce dependency on acute hospital care and clinical care. Each of the themes required significant transformation to service delivery and would be underpinned by a new governance structure which would oversee the delivery, management and implementation of the Better Care Fund programme in Brent.

Phil Porter (Director of Adult Social Care, Brent Council) explained that the new governance structure, set out at appendix 2, was designed to clarify responsibility and accountability across the health and social care system and provide clear channels of stakeholder engagement. Members of the board were advised of the membership of the BCF Exec Group and were directed to appendix 3 of the report which detailed the proposed terms of reference for BCF Implementation Board.

RESOLVED:

(i) That the assurance letter received from NHS England subsequent to the Nationally Consistent Assurance Review process be noted;

(ii) That the revised governance arrangements for implementation as detailed in the report from the Chief Operating Officer, Brent Clinical Commissioning Group and the Strategic Director, Adults, Brent Council, be approved.

8. **Date and topic of next meeting**

The board noted that the next meeting was scheduled for 2 June 2015 and the subject of the workshop would be social isolation.

9. **Any other urgent business**

None.

The meeting closed at 9.20 pm

CLLR M PAVEY
Chair

Brent

NHS

Brent Clinical Commissioning Group

Health and Wellbeing Board

2 June 2015

Report from NHS Brent CCG

For approval

NHS Brent CCG: Quality Premium 2015/2016

Purpose of the report

To gain approval from the **Health & Wellbeing Board** on the Quality Premium 2015/16 measures for Brent for 2015/16.

Summary
The Quality Premium is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

The quality premium 2015/2016 is paid to CCGs in 2016/17 to reflect the quality of the health services commissioned by them in 2015/16 http://www.england.nhs.uk/wp-content/uploads/2015/03/quality-premium-guidance-1516.pdf and is based on a combination of national measures and two local measures which were discussed and agreed by Brent CCG. Under the NHS Act 2006 (as amended by the Health and Social Care Act 2012), NHS England has the power to make payments to CCGs to reflect the quality of services that they commission, the associated health outcomes and reductions in inequalities. These are:

- **urgent and emergency care measures**: a menu of measures for CCGs to choose from locally in conjunction with their relevant Health and Wellbeing Board(s) and local NHS England team. The menu is overall worth 30 per cent of the quality premium. CCGs, with specified partners, can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure.

- **mental health measures**:- a menu of measures for CCGs to choose from locally in conjunction with their relevant Health and Wellbeing Board(s) and local NHS England team. The menu is overall worth 30 per cent of the quality premium. CCGs, with specified partners, can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure.
- **two local measures** - which should be based on local priorities such as those identified in joint health and wellbeing strategies (20 per cent of quality premium:10 per cent for each measure).

Not included in the Brent CCG template but to be noted as measures:

- *reducing potential years of lives lost through causes considered amenable to healthcare* (10 per cent of quality premium);
- *improving antibiotic prescribing in primary and secondary care* (10 per cent of quality premium)

Indicators approved and submitted to NHS England

Urgent and emergency care measures:

- Achieving a reduction in avoidable emergency admissions - 15%
- Reducing NHS-responsible delayed transfers of care - 15%

Mental health measures:

- Reduction in the number of patients with A&E 4 hour breaches who have attended with a mental health need together with a defined improvement in coding of patients attending A&E – 20%
- Reduction in people with severe mental health illness who are smokers – 10%

Two local measures (10% for each):

- People with diabetes diagnosed less than a year who are referred to structured education
- Estimated diagnosis rate for people with dementia

Brent Health & Wellbeing Board is asked to approve the above measures submitted to NHS England and which the CCG will be measured against for delivery in 2015/16.

Brent

NHS

Brent Clinical Commissioning Group

Health and Wellbeing Board

2 June 2015

Report from NHS Brent CCG

For information

Brent CCG London Ambulance Service (LAS) - performance diagnostic and transformation business case

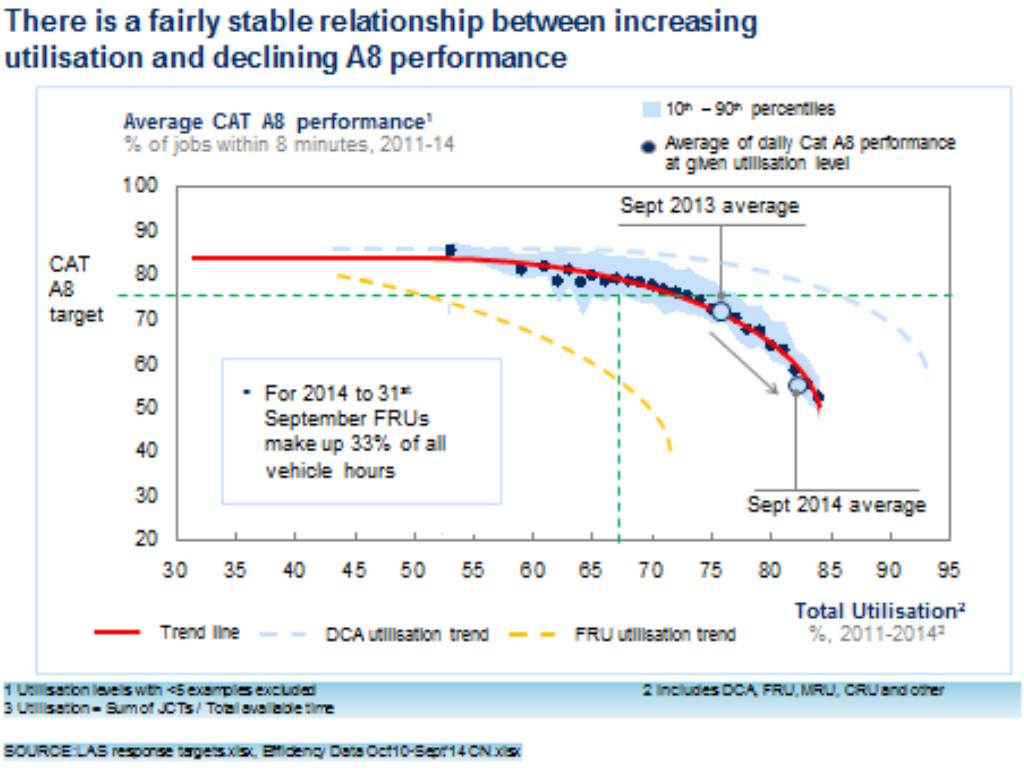
Background

The external diagnostic review undertaken by McKinsey of LAS performance during 2014/15 identified high utilisation, increasing blue light (A8) demand and being under establishment as the main drivers of performance. A separate external clinical review identified that the service was operating safely.

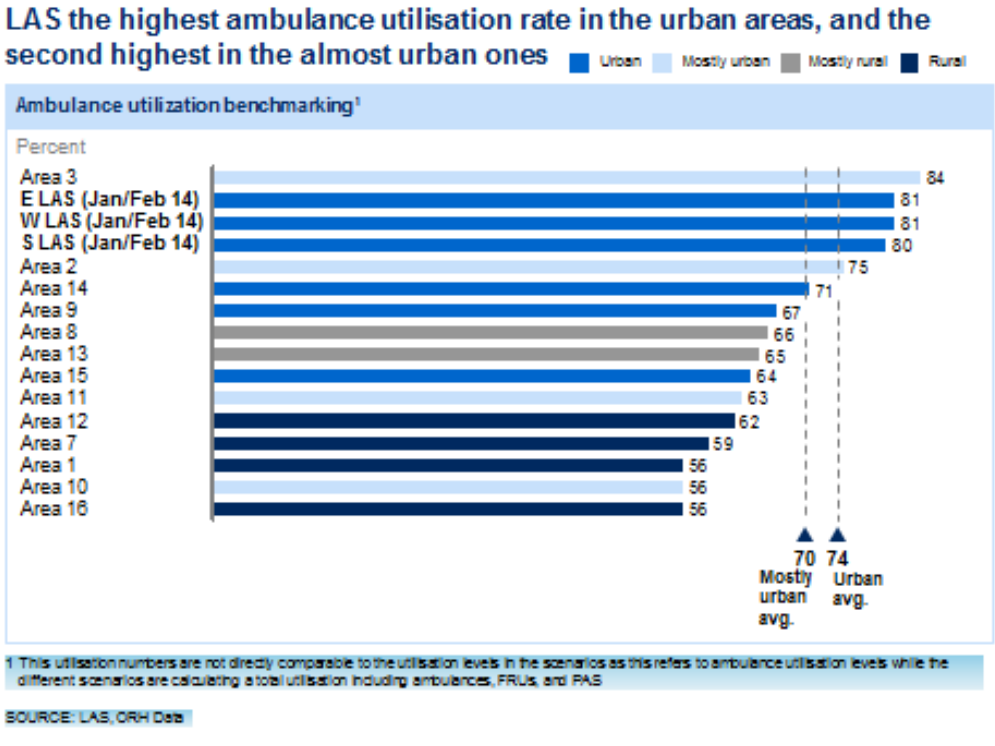
LAS utilisation, the amount of time an ambulance is in active use, has been high when compared to other ambulance services, reaching 90% utilisation whilst ambulance providers outside London average 70-74%, lower utilisation means that there is more ambulance capacity to respond. The diagnostic review identified a direct relationship between utilisation and performance and in order to reach sustainable performance, LAS utilisation needs to be reduced and staffing levels increased.

Diagnostic Review Key Findings

The performance of London Ambulance service over the last two years was mapped against the level of total utilisation of Ambulance resources. This identified a direct relationship between utilisation and performance but also that there was a marked reduction in performance when utilisation was higher.

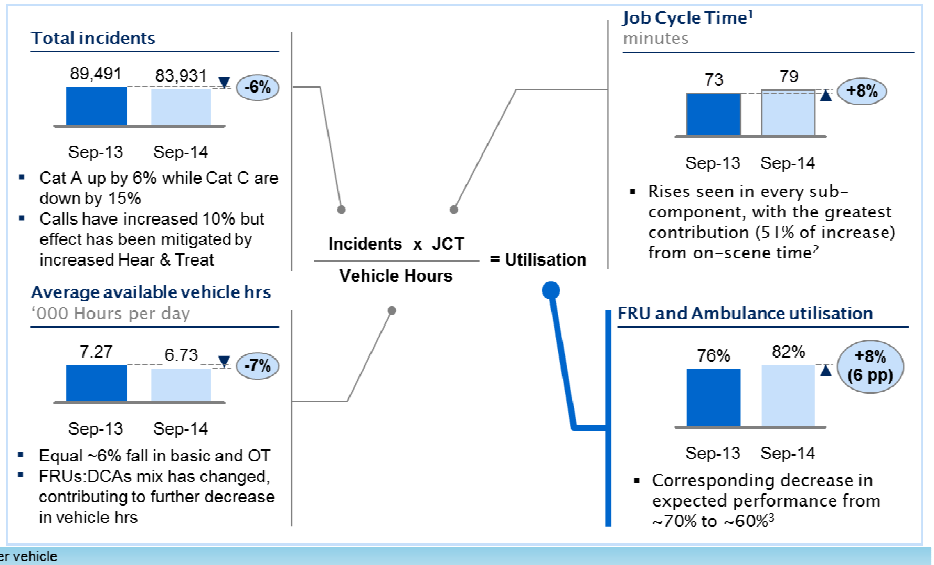


When benchmarking London Ambulance Service to other ambulance services across the country utilisation levels were higher when compared with services operating in urban areas.



There were three main drivers of utilisation identified, the number of incidents requiring a double crew ambulance have increased by 6%, the reduction in the establishment has resulted in a decrease in available vehicle hours, the time taken for each job has increased, combining to increase utlisation of the available vehicles.

Three components have driven the increase in utilisation and the associated decline in A8 performance



1 Per vehicle
2 For conveyed responses, see page 30
3 See overall utilisation curve on preceding page

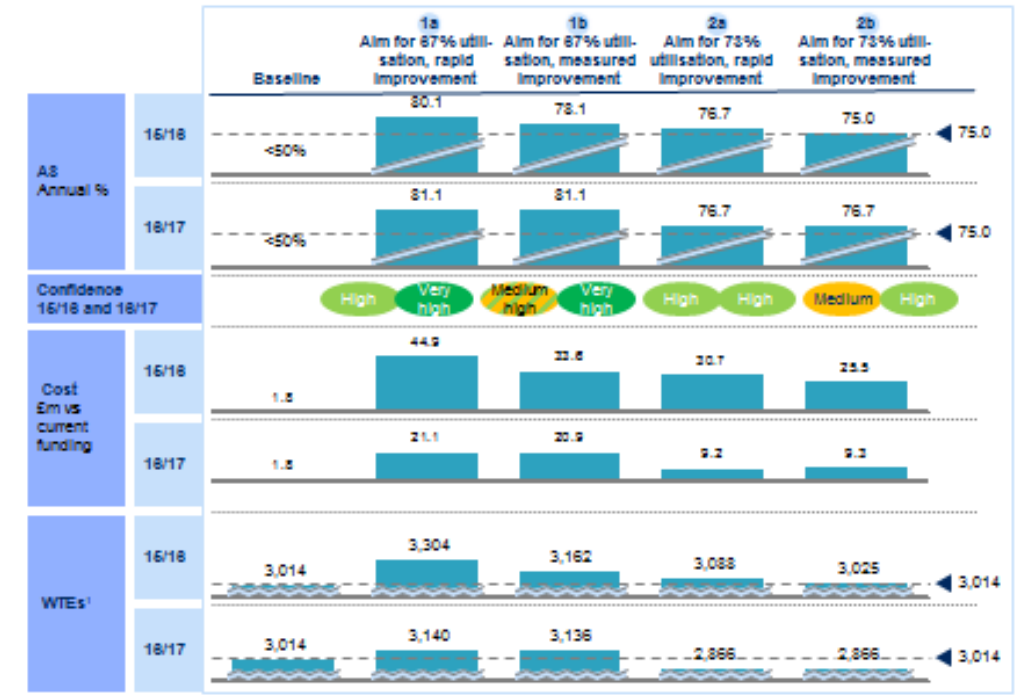
SOURCE: LAS Data

Transformation Business Case

The diagnostic work informed a business case, developed with Clinical Commissioning Groups (CCGs) across London working with London Ambulance Service on the options to achieve sustainable performance. These identified a range of schemes across staffing, vehicle capacity, training and productivity that support four options:

- **Option 1a** – An aggressive approach to increasing capacity in 15/16, providing a high theoretical confidence of A8 delivery in 15/16 at a cost of £44.9m in 15/16 and 21.1m in 16/17. This option was discounted by both LAS and CCGs due to the adverse impact on staffing as it required substantial and sustained levels of overtime not previously delivered by LAS staff.
- **Option 1b** - Adding capacity to deliver a target utilisation of 67% with a measured transition programme delivers 75% A8 performance in 15/16 and 16/17. It gives a medium to high confidence level of performance delivery in 15/16 and very high confidence level the following year. Cost is £33.6m for 15/16 and £20.9m for 16/17. This was identified as the preferred option.
- **Option 2a**- Adding less capacity compared to Option 1a and 1b resulting a lower level of reduction in utilisation at 73% utilisation rate in a rapid way with a medium confidence level of achieving A8 performance in 15/16 requiring £30m and high confidence for 16/17 needing £15m investment.
- **Option 2b** - Adding less capacity with a slower investment plan to deliver a target utilisation of 73% with a measured trajectory requiring a £26m investment in 15/16 and £9.3m in 16/17. With this option LAS will not start to recover performance until 16/17.

Summary of modelled scenarios



1 Frontline WTEs excluding PTS staff

8

Next Steps

The investment case was agreed by the 32 CCGs across London in March 2015 which has also included a gateway process that incentivises the Trust to achieve the agreed performance improvement trajectory, for example meeting their recruitment plan.

The Trust's performance has improved over the last quarter and will continue to be monitored weekly against the agreed trajectory which has sustained delivery of 75% for A8 by September 2015.

Conclusion

The Health and Well Being Board are requested to note the increased investment into LAS services to improve performance.

Bernard Quinn
Director Delivery & Performance
Brent CCG (LAS Co-ordinating Commissioner)
20th May 2015