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Brent

Brent Clinical Commissioning Group

Health and Wellbeing Board

Tuesday 26 January 2016 at 7.00 pm
Boardroom 3/4 - Brent Civic Centre, Engineers Way, Wembley HA9 0FJ

Membership:

Members		Substitute Members
Councillor Butt (Chair)	Brent Council	Councillors:
Councillor Carr	Brent Council	Denselow, Mashari, McLennan and Southwood
Councillor Pavey	Brent Council	
Councillor Hirani	Brent Council	
Councillor Moher	Brent Council	
Carolyn Downs	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	
Ian Niven	Healthwatch Brent	

For further information contact: Peter Goss, Democratic Services Manager
0208 937 1353 peter.goss@brent.gov.uk

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

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

To follow.

3 Matters arising (if any)

4 Child Death Overview Panel Annual Report 2014/15 1 - 22

This report presents the annual report of the Child Death Overview Panel (CDOP) for the Brent Local Safeguarding Children Board (LSCB). This is the seventh annual report. The CDOP reviews all child deaths of residents in the London Borough of Brent.

Ward Affected: All Wards

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

5 Children's Trust and OFSTED

Report to follow.

Ward Affected: All Wards

***Contact Officer**:* Dr Sarah Basham, Gail Tolley, Strategic Director, Children and Young People
Tel: 020 8937 6422
gail.tolley@brent.gov.uk

6 Better Care Closer to Home - phase two 23 - 26

The purpose of this report is to provide the Health and Wellbeing Board with information on the approach to reviewing and refreshing the Better Care Closer to Home strategy. The first phase of this programme was set out in the Better Care Closer to Home strategy 2012-2015 and focussed on moving services out of hospital into more community settings. Phase two will set out the approach to delivering the vision of the NHS Five Year

Forward View and the North West London transformation programmes at a local level.

Ward Affected:	***Contact Officer:*** Sarah Mansuralli, Chief
All Wards	Operating Officer, Brent CCG
	sarah.mansuralli@brent-harrowpcts.nhs.uk

7 Outcome based reviews

The Board will receive a presentation.

Ward Affected:	***Contact Officer****:* Phil Porter, Strategic Director,
All Wards	Community Well-being
	Tel: 020 8937 5937
	phil.porter@brent.gov.uk

8 London Health and Care Collaboration Agreement 27 - 42

The purpose of this report is to provide the Health and Wellbeing Board with information on progress of the collective agreement by London and National Partners to transform health and wellbeing outcomes, inequalities and services in London through new ways of working together and with the public.

Ward Affected:	***Contact Officer****:* Carolyn Downs, Chief
All Wards	Executive, Rob Larkman, Chief Officer, BEHH
	Tel: 0208 966 1129
	carolyn.downs@brent.gov.uk,
	Rob.larkman@brent-harrowpcts.nhs.uk

9 Update on Winter pressures 43 - 48

The purpose of this report is to update the Health and Wellbeing Board on the actions implemented in response to additional winter pressures; the longer term approach to managing these additional pressures; the mechanisms that underpin joint working; and the impact of this as far as it can be measured at this point, half way through winter.

Ward Affected:	***Contact Officers:*** Phil Porter, Strategic Director,
All Wards	Community Well-being
	Tel: 020 8937 5937
	phil.porter@brent.gov.uk
	Sarah Mansuralli, Chief Operating Officer, CCG
	sarah.mansuralli@brent-harrowpcts.nhs.uk

10 Updates on Health and Wellbeing priorities

a) Giving every child the best start in life

To follow.

b) Helping vulnerable families

To follow.

c) Improving mental well being through life 49 - 50

d) Working together to support the most vulnerable adults 51 - 52

e) Empowering communities to take better care of themselves 53 - 56

11 Any other urgent business

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

Date of the next meeting: Tuesday 22 March 2016

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.

Brent

NHS Brent Clinical Commissioning Group

Brent Health and Wellbeing Board

26 January 2016

Report from the Director of Public Health and the Designated Doctor for Unexpected Child Deaths

For discussion

Wards affected: ALL

Brent Child Death Overview Panel Annual Report 1st April 2014 – 31st March 2015

1.0 Summary

1.1 This annual report is provided by the Child Death Overview Panel (CDOP) for the Brent Local Safeguarding Children Board (LSCB).

1.2 This is the seventh annual report. The CDOP reviews all child deaths of residents in the London Borough of Brent

1.3 The CDOP is a subgroup of Brent LSCB as set out in Regulation 6 (SI No 2006/90) of the Children Act 2004. The Child Death review process is a statutory requirement as outlined in Chapter 5 of the Working Together to Safeguard Children 2013, (previously Chapter 7 of Working Together to Safeguard Children 2006, reviewed in March 2010 and March 2013). Terms of reference have been agreed and revised to include the latest guidance.

1.4 The process for management for unexpected child deaths is revised regularly and uploaded on the LSCB website: http://media.inzu.net/884ef2e464a01b98abb12a62a68a525c/mysite/articles/100/1_ChildDeathArrangementsRapidResponseProcessSept2012.pdf

1.5 The report was presented to the Brent LSCB in June 2015.

1.6 The report analyses Sudden Unepxected Deaths in Infancy since the commencement of the CDOP process in 2008. The importance of safe sleeping practices are highlighted

2.0 Recommendations

2.1 The Health and Wellbeing Board is asked to consider the 2014/15 CDOP report.

2.2 Partners are asked to consider how they can contribute the promotion of messages about safe sleeping

Contact Officers

Dr Melanie Smith Director of Public Health
Melanie.smith@brent.gov.uk

BRENT LSCB AND NHS BRENT CCG

CHILD DEATH OVERVIEW PANEL

ANNUAL REPORT

1st APRIL 2014 – 31st MARCH 2015

Dr Melanie Smith -– Director of Public Health
Dr Arlene Boroda -– Designated Doctor for Unexpected Child Deaths
Oosman Tegally -– Child Death Overview Panel Coordinator

Brent Local Safeguarding Children Board
Child Death Overview Panel
Annual Report for 01/04/2014 – 31/03/2015

1. OVERVIEW

This annual report is provided by the Child Death Overview Panel (CDOP) for the Brent Local Safeguarding Children Board (LSCB). The CDOP is a subgroup of Brent LSCB as set out in Regulation 6 (SI No 2006/90) of the Children Act 2004. The Child Death review process is a statutory requirement as outlined in Chapter 5 of the Working Together to Safeguard Children 2013, (previously Chapter 7 of Working Together to Safeguard Children 2006, reviewed in March 2010 and March 2013).

This is the seventh annual report. The CDOP reviews all child deaths of residents in the London Borough of Brent. Terms of reference have been agreed and revised to include the latest guidance.

The process for management for unexpected child deaths is revised regularly and uploaded on the LSCB website (http://media.inzu.net/884ef2e464a01b98abb12a62a68a525c/mysite/articles/100/1_ChildDeathArrangementsRapidResponseProcessSept2012.pdf).

The CDOP continued the child death review process for the deaths that were reported in the previous years:

38 deaths in 2008 – 2009 (this was the year in which CDOPs were established).
26 in 2009 –2010.
38 in 2010 – 2011.
41 in 2011 – 2012.
43 in 2012 – 2013
30 in 2013 – 2014
24 in 2014 – 2015

	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
Expected Deaths	21	15	28	26	30	14	18
Unexpected Deaths	17	9	10	15	13	16	6[1]
Total	**38**	**26**	**38**	**41**	**43**	**30**	**24**

Table 1: Total Number of Reported Child Deaths in Brent - 01/04/2008 31/03/2015

[1] One of these deaths initially classified as 'unexpected' was later determined by the CDOP paediatrician to be 'expected'

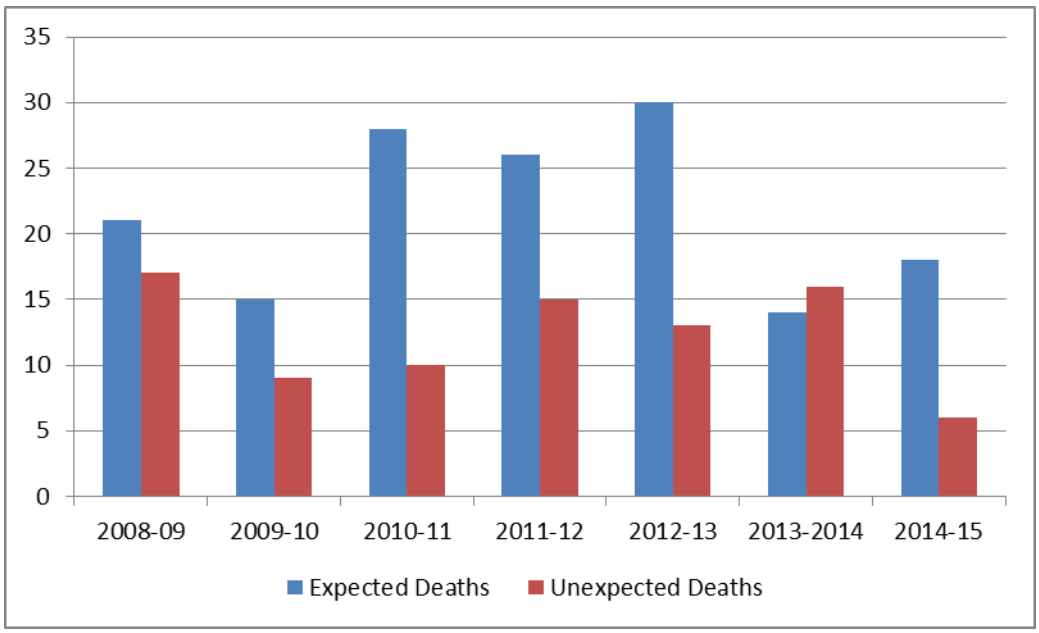


Chart 1: Expected/Unexpected Child Deaths per year.

The total number of reported deaths for the year 01/04/2014 – 31/03/2015 is 24

Age range of deaths	Unexpected	Expected	TOTAL
Neonatal deaths (<4wks)	**2**	**10**	**12**
Infant death (4wks – 1yr)		**4**	**4**
Children between 1-4 years of age	**4**	**3**	**7**
Children between 5-9 years of age			
Children between 10– 14 years of age			
Young people between 15 – 18 years of age		**1**	**1**
Total	**6**	**18**	**24**

Table 2: Age range of child deaths for the year 2014-2015

2. STAFFING

The Chair is the Director of Public Health from the Brent Local Authority and the Vice Chair is the Designated Paediatrician for Unexpected Deaths in Childhood.

The child death co-ordinator commenced in May 2009 as a fixed term, part time post-holder, taking over from a locum independent consultant. The post became permanent part–time in 2012 and is managed by the Designated Doctor (see structure chart - Appendix 1 & 2).

The Designated Paediatrician for Unexpected Deaths in Childhood is also the Designated Doctor for Safeguarding Children. The Designated Doctor and Named Nurse for Community Services Brent can provide the Rapid Response home visits for unexpected child deaths.

3. OFFICE ACCOMMODATION

The Designated Single Point of Contact (SPOC), who is also the Child Death Overview Panel (CDOP) coordinator, is based at Wembley Centre for Health and Care in NHS Brent CCG. This arrangement provides good access to specialist health advice and access to the Safeguarding Children Team (who undertake the rapid response).

4. CDOP PANEL MEETINGS

There have been regular meetings to discuss and review the Child Death cases. There has been good attendance from key partner agencies. All CDOP panel meetings have taken place at the Wembley Centre for Health and Care. Attendance for 2014/15 has been summarised in Appendix 3. The Child Death Overview Panel meets quarterly, or more often, depending on the number of child death cases that are ready for review.

Meetings were held on the:

- 03/07/2014
- 10/09/2014
- 15/01/2015
- 04/03/2015

The CDOP reviewed 29 child deaths cases in the year 2014-2015.
(03/07/2014 – **8**, 10/09/2014 – **5,** 15/01/2015 **- 12,** 04/03/2015 **- 4)**

5. Rapid Response

The current arrangements for the on call rota in NHS Brent are in line with Working Together 2006, revised in 2010 and 2013, covering 9am–5pm, Monday to Friday, weekends and bank holidays. Three health professionals have completed the Warwickshire University Advanced Child Death training programme and also nurses and social workers. It is anticipated that there will be an expanded team to join the rota.

Two home visits have been provided by a Hospital team where the children were certified as passed away. There were rapid response child death strategy meetings to share information regarding the death and to agree what processes will be followed to ascertain the cause of the child's death.

Of the 6 **unexpected child deaths**, there were 4 rapid response meetings which were attended by a number of professionals. Those cases where rapid response meetings were not held were in cases where rapid response home visits were undertaken and full information was shared at the time or the death was in a health setting that gave a full picture of what was known about the case. The rapid response meetings facilitated good information at the outset.

6. ANALYSIS

Child Deaths are categorised into four groups:

- **Neonatal –** under 28 days old in hospital
- **SUDI –** sudden unexpected death of an infant under 2 years.
- **Unexpected –** death of a child under 18 years
  Death not expected in the previous 24 hours.
- **Expected -** death of a child under 18 years **(natural causes).**

The panel reviews every death of a child irrespective of the category it falls in, to ensure the appropriate involvement and response from the statutory agencies. The Panel considers the time period before, at and following the child's death and may include the antenatal period.

In some of the cases the reviews were delayed until all the information was made available from the Coroners' investigations which took extended time.

7. SUMMARY OF FINDINGS

Between1st April 2014 and 31st March 2015, **24** child deaths were notified to the CDOP for children who were **resident** within the Brent LSCB area at the time of their deaths. This number is not the same as the **number of deaths reviewed.** There can be a delay in obtaining information particularly when inquests need to be completed so cases may not be considered for review in the same year as they are notified.

The number of Brent child deaths reported from 01/03/2008 – 31/03/2015 is outlined in the chart above (Chart 1).

- **Number of deaths each month**

The number of deaths each month over 2014 – 2015 has varied from 1 to 4 as shown below.

April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
2	**2**	**3**	**3**	**3**	**4**	**0**	**0**	**2**	**4**	**0**	**1**

Table 3: Monthly figures of child deaths.

- **Gender**

The 24 deaths (2014-2015) comprised a total of 12 males and 12 females

Gender of cases	
Males	**Females**
12	**12**

Table 4: Gender of child deaths.

- **Child Deaths by Locality**

Willesden - 3
Kingsbury - 6
Harlesden - 6
Kilburn - 2
Wembley - 7

- **Postcode of family home at time of child death**

Area	NW2	NW6	NW9	NW10	HA0	HA3	HA9	W11	W10
No.	**3**	**1**	**6**	**6**	**5**	**1**	**1**	**1**	**0**

Table 5: Postcode of family home of child deaths

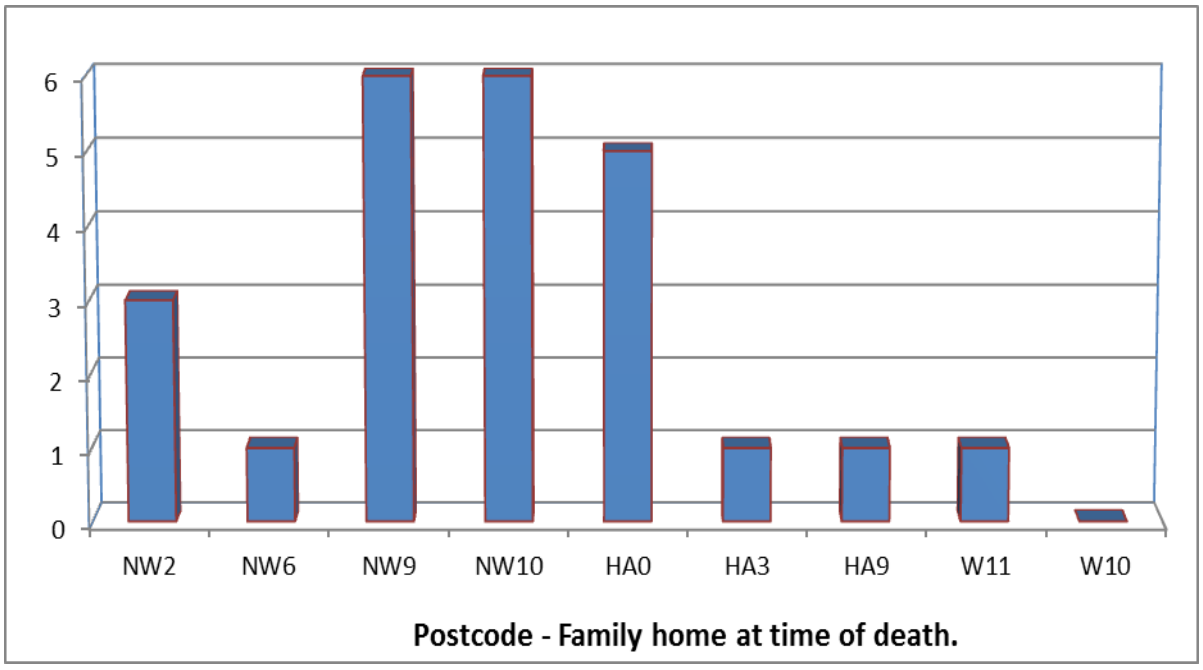


Chart 2: Postcode of family home of child deaths

- **Place of Death**

The child deaths in hospital were recorded at one of eight hospitals. The number of deaths in each hospital ranged from 1 to 9. 19 of the deaths occurred in a hospital setting and 4 in a hospice or at home.

St. Mary's Hospital.	NWLH	Royal Free Hospital.	Chelsea and Westminster Hospital	QCCH	UCLH	The Royal Brompton Hospital	Birmingham Children's Hospital	Home/ Hospice
2	9	1	1	3	1	2	1	4

Table 6: Hospitals/ Locations of Child deaths

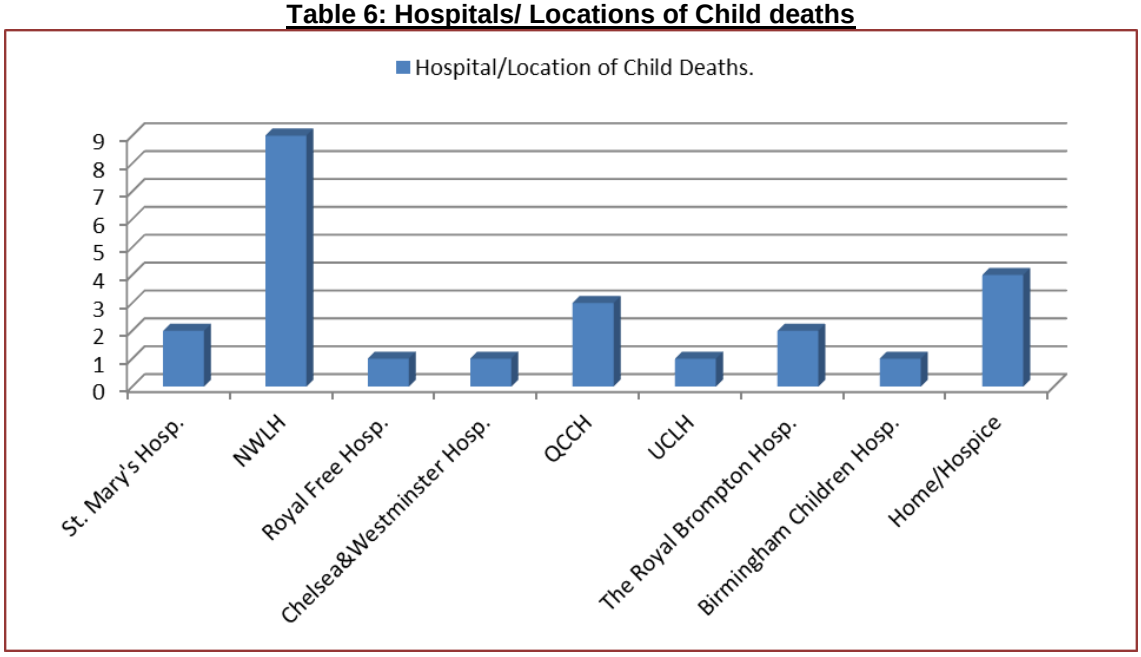


Chart 3: Hospitals/ Locations of Child deaths.

7. 3 Comparison of infant mortality rates in London Boroughs:

(Information provided by Brent Council public health team)

Chart 4 compares infant mortality rates in Brent against our statistical neighbours and against the London and England averages during the periods 2010-12 and 2011-13. In Brent, the rate of infant deaths in 2011-13 was 5.1 per 1,000 live births[2]. This equates to a total of 80 deaths during that period, or about 25 deaths per year. The rate of infant mortalities in Brent in 2011-13 was higher than in London, England, and any of the statistical neighbours.

Figure 1

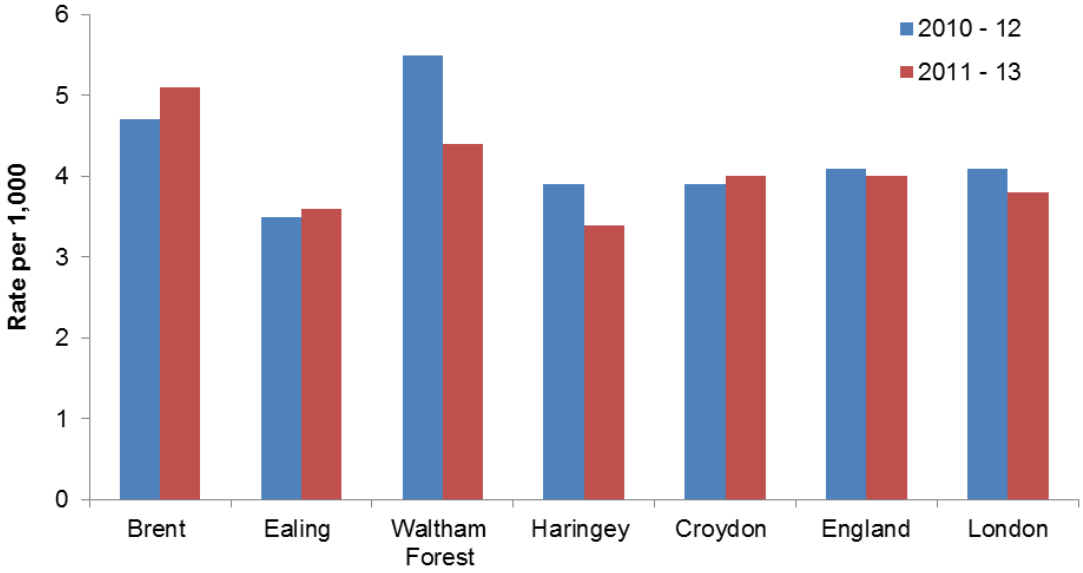


Chart 4: Brent Infant Mortality Rates compared to statistical neighbours 2010-2012, 2011-2013

[2] ONS

Chart 5 identifies the longer term trend of infant mortalities since 2001-03 comparing Brent against its statistical neighbours. Infant mortality rates in Brent have fluctuated quite significantly between 2001-03 and 2011-13. In 2001-03, the rate of infant mortality in Brent was 8 per 1,000 live births, higher than any of its statistical neighbours.

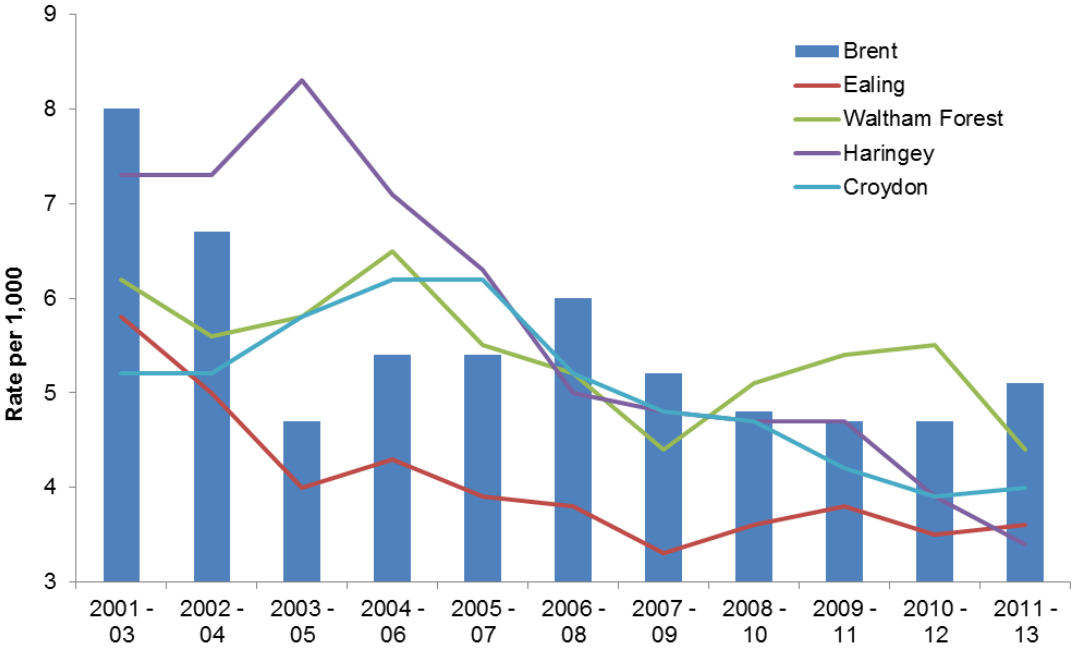


Chart 5: Brent Infant Mortality Rates compared to statistical neighbours from 2001-2013

Chart 6 compares rates of child mortalities (ages 1-17 years) in Brent for 2009-11 and 2010-12. In 2010-12, the rate of child mortality in Brent was 18.3 per 100,000 children aged 1-17 years. This equates to 12 deaths per year. The rate in Brent is significantly higher than the England average which was 12.5 per 100,000.
Furthermore, the child mortality rate in Brent in 2010-12 was higher than any of its statistical neighbours. However, the rate in Ealing (19.4 per 100,000) was slightly higher than the rate in Brent (17.6 per 100,000) in 2009-11.

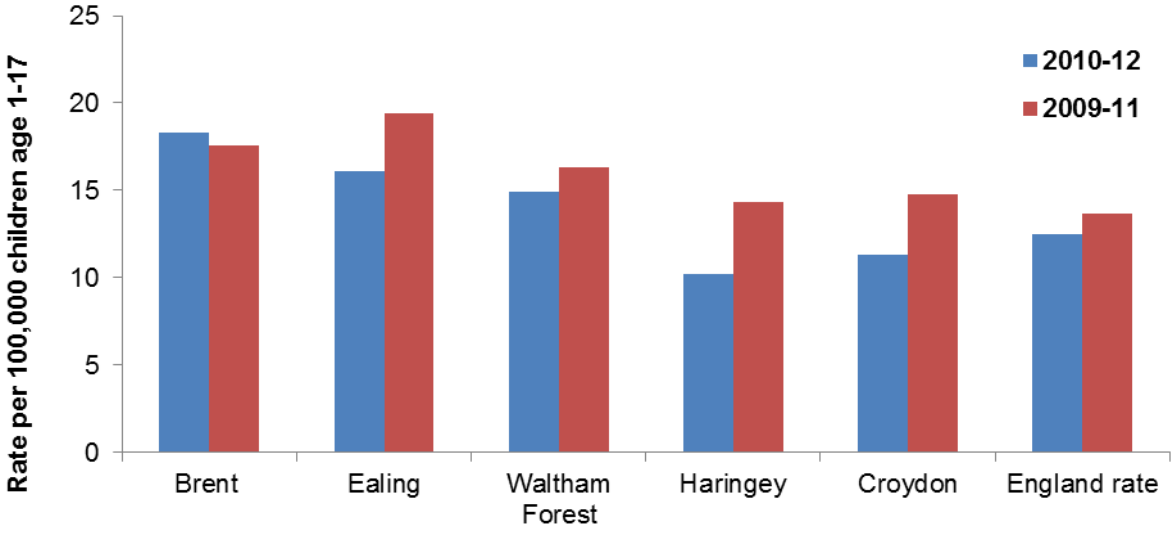


Chart 6: Brent rates of child mortalities (ages 1-17 years) for 2009-11 and 2010-12

8.0 CHILD DEATH OVERVIEW AND PANEL MEETINGS APRIL 2014 – MARCH 2015.

The panel completed reviews on a total of **29** child deaths during 2014-2015.
1 from the year April 2011 – March 2012,
1 from the year April 2012 – March 2013,
7 from the previous year April 2013 – March 2014 and
20 for this period April 2014 – March 2015.

The table below shows the time span in which the child death cases were brought to panel and completed (from date of death to the date the review was completed).

No. of deaths reviewed within the following time periods.	Deaths reviewed with Modifiable Factors	Deaths reviewed with No Modifiable Factors	Number of child deaths where there was insufficient information to assess if there were modifiable factors
Under 6 months		20	
6 - 7 months			
8 - 9 months		1	
10 - 11 months		1	
12 months		3	
Over 12 months	3	1	
Total	**3**	**26**	

Table 7: Time span of Child Death review

9.0 DEMOGRAPHICS

Table 2 : Age ranges for child deaths reviewed for April 2014 - March 2015

Age range of deaths	Unexpected	Expected	TOTAL
Neonatal deaths (<4wks)	2	10	12
Infant death (4wks – 1yr)	4	3	7
Children between 1-4 years of age	1	4	5
Children between 5-9 years of age	2		2
Children between 10– 14 years of age	2		2
Young people between 15 – 18 years of age		1	1
Total	**11**	**18**	**29**

Table 8: Age ranges for child deaths Reviewed for April 2014- March 2015

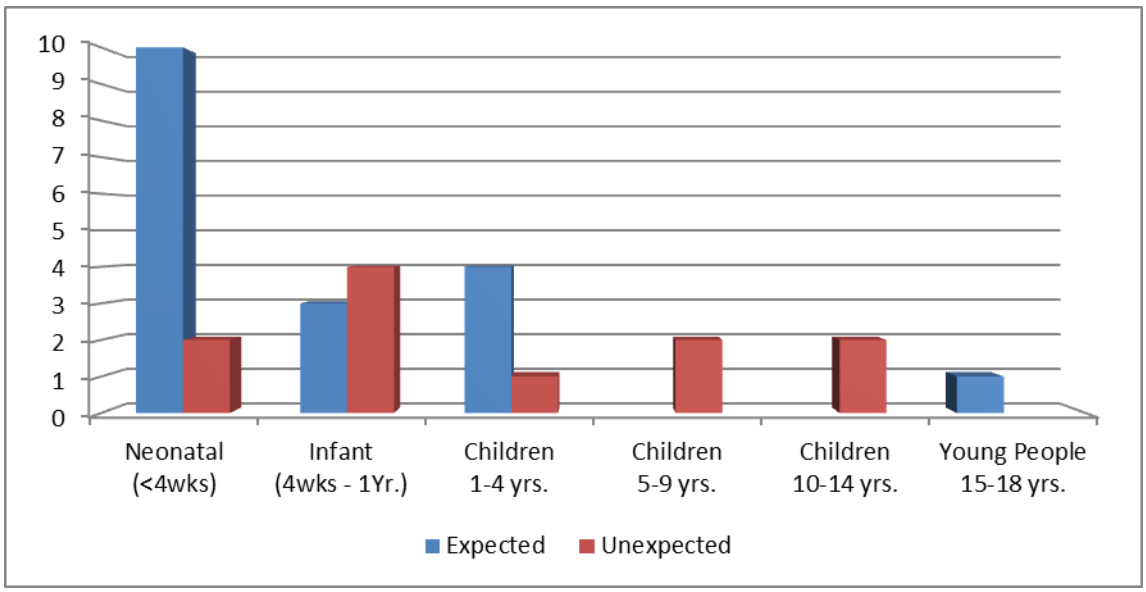


Chart 7: Age ranges for child deaths reviewed - April 2014 - March 2015

- **Gender of Reviewed cases.**

From the **29** children reviewed at panel**,** 1 April 2014 – 31 March 2015**,** their gender was:

Gender of reviewed cases	
Males	**Females**
18	**11**

Table 9: Age ranges for child deaths Reviewed for April 2014- March 2015

- **Ethnicity**

Ethnicity data is collected for all child deaths and linked into research about Child Deaths not only within London but nationwide. This provides valuable information especially within Brent due to its ethnically diverse population

Table 10: Ethnicity of 24 child deaths from 1st April 2014 – 31st March 2015.

White: English/Welsh/Scottish/Northern Irish/British	3
White: Irish	1
White: Gypsy or Irish Traveller	
White: Any Other White background	
Mixed: White & Black Caribbean	
Mixed: White & Black African	
Mixed: White & Asian	
Mixed: Any other mixed/multiple ethnic background	
Asian or Asian British: Indian	4
Asian or Asian British: Pakistani	2
Asian or Asian British: Bangladeshi	

Asian or Asian British: Chinese	
Asian or Asian British: Any other Asian background	3
Black: Caribbean	3
Black: African	4
Any other Black/African/Caribbean background	
Other: Arab	2
Other: Any other	1
Not stated	1
TOTAL	**24**

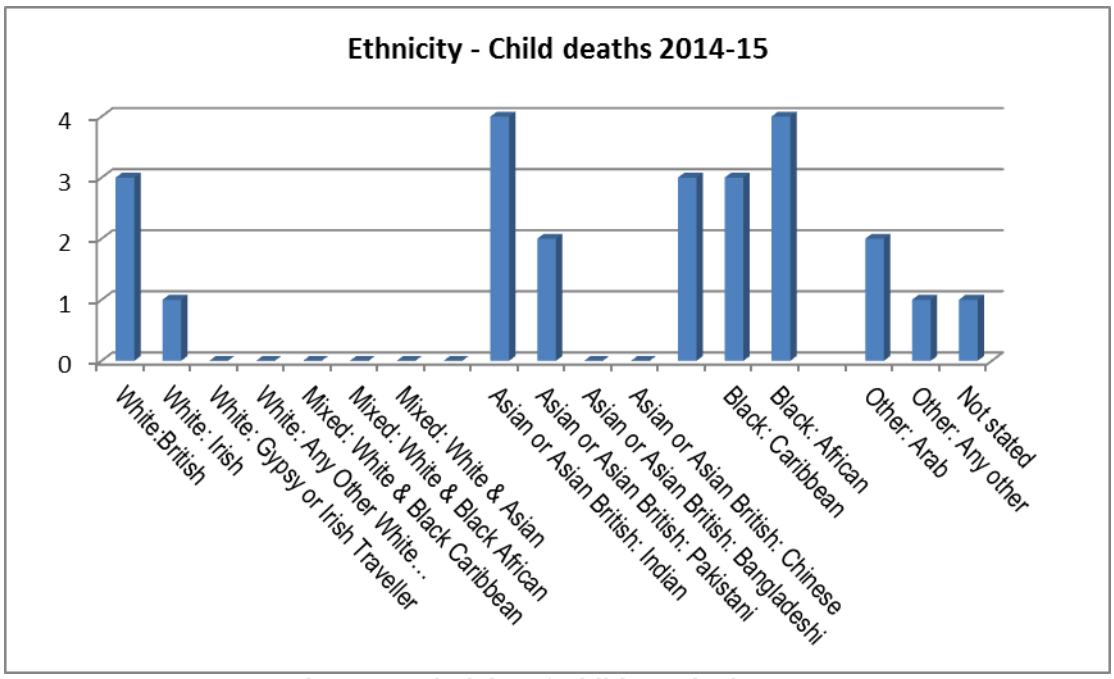


Chart 8 – Ethnicity of Child Deaths in Brent

10.0 CATEGORIES OF DEATH

The panel reviews cases and decides on the category the death should be classified within. There are two categories into which each death is classified:
Modifiable Factors (Preventable) and No Modifiable Factors (Not Preventable)

Modifiable Factors Identified. The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths

No Modifiable Factors Identified. The panel have not identified any potentially modifiable factors in relation to this death.

It is important to recognise that this categorisation is to inform efforts to reduce childhood deaths, it does not in itself carry any implication of blame on any individual party, but simply acknowledges where factors are identified which, had they been different, may have resulted in the death being prevented.

Table 11: Breakdown of categories for the 29 deaths reviewed:

Expected death from natural causes: TOTAL Chromosomal, genetic and congenital anomalies Perinatal/neonatal event Chronic medical condition	 10 7 1		18
Unexpected deaths – these include SUDI Trauma - Road traffic accident Chromosomal, genetic and congenital anomalies Deliberately inflicted injury - Murder by asphyxia Perinatal/neonatal event (prematurity) Acute medical or surgical condition 1). SUDEP. 2). Stevens Johnson Syndrome Infection		 2 1 2 2 1 2 1	11
Total	**18**	**11**	**29**

Expected deaths:
Modifiable Factors: The panel found that there were modifiable, or possible modifiable factors, in three of the cases reviewed. In one case there was a possible link to Vitamin D deficiency.
One child was found lying on his front and possible modifiable factor was identified in that safer sleep information might have prevented this death.
One child with pre-existing medical conditions died after an anaphylactic reaction to medication.

Unexpected Deaths:
This year the CDOP completed the review for 2 siblings who died at the hands of their mother from asphyxia. They were also the subject of a Brent SCR and a number of recommendations were made across the partnerships.They are the first children the CDOP has reviewed that have died from inflicted injury

12.0 TRAINING

The Paediatrician for Child Deaths attended the study day Unexpected Death in Childhood on 11 April 2014 in Birmingham organised by the Child Bereavement Charity.

A study session titled ‘Preventing Child Deaths’ was convened by Brent CDOP on Friday 12th of September 2014 in the CCG. This was very well attended. There were speakers and presentations on consanguinity, clinical mishaps, Vitamin D Deficiency, and talks by the Lullaby Trust, Child Bereavement Charity and Brent Samaritans. There was good discussion during these sessions on all the topics presented:

- Consanguinity – at the NWLH genetics clinic there is a rapid referral system for families needing urgent input and advice re genetic implications for the unborn baby.
- Recognition by primary care of the needs of ill babies and the need to respond quickly was reinforced.
- Bereavement counselling – referral for families to the relevant charities for support
- Safer sleep practices and preventing child deaths – material supplied as produced by the Lullaby Trust

13.0 THE CHILD DEATH REVIEW PROCESS

The process for the review of child deaths has followed the London Child Protection procedures and Working Together to Safeguard Children 2013 as previously happened. Notifications of deaths to the SPOC have improved as London-wide people are now more aware of the need to ensure good communication. The professionals working in this field are increasingly aware of the need to ensure effective, timely and comprehensive referrals.

14.0 LINKING UP WITH LONDON CDOP

The CDOP coordinator attended one London SCB SPOC meeting. The Paediatrician for Child Deaths has attended three of the London SCB CDOP Chairs network meetings. A joint meeting took place with the Harrow CDOP on 31 October 2014 to share interesting cases and learning.

15.0 PUBLIC HEALTH AND PREVENTION

15.1 Detection of GROUP B strep infection antenatally, preventing infection and possible mortality: (Report by Dr Rao and Mrs Nartey, LNWHC Trust, March 2015):

Dr Rao and Ms Nartey reported that there were a total of 4842 infant births from March 2014 – February 2015 at Northwick Park Hospital (NPH). A total of 3085 (64%) pregnant women were screened after 35 weeks for Group B infection, as the programme was rolled out across services provided by NPH for Brent and Harrow mothers.

From the total number of pregnant women screened, 28-30% were found to be GBS positive. There were no mothers who were screened or babies of mothers screened that developed an infection post-delivery.

In the group that were not screened, 2 babies were found to have an early infection and were treated accordingly and 3 mothers had bacteraemia which is associated with GBS and was treated accordingly.

None of the women who received antibiotics had an adverse reaction to antibiotics.

In 2012, the early onset GBS invasive infection rate in neonates was 1.14/100 live births and maternal blood stream infection rate was 0.76/1000 live births. The 2013 rates were similar. (Information provided by NPH)

15.2 Sudden unexplained deaths in infancy (SUDI):

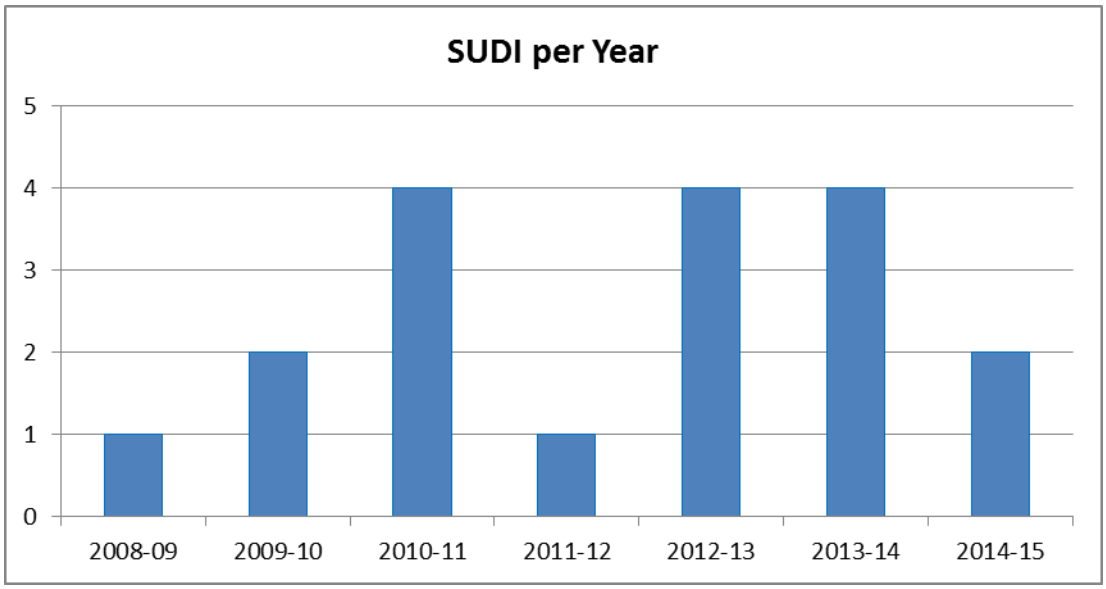


Chart 9 – Numbers of Brent SUDI's per year

There have been 18 reported of cases of SUDI since 2008 as shown in table 10.

Table 12: Chart of SUDIs from 2008-2015

Year	No. of SUDI	Issues identified	No factors identified
2008-09	1	Found at end of cot	
2009-10	2	One case of co-sleeping	1
2010-11	4	All four cases reported to be co-sleeping	
2011-12	1		1
2012-13	4	Three cases reported to be co-sleeping	1
2013-14	4	2 cases of children lying prone, face down, one was an ex-premature baby and one co-sleeping.	
2014-15	2	One child was supported by a wedge in cot and one reported to be co-sleeping.	
TOTAL	18		

Table 13: Postal Codes of Brent SUDI's from 2008- 2015

NW10	NW6	NW9	NW2	W10	HA0	HA9
7	2	2	2	1	3	1

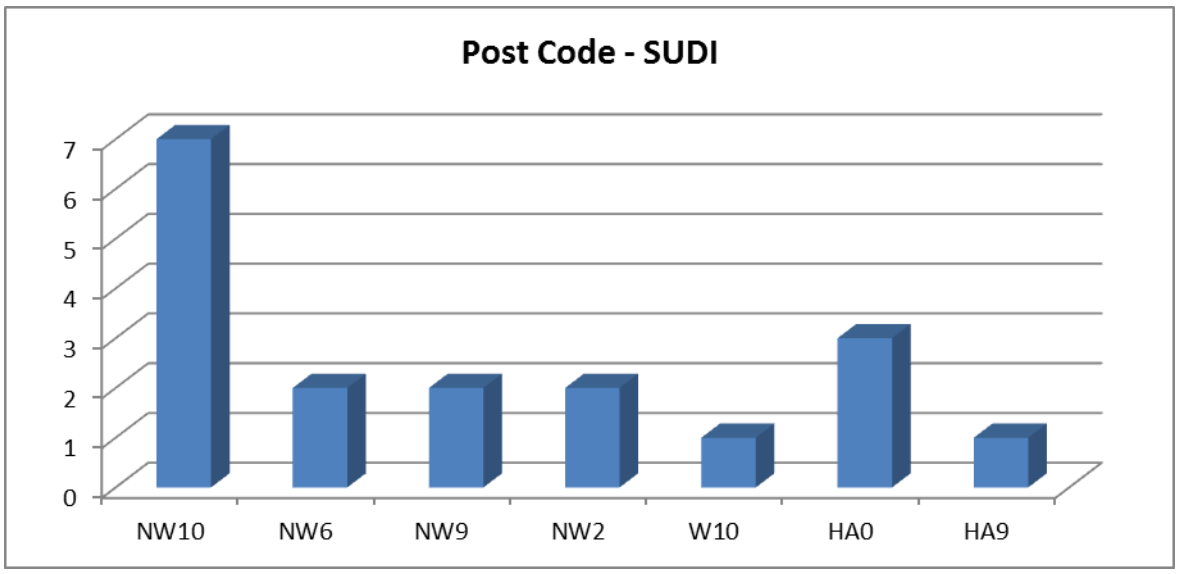


Chart 10 – Postal code of SUDI's from 2008- 2015

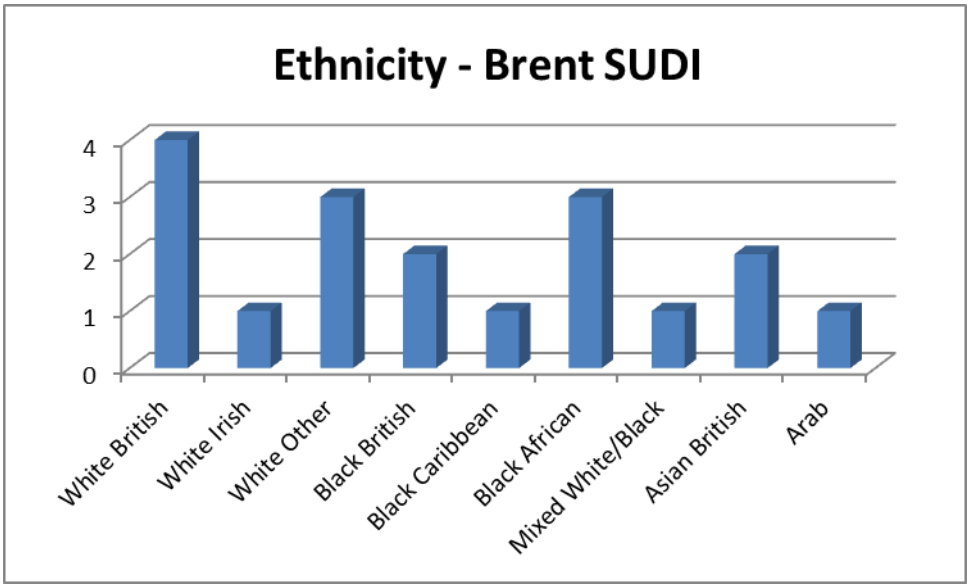


Chart 11 – Ethnicity – Brent SUDI

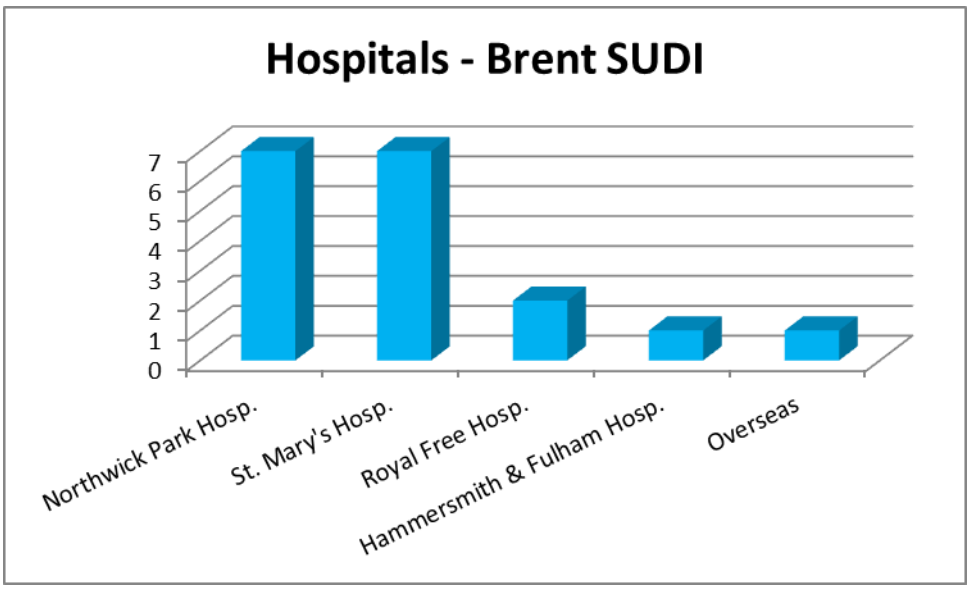


Chart 12 - Hospitals where child attended/died

There were 10 cases of co-sleeping; two infants were reported to be sleeping on their front. One infant was found at the end of his cot with a blanket around him.
One infant was an ex-premature baby and one infant was placed on his side with a wedged pillow in his cot.

There were no factors identified in the three other cases.

Despite being low in comparison to the number of live births in the Borough (5240 in 2010; ChiMat 2012), each of these infant deaths are catastrophic events for families (Waite et al 2011).

16.0 LEARNING THE LESSONS:

Over the years of the child death review process the themes are collated and disseminated across front line staff. They are as follows:

1. There are still many cases of SIDS where co-sleeping remains a risk factor. Information and leaflets on safer sleep for babies should be used by frontline professionals to educate parents about safe sleep practices in babies.
2. Vitamin D deficiency was raised as a concern in deaths over the years. Promotion of Vitamin D supplementation in pregnant women and in children with risk factors for this deficiency should continue.
3. Bereavement care for parents and staff is important.
4. Joint home visits following an unexpected child death provide an opportunity to assess the full family picture
5. Following the death of a child in a local hospital, a thorough investigation was carried out of the clinical care of the case. The Trust now has completed an action plan and embedded the lessons learned during the process aiming to improve clinical care and prevent repetition of errors.
6. Listening to concerns that parents have about clinical care is important in addressing concerns and can also avoid unrealistic expectations about chronic conditions in children.

17.0 ISSUES:

Child deaths have needed to be reviewed by the Coroner before coming to the CDOP. In some cases there are delays due to further investigations and information required at the Coroner's inquest hearing or investigation. Communication with the Coroner's offices is via Coroners officers. Recently the CDOP health professionals met with the local Coroner to share information and to refresh communication channels.

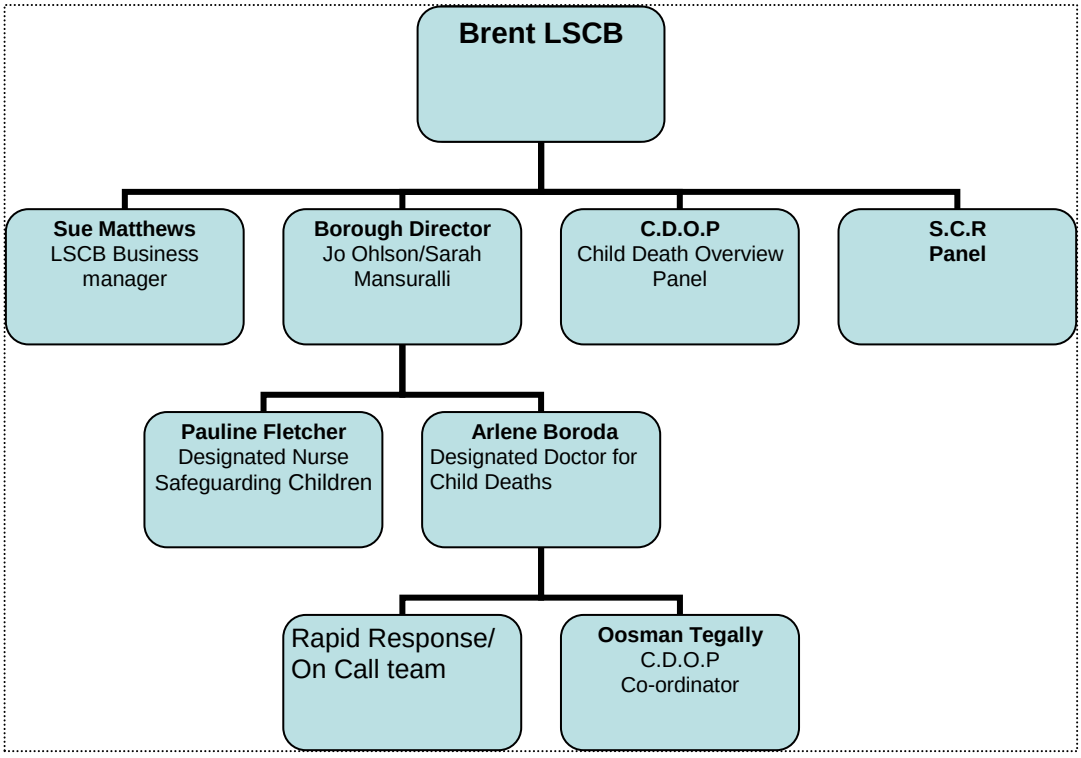
Accessing information from health providers has been difficult in some cases.

Parents have not yet been involved in the review process but they are informed about the Child Death Review process. Information about the Child Death Review process and other relevant information including bereavement care and counselling are shared with parents at the hospitals. A representative from the charity The Lullaby Trust (formerly FSID) attends the CDOP meeting and is a representative of the parents.
The panel communicates the decisions with the parents and universal staff including GPs that had contact with the children.

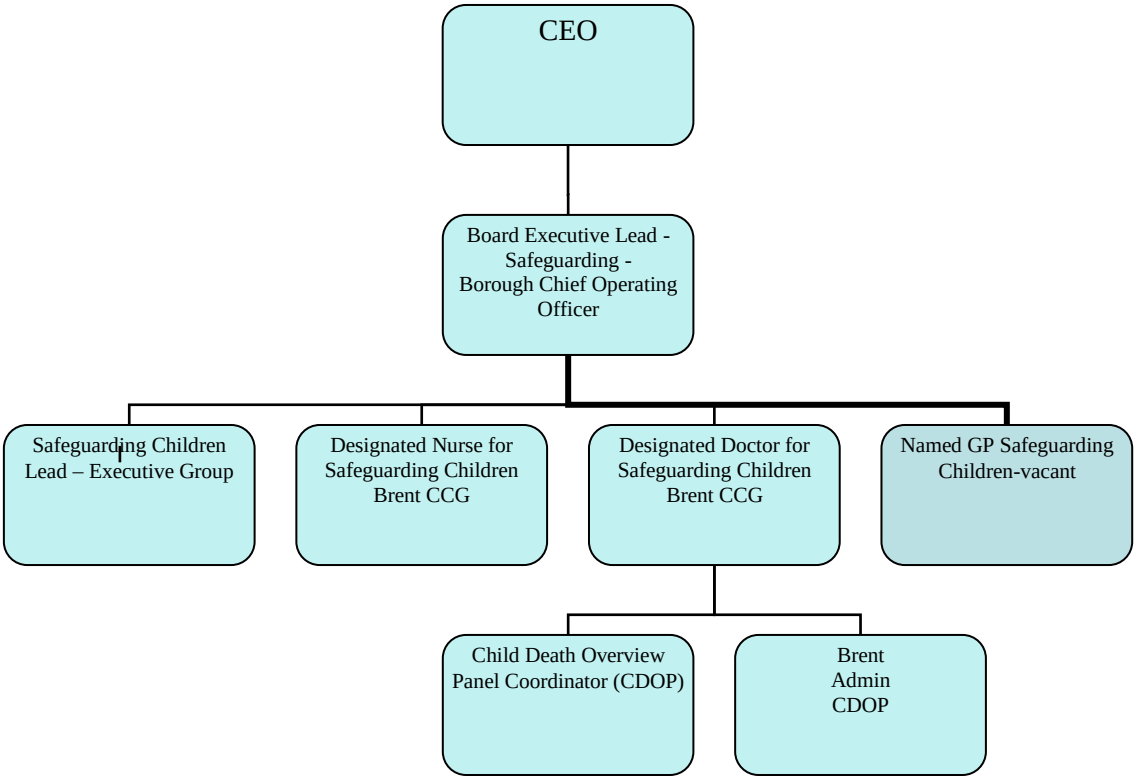
Appendix 1

Postholders

Executive Lead for Safeguarding Children- Jo Ohlson then Sarah Mansuralli
Public Health Consultant –Dr Melanie Smith
Designated Doctor for Unexpected Child Deaths- Dr Arlene Boroda
CDOP Co-ordinator- Oosman Tegally
Designated Nurse for Safeguarding Children NHS Brent CCG- Pauline Fletcher
Rapid response on call – Liz Reid, Dr Arlene Boroda
Head of Safeguarding (Social Care) - Sarah Alexander
Brent and Harrow Metropolitan Police CAIT –DS Jason Dawson
Administration -Maxine McLeod



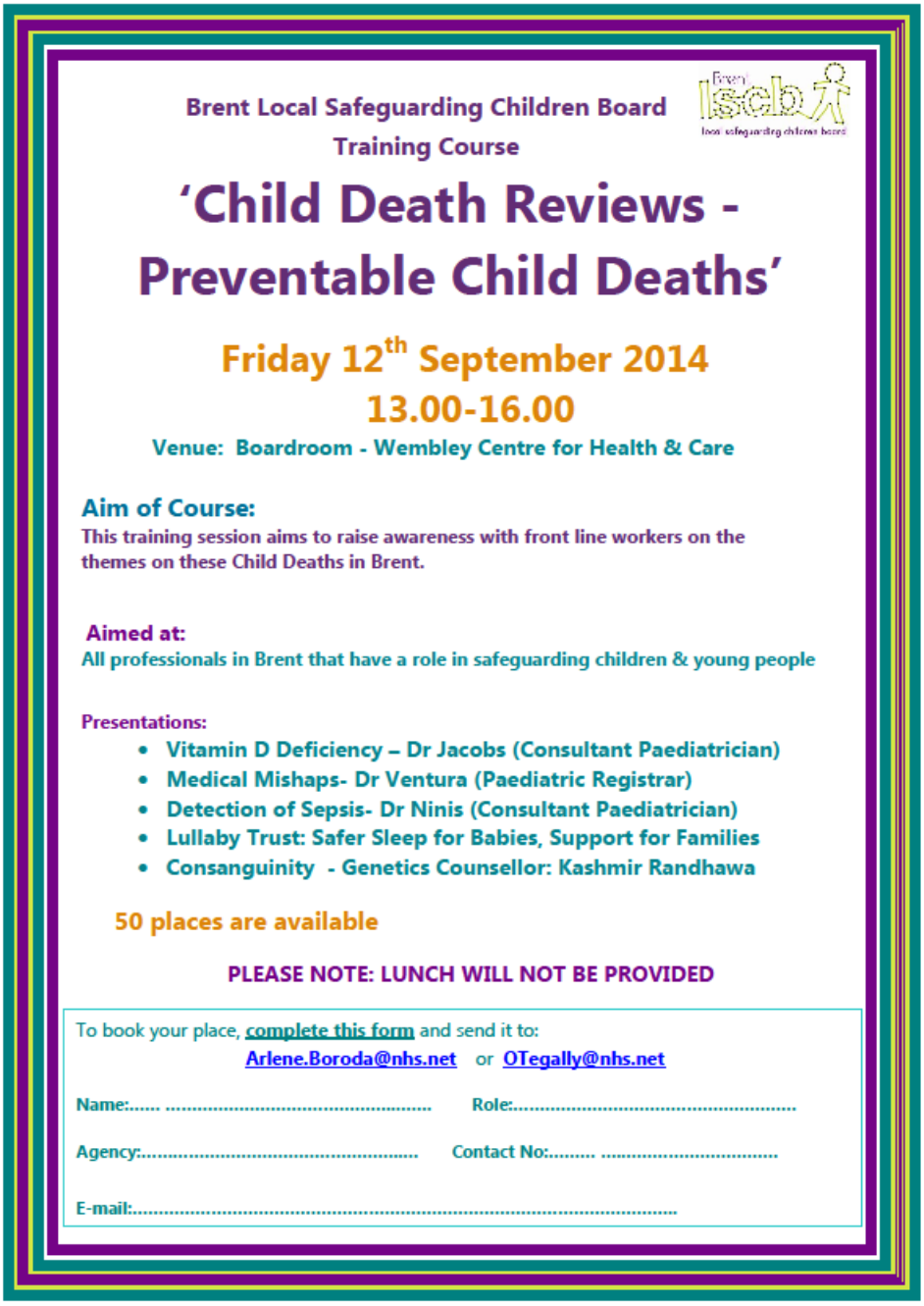
Appendix 2
NHS BRENT SAFEGUARDING CHILDREN STRUCTURE CHART



Appendix 3:
CHILD DEATH OVERVIEW PANEL MEMBERSHIP ATTENDANCE 2014 - 2015

	03/07/2014	10/09/2014	15/01/2015	04/03/2015
Public Health Consultant	Present	Apologies	Present - Chair	Present - Chair
Designated Doctor for Child Deaths for NHS Brent CCG	Present - Chair	Present - Chair	Present	Present
CDOP Co-ordinator	Present	Present	Present	Present
Designated Nurse for Safeguarding Children NHS Brent CCG	Present	Present	Present	Present
Police/CAIT	Present	Present	Represented – (MIT)	Present
Social Care - Head of Safeguarding Children	Present	Present	Present	Present -Represented
Bereavement midwife NWLH	Present	Present	Present	-
The Lullaby Trust (FSID)- parents	Present	Present	Apologies	Present

Appendix 4



Brent Local Safeguarding Children Board

Training Course

'Child Death Reviews - Preventable Child Deaths'

Friday 12th September 2014

13.00-16.00

Venue: Boardroom - Wembley Centre for Health & Care

Aim of Course:

This training session aims to raise awareness with front line workers on the themes on these Child Deaths in Brent.

Aimed at:

All professionals in Brent that have a role in safeguarding children & young people

Presentations:

- Vitamin D Deficiency – Dr Jacobs (Consultant Paediatrician)
- Medical Mishaps- Dr Ventura (Paediatric Registrar)
- Detection of Sepsis- Dr Ninis (Consultant Paediatrician)
- Lullaby Trust: Safer Sleep for Babies, Support for Families
- Consanguinity - Genetics Counsellor: Kashmir Randhawa

50 places are available

PLEASE NOTE: LUNCH WILL NOT BE PROVIDED

To book your place, complete this form and send it to:

Arlene.Boroda@nhs.net or OTegally@nhs.net

Name:..... ..... Role:.....

Agency:..... Contact No:..... .....

E-mail:.....

Brent Health and Wellbeing Board
26 January 2016

Report from the Chief Operating Officer, Brent Clinical Commissioning Group

Wards affected: ALL

Better Care Closer to Home – Phase Two

1.0 Summary

1.1 The purpose of this report is to provide the Health and Wellbeing Board with information on the approach to reviewing and refreshing the Better Care Closer to Home Strategy. The first phase of this programme was set out in the Better Care Closer to Home strategy 2012-2015 and focussed on moving services out of hospital into more community settings.

1.2 Phase two will set out the approach to delivering the vision of the NHS Five Year Forward View and the North West London transformation programmes at a local level. The strategy further provides the local medium term priorities to inform the development of the five year Sustainability and Transformation Plan, the system wide plan, and the Better Care Fund developments in 2016/17 and beyond.

1.3 The phase two strategy will be informed by patient, public and partner engagement throughout January and February and a final draft will be presented to the Health and Well Being Board at its next meeting in March.

2.0 Recommendations

2.1 The Health and Wellbeing Board is requested note and support the approach to reviewing and refreshing the Better Care Closer to Home strategy for phase 2, covering the period 2016-2019.

2.2 The Health and Wellbeing Board is invited to provide comments on the approach and priorities of the strategy.

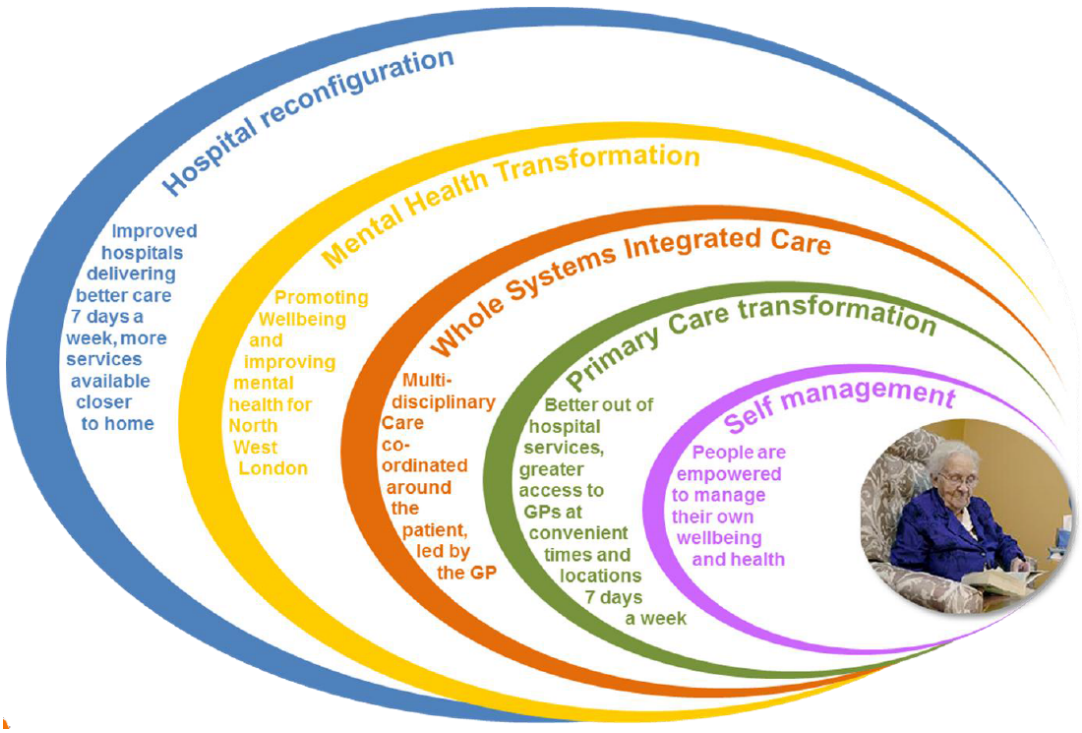
3.0 Detail

3.1 Better Care Closer to Home phase one focussed five objectives:

- Easy access to high quality responsive primary care (GP Access Hubs)
- Rapid response to urgent needs (development of urgent care centre and walk in centres)
- Providers (Health and Social Care) working together (Integrated Care Programme)
- Simplified Planned Care Pathways (Community ophthalmology and cardiology pathways, Brent Integrated Diabetes Service)
- Appropriate time in hospital (Ambulatory Care pathways)

3.2 The NHS Five Year Forward View has laid the foundation for a substantial change in the way health services are organised and delivered. It has also acted as a catalyst for local responses to ensure NHS services are accessible, high quality and cost effective.

3.3 Taking on board the vision set out in the Five Year Forward View and the North West London transformation plans as pictured below, the Better Care Closer to Home strategy phase two (2016-2019) will set out the steps the CCG will take to deliver its transformation plans locally.



3.4 The framework for Better Care Closer to Home phase 2 draws on the North West London vision deliver patient-centred care in all care settings, ensuring reduced inequality of care outcomes and delivery of services that are designed to the needs of the local population. The approach further reaffirms the CCG's commitment to commissioning services that provide:

- Personalised care to enable patients and residents to proactively management their care and keep them as healthy as possible in the community.

- Localised care to enable better access and equity of access for all patients in Brent.

- Integrated care to ensure better coordinated and more efficient services that meet the holistic needs of Brent patients and residents.

- Centralised care to ensure greater access to specialist support and better pathways between providers of care.

3.5 What the vision means for Brent's local commissioning of care is summarised in the priorities below:

- Expand accessibility to tools and resources to encourage self-management.
- Proactively engage with the Brent population to incorporate their views
- GP networks offering improved access and quality to responsive and proactive primary care
- Redesign of Primary Care settings and pathways to ensure flows from hospital are well managed and offer high quality and efficient care
- Improvements to the responsiveness and coordination of mental health services across all settings of care
- Integration with providers and services across the health and care system
- Outcome based commissioning to improve the patient experience of care
- Specialised and integrated pathways across providers of specialised care and then through to primary/community care for on-going case management.

3.6 In developing the Better Care Closer to Home phase two, the CCG will produce a roadmap covering the period of the phase two strategy of the intended service developments. The roadmap will be a visual, comprehensive summary of the strategy, capturing the strategic milestones for delivery in Brent over the next three years. The aim of the roadmap is to enable us to:

- Engage with the public and patients on the CCG's medium term goals
- Identify connections and interdependencies between the various transformation programmes
- Identify opportunities for alignment with partner agencies

3.7 Better Care Closer to Home phase two will provide the narrative to the strategic milestones for delivery identified in the roadmap for 2016-2019. This is supplemented by the annual CCG commissioning intentions/plans which are produced between September and December with involvement from the public, partner agencies and health professionals to set out the detailed narrative descriptions of the aims, objectives and priorities of the financial year ahead.

3.8 A feedback event on the 2016/17 commissioning intentions will take place at the next Health Partners Forum on 27th January. The CCG will present its approach to developing the Better Care Closer to Home phase two and roadmap to ensure early engagement in the process.

4.0 Financial Implications

4.1 The CCG's strategy, roadmap and commissioning intentions detail the approach to commissioning of services, using financial allocations to purchase healthcare as part of discharging its statutory duties.

5.0 Legal Implications

5.1 Nil

6.0 Diversity implications

6.1 The Better Care Closer to Home strategy will set out the CCG's approach to ensuring improved access, equity and quality of care for Brent patients and residents.

Background Papers
Background papers are available on request.

Contact Officer

Name: Sarah Mansuralli
Job title: Chief Operating Officer
Tel: 020 8900 5367

Brent

NHS Brent Clinical Commissioning Group

Brent Health and Wellbeing Board

26 January 2016

Report from the the Chief Executive of Brent Council and the Chief Officer of Brent Clinical Commissioning Group

Wards affected: ALL

London Health and Care Collaboration Agreement

1.0 Summary

1.1 The purpose of this report is to provide the Health and Wellbeing Board with information on progress of the collective agreement by London and National Partners to transform health and wellbeing outcomes, inequalities and services in London through new ways of working together and with the public.

2.0 Recommendation

2.1 The Health and Wellbeing Board note and support the London Health and Care Collaboration Agreement on the basis that it supports continued closer working to improve outcomes for Brent residents, but implies no changes to Council or CCG governance or decision-making powers.

3.0 Detail

3.1 The London Agreement is a collective Agreement between all 33 Local Authorities, 32 Clinical Commissioning Groups (CCGs), the Mayor, NHS England and Public Health England. It is a commitment by all these bodies to transform health and wellbeing outcomes, inequalities and services in the capital, through new ways of working together and with the public.

3.2 This agreement is designed to support the widest and fastest improvement in the health and well-being of 8.6 million Londoners through a major

transformation programme. At its heart is the reform and updating of the way that public services are provided.

3.3 The agreement reports how this will be achieved and confirms support from all the parties concerned. The parties have a shared commitment to deliver on the 10 aspirations to promote health and well-being set out in Better Health for London: Next Steps and, in doing so, deliver on the NHS Five Year Forward View.

3.4 The London Agreement sets out high-level objectives and principles that reflect:

- The need to shift from reactive care to prevention, early intervention, self-care and care closer to home that maximises people's independence and wellbeing.
- The need to address both quality and sustainability of health and care services.
- The scale and complexity of the health and care system in London - transformation will be driven at three geographical levels: local, sub-regional and pan-London.
- The need to tailor solutions to the different needs of people and places – an underpinning principle of subsidiarity sets the expectation that power and funding should be devolved to the lowest appropriate level.
- Recognition that locally shaped solutions will progress at different paces - underpinned by a commitment from all to make as rapid progress as possible.

3.5 There have been several iterations of the London Agreement, taking on board comments from individual CCGs and Local Authorities. The final version was produced on 18th December. The final agreement implied no changes to Local Authority or CCG governance or decision-making powers. As a result, the CCG Governing Body ratified the London Agreement at its Governing Body meeting on 13th January.

3.6 The London Agreement recognises that considerable progress can be made on reform within existing powers and is a commitment by all parts of London to make progress at pace and scale. But, it also notes that a range of devolution of functions, powers and resources will be needed from government and national NHS bodies to unlock or accelerate progress. Hence the London Agreement announced pilots which will test different elements of greater integration, collaboration and devolution.

3.7 The London Agreement will not change, but the way it is implemented is entirely amenable to development and change, especially as the pilots develop. It is anticipated that the pilots will help to identify potential opportunities for benefits realisation.

3.8 The London devolution pilots within the London Agreement will explore four themes:

- Sub-regional care integration – Barking & Dagenham, Havering and Redbridge (Outer North East London)
- Sub-regional estates – Barnet, Camden, Enfield, Haringey, Islington (North Central London)
- Local care integration – Hackney (including the Borough of Hackney and City & Hackney CCG); Lewisham
- Local prevention – Haringey

3.9 The London Agreement commits London Local Authorioties and CCGs:

- Where they are part of a devolution pilot, to work for the success of that pilot and the swift and successful transfer of learning to other parts of London.
- Where they are not part of a pilot like Brent, to continue to work together and be ready to take advantage of devolution secured by the pilots – including developing sustainability and transformation plans locally and sub-regionally.

3.10 The Office of London CCGs and Local Authorities will be reporting back to London CCG COs and Chairs and London Councils regularly and, through this, the Health and Wellbeing Board will be routinely updated.

3.11 On the back of the London Agreement, the government and other national bodies have signed a parallel Devolution Agreement in support of London's approach to reform and committing them to work with London partners to shape suitable devolution to support this. This will be done primarily through the pilots, but they also offer a continuing dialogue with London partners on other issues arising which would support health and social care integration and devolution, such as capital and estates, system finances, workforce and skills, and public health.

3.12 The London Agreement reinforces the importance of locally owned and shaped solutions for health and care. The Devolution Agreement provides an important step towards devolution to local and sub-regional partnerships to reinforce that. The London approach will be developed on three geographical levels: local, sub-regional and pan-London. The shape and pace of the spread of devolution across London will vary according to the strategy ad readiness to progress of each locality and sub-region.

3.13 Pilots will have full programme plans in place from April 2016, with a clear identification of the specific powers and resources of which they will be seeking devolution.

3.14 The risks to the London Health and Care Collaborative will be identified at a pan-London level. There will be separate risks attached to any proposed pilot schemes at a local, regional and pan-London levels and theses will be identified as part of scoping the pilots.

4.0 Financial Implications

4.1 To be confirmed.

5.0 Legal Implications

5.1 To be confirmed.

6.0 Diversity implications

6.1 London's model of reform aims to address the whole health and care system to enable a rebalancing towards prevention, early intervention; supporting independence and wellbeing. It aims to engage and empower the diverse communities of Brent and the wider health economy across London to deliver improved clinical outcomes and patient experiences.

7.0 Staffing/Accommodation Implications

7.1 To be confirmed.

Appendix

Draft London Health and Care Collaboration Agreement.

Contact Officers

Name: Carolyn Downs
Job title: Chief Executive, Brent Council

Name: Rob Larkman
Job title: Chief Officer, Brent CCG

London Health and Care Collaboration Agreement

1. Purpose

The central purpose of the initiative supported by this Agreement is to ensure the widest and fastest improvement in the health and well-being of 8.6 million Londoners through a transformation in the way that health and care services are delivered, how they are used and how far the need for them can be prevented.

To that end this document sets out a collective agreement by London and National Partners to transform health and wellbeing outcomes, inequalities and services in London through new ways of working together and with the public. It describes our goals for achieving these results and the principles which guide us in transforming health, health care and social care. At its heart is the reform and updating of the way that public services are provided. Devolution is a small but essential component unlocking far broader changes and accelerating integration and more effective collaboration in London.

The Agreement reports how this will be achieved and in doing so it confirms support for this approach by all signatories; both London and national. This Agreement builds on the vision for health and care set out by London Partners in March 2015[i] and London's response to the invitation by HM Treasury to submit devolution proposals as part of the 2015 Spending Review[ii],[iii].

2. Parties

The Parties to the agreement are:

- All 32 London Clinical Commissioning Groups (CCGs),
- All 33 local authority members of London Councils
- The Mayor
- NHS England
- Public Health England

The term 'London Partners' encompasses all 32 London Clinical Commissioning Groups (CCGs), all 33 local authority members of London Councils, the Greater London Authority, NHS England London Region and Public Health England London Region.

All parties agree to act in good faith to support the objectives and principles of this agreement for the benefit of all Londoners.

3. Aspirations and objectives

The parties have a shared commitment to deliver on the 10 aspirations to promote health and wellbeing set out in Better Health for London: Next Steps and, in doing so, deliver on the NHS Five Year Forward View and secure the sustainability of health services and social care.

Aspiration	2020 Ambition
Give all London's children a healthy, happy start to life	Ensure that all children are school-ready by age 5 Achieve a 10% reduction in the proportion of children obese by Year 6 and reverse the trend in those who are overweight
Get London fitter with better food, more exercise and healthier living	Help all Londoners to be active and eat healthily, with 70% of Londoners achieving recommended activity levels.
Make work a healthy place to be in London	Gain a million working days in London through an improvement in health and a reduction in sickness absence.
Help Londoners to kick unhealthy habits	Reduce smoking rates in adults to 13% - in line with the lowest major global city and reduce the impact of other unhealthy habits.
Care for the most mentally ill in London so they live longer, healthier lives	Reduce the gap in life expectancy between adults with severe and enduring mental illness and the rest of the population by 5%.
Enable Londoners to do more to look after themselves	Increase the proportion of people who feel supported to manage their long-term condition to the top quartile nationally.
Ensure that every Londoner is able to see a GP when they need to and at a time that suits them	Transform general practice in London so Londoners have access to their GP teams 8am-8pm, and primary care is delivered in modern purpose-built/designed facilities.
Create the best health and care services of any world city, throughout London and on every day	Work towards having the lowest death rates for the top three killers. Close the gap in care between those admitted to hospital on weekdays and at weekends.
Fully engage and involve Londoners in the future health of their city	Achieve 10 basis point improvements in polling data on how organisations that deliver health or health-related services engage Londoners in service design.
Put London at the centre of the global revolution in digital health	Create 50,000 new jobs in the digital health sector and ensure that innovations help Londoners to stay healthy and manage their conditions.

To meet these aspirations, the parties share the following objectives:

- To achieve improvement in the health and wellbeing of all Londoners through a stronger, collaborative focus on health promotion, the prevention of ill health and supporting self-care
- To make rapid progress on closing the health inequalities gaps in London
- To engage and involve Londoners in their health and care and in the health of their borough, sub-region and city including providing information so that people can understand how to help themselves and take responsibility for their own health
- To improve collaboration between health and other services to promote economic growth in the capital by addressing factors that affect both people's wellbeing and their wider economic and life opportunities, through stronger partnerships around housing, early years, employment and education
- To deliver integrated health and care that focuses on maximising people's health, wellbeing and independence and when they come to the end of their lives supports them with dignity and respect
- To deliver high quality, accessible, efficient and sustainable health and care services to meet current and future population needs, throughout London and on every day. To reduce hospitalisation through proactive, coordinated and personalised care that is effectively linked up with wider services to help people maintain their independence, dignity and wellbeing.

- To invest in fit for purpose facilities for the provision of health and care services and to unlock the potential in the health and care estate to support the overall sustainability and transformation of health and care in the capital
- To secure and support a world-class workforce across health and care
- To ensure that London's world-leading healthcare delivery, academic and entrepreneurial assets provide maximum benefit for London and the wider country and that health and care innovation is facilitated and adopted in London.

4. Principles

All parties have agreed key principles for reform and devolution:

- Improving the health and wellbeing of Londoners will be the overriding driver for reform and devolution.
- We will work to secure a significant shift from reactive care to prevention, early intervention, self-care and care close to home that supports and enables people to maximise their independence and wellbeing.
- London will remain part of the NHS and social care system, upholding national standards and continuing to meet and be accountable for statutory requirements and duties, including the NHS Constitution.
- Joint working will improve local accountability for services and public expenditure. Where there is local agreement to change accountability arrangements, accountability to NHS England will be maintained – in relation to issues including delivery of financial requirements, national standards and the NHS Constitution. Changes to current accountabilities and responsibilities will be agreed with government and national bodies as necessary and may be phased to balance the pace of progress with ensuring a safe transition and strong governance. We commit to fulfil the legal requirements for making significant changes to commissioning arrangements.
- Decision-making will be underpinned by transparency and the open sharing of information between partners and with the public.
- Transformation will be locally owned and led and will aim to get the widest possible local support. We will ensure that commissioners, providers, AHSNs, patients, carers, the health and care workforce, the voluntary sector and wider partners are able to work together from development to implementation to shape the future of London's health and care.
- All decisions about London will be taken in or at least with London. Our goal is to work towards resources and control being devolved to and within London as far as possible, certainly in relation to outcomes and services for Londoners.
- Collaboration and new ways of working will be needed between commissioners, providers, patients, carers, staff and wider partners at multiple levels. Recognising that the London system is large and complex, commissioning and delivery will take place at three levels: local, sub-regional or pan-London. A principle of subsidiarity will underpin our approach, with decisions being made at the lowest appropriate level.
- Given London's complexity we recognise that progress will happen at different paces and in different orders across the different spatial levels. We will ensure that learning, best practice and new models for delivery and governance are shared to support and accelerate

progress in all areas. Subsidiarity as a principle will extend to the adoption of ideas piloted in other areas to allow flexibility and adaptation to local conditions.

- The people that work in health, health care and social care are critical to achieving London's transformation goals. We will build on London's position as the home of popular and world-class health education, to develop new roles, secure the workforce we need and support current and future staff to forge successful and satisfying careers in a world-class London health and care system.
- We recognise that considerable progress can be made, building on existing foundations, with existing powers and funding – and we are committed to doing so. But devolution is sought to support and accelerate improvements. A series of devolution pilots will be established through which detailed business cases for devolution of powers, resources and decision-making can be developed in partnership with government and national bodies. Through these, devolution may be secured both for the pilots themselves and also for other parts of London, contingent on these areas also developing suitable plans, delivery and governance arrangements.
- While embedding subsidiarity, we will ensure the strategic coherence and maximise the financial sustainability of the future health and care system across London. Political support for jointly agreed change will be an important feature of the arrangements. New London-level arrangements, including governance and political oversight, will be established to secure this. We commit to minimising bureaucracy as much as possible to enable delivery of local innovation.
- In 2016/17 - and drawing from the experiences of the pilots - sustainability and transformation plans for health and care will be developed as part of NHS and local authorities' planning arrangements. These will draw on learning from the devolution pilots, other transformation initiatives including the Vanguard programme and any London-wide initiatives. A London-level picture, drawn from sub-regional health economy plans, will enable oversight of the impact on health outcomes and financial sustainability of the system across the capital.
- We recognise that London provides expertise and services for people who live outside the capital and that benefit the country more widely. London will work collaboratively with other regions and national bodies to consider and mitigate the impact of London decisions on surrounding populations reliant on London-based services.

4. Scope of Intervention

London's Health Proposition covers all aspects of health and care, specifically:

- primary care
- acute care (including specialised commissioning)
- community services
- mental health services
- social care (adult and child)
- public health, including maximising opportunities to influence wider determinants of health

Key enablers will include:

- devolution of funding and commissioning powers as agreed with the relevant national bodies
- additional fiscal and regulatory powers devolved to promote health through planning, licensing and employment support
- changes to governance and regulation
- joint capital strategic planning
- joint workforce strategic planning
- full involvement in development of new payment mechanisms to support new models of care
- full involvement in decisions about provider performance

5. Spatial levels for London Intervention

The London approach will be developed on three geographical levels: local, sub-regional and pan-London. There is recognition that acute service transformation will require collaboration across sub-regional footprints and place based budgets will support the linkages between locally led out of hospital transformation and sub-regionally co-ordinated hospital network transformation.

Core components of the London approach across the three geographical levels for action will include:

Locally:

- joint multi-year local integration planning, supporting Health and Well Being Board strategies, to secure increased prevention, early intervention, personalisation and integrated out of hospital health and care services – and alignment of provider plans
- aspiration to achieve full pooling and joint commissioning of NHS, social care and public health commissioning budgets through s75 agreements
- local public asset plans and scheme development to secure facilities to deliver accessible, multi-purpose, integrated out of hospital services and build on local schemes in place to provide other public sector services

Sub-regionally:

- Delivery of local Health and Well Being Board aspirations through accountable strategic partnerships based on joint committees established to lead transformation at sub-regional scale
- Joint health and care strategies to develop new models of care across acute, primary and social care settings
- Joint commissioning to secure delivery of sub-regional plans that are clinically and financially sustainable for all parts of the health and care system within the geography
- Sub-regional estate plans and scheme development to unlock redevelopment of un- or under-used NHS estate, aligned with local public asset planning

Pan-London:

- The London Health Board, chaired by the Mayor of London, will provide political leadership, oversight and support for the London strategy including delivery of the

ambitions of Better Health for London and commitment to the vision set out in the Five Year Forward View

- A pan-London Health and Social Care Devolution Programme Board (the "Devolution Programme Board") will support and account to the London Health Board. Members will represent their organisations and partnerships to support devolved working at all levels. Initially this Board will not have statutory or legal responsibilities but will provide oversight and steering of the devolution programme, including supporting the devolution pilots. Its role will be reviewed as devolution occurs and where this necessitates the need for pan-London co-ordination and decision making.
- A partnership for strategic estate planning, fully aligned with the London Land Commission and sub-regional strategies, to unlock the value of the health and care estate
- Workforce planning and skills development to match the pace of health system transformation
- Collaboration to support city level action to address the wider determinants of health where this is the most effective scale; including transport, planning, regulatory and fiscal interventions to support the public health agenda.
- Development of London wide financial and other frameworks, such as new payment models, for use at sub-regional and local level.

London Partners are committed to progress improvements as swiftly as possible within their existing powers and resources, building on a growing range of activity including the Healthy London Partnership and London Prevention Board, co-commissioning arrangements already underway in almost all CCGs with the aspiration to extend this across London, experiences of the Better Care Fund, integration pioneers and NHS Vanguards, as well as strategic impetus created through Health and Wellbeing Boards. CCGs have organised into sub-regional strategic planning groups and London's boroughs are working with CCGs and NHSE to accelerate progress within existing powers, including developing joint sub-regional arrangements[iv].

London Partners are also seeking devolution of functions, powers and resources from government and national bodies where that can assist, enable or accelerate improvements. London seeks to draw from and develop the menu of asks described in the London Proposition submission to HM Treasury[iii]. Recognising the size and organizational diversity of London's health and care system, London will test different elements of greater integration, collaboration and devolution in different parts of the system. A series of pilots are being established through which detailed cases for new devolved powers, resources and authority will be developed in partnership with government and national bodies to produce faster transformation than can be achieved in the current system. A co-production approach between local and national partners is intended to facilitate ultimate decisions on devolution – both by national bodies to devolve and by local bodies to 'receive' devolution.

Devolution agreements reached through individual pilots will be converted into contingent menus of devolution opportunities open to other localities and sub-regional partnerships across London. London partners will support the pilots to:

- develop their devolution business cases;
- draw insights from the pilots and other major initiatives to:

    - inform a strategic view on the implications for sustainable and high quality health and care across the whole of London;
    - ensure the learning from pilots is made available to other parts of London; and
- agree with national partners the conditions other parts of London would need to satisfy to unlock devolution from the contingent menus to support and accelerate their own transformation plans.

The shape and pace of the spread of devolution across London will vary according to the strategy and readiness to progress of each locality and sub-region.

Pilots will have full programme plans in place from the beginning of April 2016, with a clear identification of the specific powers and resources of which they will be seeking devolution. They will also have put in place the arrangements for taking these programmes forward, including securing appropriate input from London and National Partners. Each pilot plan will set out clear timelines, but the expectation is that the devolution of specific powers and resources required by the pilots will be negotiated during 2016/17 with a view to powers being operational from April 2017. This will be supported by robust governance arrangements and a clear delivery plan.

The London devolution pilots will explore four themes:

- Sub-regional care integration – Barking & Dagenham, Havering and Redbridge (Outer North East London)
- Sub-regional estates – Barnet, Camden, Enfield, Haringey, Islington (North Central London)
- Local care integration – Hackney (including the Borough of Hackney and City & Hackney CCG); Lewisham
- Local prevention – Haringey

Statements of support from partners in the pilot areas are annexed in Appendix 1.

In line with commitments by all partners to the 10 aspirations for London, action will be taken on obesity at all levels across London, with all partners acting within their spheres of influence and exploring the potential for further actions in collaboration.

A partnership for strategic estate, aligned with sub-regional strategies, will unlock the value of health and care estate by working at local, sub-regional and London level. The London Land Commission will be a key partner, with strategic alignment of objectives, operational synergies as appropriate and cross-representation of membership.

6. Commitments by partners

The partners to this agreement commit themselves not only to collectively working to support the success of the London intervention and partnering with pilots, but also to contribute in specific ways as follows:

NHS England

- Will actively facilitate links to other national bodies across the NHS (including NHS Improvement and Health Education England). In particular, NHS England is committed to working with London to support progress towards greater involvement of London partners in decisions about provider performance and to support an integrated approach to workforce strategy across London.
- Commits to supporting the design and delivery of innovative models of health and care delivery as set out in the Five Year Forward View and Better Health for London, and use the learning from pilots to support national delivery of new models of care and efficiency.

Public Health England

- Commits to actively facilitate links to other public health bodies in order to accelerate the rate at which the system improves health outcomes for Londoners.
- Commits to supporting prevention and health promotion elements of all London pilots.

London Boroughs and London CCGs

- Where they are part of a London pilot, commit to working for the success of the pilot and the swift and successful transfer of learning and new powers to all other parts of London.
- Where they are not members of pilots, commit to continue to work together to improve health outcomes and to ensuring their readiness to swiftly take advantage of the outcomes of London pilots.
- Commit to developing sustainability and transformation plans for health and care to 2020/21 at all three geographic levels as part of NHS and local authorities planning arrangements to deliver rapid progress towards financial balance and improved outcomes. This aligned with the Five Year Forward View will describe how a clinically and financially sustainable landscape of commissioning and provision could be achieved, subject to the resource expectations set out in the Five Year Forward View, appropriate transition funding being available and the full involvement and support of national and other partners.

The Mayor and GLA

- Commit to continued working on behalf of London to encourage national government to support faster transformation in health outcomes for Londoners.
- Commit to leading a coalition of London government in engagement with Londoners on the future shape and priorities of their health and care system.
- Commit to ensuring that the London Land Commission supports and facilitates a strategic approach to health and care capital & estate management and supports the work of the sub-regional estates pilot.
- Commit to exploring planning, regulatory and fiscal levers to support the prevention agenda
- Commit to delivering health promotion and prevention programmes that support local action including action on obesity and air quality, the Healthy Schools London programme and the London Healthy Workplace Charter
- Commit to work with London partners to revise the Health Inequality Strategy and coordinate activity on city-wide elements (e.g. transport, airport quality) to reduce health inequalities

London partners will continue to deliver the NHS Constitution and Mandate and ensure clear accountability, governance and value in relation to the health funds delegated or devolved to London.

6. Engagement

Building on the public and stakeholder engagement undertaken by the London Health Commission, we commit to significant public and patient engagement at local, sub-regional and – where appropriate – London level to support co-development of pilots and wider devolution plans. Building on our asset-based approach, we will ensure that all partners – including Londoners, health and care commissioners, providers, AHSNs and the voluntary sector - are able to work together from development to implementation to shape the future of health and care.

7. Governance for the set-up phase

Governance mechanisms will reflect pan-London, sub-regional and local working, underpinned by subsidiarity, with decisions taken at the most local level, consistent with the principles underpinning devolution.

The local and sub-regional pilots will form the heart of the set up phase, testing how the principles of greater collaboration, integration and devolution are applied in practice. Governance arrangements must be co-developed, owned and agreed by local partners. They will therefore be developed by individual pilots and may take different forms in different areas. We expect that key principles would underpin these governance arrangements:

- Health and care commissioners will jointly develop, engage on and deliver strategic plans, with joint decision-making and pooled resources where possible
- Providers will be key partners in plans, engagement and implementation
- Robust mechanisms will preserve financial and clinical accountability to relevant bodies
- Individual pilots will work with other devolution pilots and at sub-regional and London level to share learning and, where appropriate, to undertake strategic or enabling activities together
- Devolved decision making and resources from relevant bodies would be released based on the decision-making criteria published by those bodies, working in partnership to meet this threshold.

At the local level, governance will:

- Seek to maximise pooling of finances compatible with the local context
- Appropriately engage the public, providers and other interested parties

At sub-regional level, governance will:

- Free members to act in line with the interests of the area covered by the partnership
- Ensure decision making on an equal footing between places and types of institution

At London level, governance arrangements for the set up phase will:

- Exercise appropriate pan-London functions from the London Partners agreement with central government and national bodies and oversee the development of those areas of devolution where partners agree pan-London working is desirable

- Set up London health and care devolution: Support the devolution pilots in their development of the business cases for full devolution at sub-regional and local levels and extrapolate from the learnings of pilots, other transformation initiatives and sub-regional health economies sustainability and transformation plans to develop a London level picture of the impact on health outcomes and financial sustainability of the system across the capital
- Facilitate links to national bodies to support the devolution pilots
- Consider equity for populations within and between pilots, and across London boundaries
- Oversee delivery of the Better Health for London ambitions and commitment to the vision set out in the Five Year Forward View

These functions will evolve as the set up phase draws to an end and devolution is implemented. The governance arrangements will therefore also change.

The functions of this set up phase will be administered by building on existing structures:

- The London Health Board, chaired by the Mayor, will provide political leadership, oversight and support for the London strategy.
- A Devolution Programme Board will be established in January 2016 accounting to the London Health Board. Initially this Devolution Programme Board will not have statutory or legal responsibilities but will provide strategic and operational oversight and steering of the devolution programme, including supporting the devolution pilots. The Devolution Programme Board will not affect or replace the statutory responsibilities and accountabilities of each partner. The Devolution Programme Board will also be accountable to the individual Parties of the Agreement through their respective membership. The Devolution Programme Board will include two representatives of each constituent partner within the London Health Board:

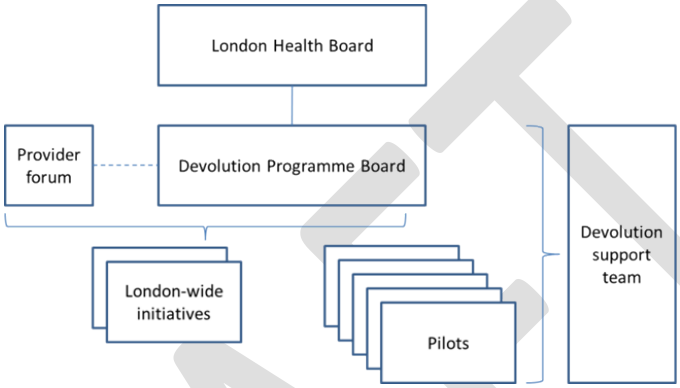
Local authorities	Two representatives appointed by London Councils
London CCGs	Chair of London Clinical Commissioning Council and Chair of London CCG Chief Officers Group
GLA	Head of Paid Service; Director, Health and Communities
PHE	Regional Director; Deputy Regional Director
NHS England	Regional Director; Regional Finance Director
Invited members:	Devolution Programme Director
	NHS Improvement
	NHS England
	Public Health England
	Central government partners as appropriate

- The Devolution Programme Board will provide assurance to all parties that the key objectives are being met and that the programme is performing within the boundaries and principles set by the Agreement.
- The Devolution Programme Board as proposed would not have the statutory responsibility to hold budgets. If delegated or devolved budgets were to be granted to London, a formal joint committee with statutory responsibility, or fund-holding by a partner organisation with delegation would need to be agreed by all partner organisations. Board members would

then need the ability to act on behalf of regional and local partners to agree strategic priorities and to create frameworks that support devolved working at all levels.

- It is recognised that no collaborative provider forum formally exists in London. One of the tasks of the set up phase will be to support providers to come together to engage in cross-sector collaboration and provide a robust mechanism for collective decision-making. Providers will be invited to propose their preferred method for engagement with devolution discussions.

The proposed governance structure for the set up phase is outlined below:



7. Timetable for Action

January 2016

- Pilots develop business plans for delivery and clarify devolution asks, in partnership with national organisations
- London Devolution Programme Board established and resource commitments secured

By April 2016

- Providers establish their preferred form of arrangements to enable them to provide a collective response to the London project.

From April 2016

- All pilots complete business plans, confirm new models of working and negotiate devolution to support delivery (each pilot will set out a clear programme and timeline for its work).
- Formal local government involvement in sub-regional health and care strategies.

By June 2016

- Sustainability and transformation plans for health and care developed at local and sub-regional level as part of NHS and local authorities' planning arrangements.

By December 2016

- An agreed London level picture of the impact on health outcomes and financial sustainability of the system across the capital, extrapolating from the learnings of pilots, other transformation initiatives and local and sub-regional health economies' plans, enabling strategic plans at all three geographic levels.

By April 2017

- Menus of devolution agreed and available for local and sub-regional partnerships in London.
- Pilots commence devolved arrangements subject to robust plans and governance arrangements.
- Local and sub-regional areas across London explore when and how to draw down these powers to unlock and accelerate their improvement plans and commence development of detailed plans and governance and accountability arrangements.

By April 2019

- Significant progress on transformation across the whole of London, demonstrably unlocking long-standing problems and improving outcomes and efficiency

8. Support structure and resources

The London Health proposition will be supported by full-time resources including a Programme Director and dedicated team.

- The programme team will be accountable to the Devolution Programme Board.
- All London Health Board partners will contribute to resourcing the programme in cash and in-kind support.
- In addition, pilot areas will contribute in part to resourcing individual pilots.
- London Health Board resources will be directed to support this work. Additional funding will be required to support the transformation process and a full programme and resourcing plan will be agreed with all parties in January 2016.

Appendix: Statements of support from health and care partners in pilot areas

[DN: to be added]

[i] Better Health for London: Next Steps March 2015
[ii] HM Treasury A country that lives within its means: spending review July 2015
[iii] The London Proposition: Health section. 4 September 2015
[iv] London Councils Leaders Committee, July 2015 : http://www.londoncouncils.gov.uk/node/26669

Brent

NHS Brent Clinical Commissioning Group

Brent Health and Wellbeing Board

26 January 2016

Report from Chief Operating Officer, Brent Clinical Commissioning Group and Strategic Director Community Wellbeing, Brent Council

Wards affected: ALL

Update on winter pressures

1. **Summary**

1.1 The purpose of this report is to update the Health and Wellbeing Board on the actions implemented in response to additional winter pressures; the longer term approach to managing these additional pressures; the mechanisms that underpin joint working; and the impact of this as far as it can be measured at this point, half way through winter.

2.0 Recommendations

2.1 The Health and Wellbeing Board is requested to:

- Note the report, receive assurance that plans and governance mechanisms are in place to support NHS resilience over the winter so that patients get swift access to safe services

- Comment on the strategic direction ahead of a full paper being brought to the March Health and Wellbeing Board as part of the sign off of the 2016/17 Better Care Fund plan.

3. Introduction

3.1 In November 2015, the Health and Wellbeing Board received a report highlighting increased demand in hospitals in winter, and the increased strain this puts on all parts of the health and social care economy. The report stressed the importance of partnership working, where there is not full integration, to system resilience. In other words, the importance of working together across health and social care organisations to support Brent residents.

3.2 Partnership working is even more important when you consider the fact that:

- A substantial proportion of Brent residents that go to hospital attend a London Northwest Hospital Trust hospital, but significant number also attend other Trusts including the Royal Free and Imperial (St Mary's).

- London North West Hospital Trust provides healthcare for people from a range of boroughs other than Brent, most notably Harrow and Ealing, with each borough having its own policies and services across health and social care, creating particular challenges for the hospital.

3.3 Although it has been a mild winter so far, and we haven't yet experienced a significant spike in demand, we are only half way through the winter period, which means there is no room for complacency. Moreover, while winter is clearly a period of particular pressure on the system, the increasing demographic pressures in the system mean that responding to winter this year is a fundamental part of establishing sustainable year-round delivery for the future.

4. Update on actions for Winter 2015/16

4.1 The response to winter is based on core health (acute and community), social care and housing services. An overview of the additional initiatives in place or being planned for immediate implementation are attached at Appendix 1.

4.2 It is worth noting a number of particularly important initiatives:

- The 22 residential and nursing beds jointly commissioned by Brent Council and Brent CCG. The beds are specifically commissioned, based on analysis of last winter and predicted demand for this winter, to meet the needs of the hospital discharge pathway, including access 7 days a week and streamlined assessment processes in the care home to ensure easy access. The beds were live for the start of winter, and after some teething issues we are currently fully operational
- 7 day social care working commenced in January 2016 with social workers in London NorthWest Hospital Trust to facilitate social care discharges 7 days a week. The social workers have access to specifically commissioned homecare provision to ensure social workers can assess

and discharge. The numbers being discharged at the weekend are currently relatively low and this will need close monitoring and evaluation of the pilot to determine effectiveness.

- 4 of the 16 hospital discharge social workers are now based at Northwick Park, to facilitate ward based working
- There is now some dedicated housing support to London NorthWest Hospital Trust. This has been in place since the end of November to help discharges where the person funds themselves homeless whether that meets the Council's statutory threshold or not.

4.3 The Council and CCG are jointly funding these additional initiatives in order to test 'what works'. As part of this approach we have also invested in additional analytical capacity to compile health and social care datasets and provide better analysis for long term planning.

4.4 While a number of key initiatives are in place, there is still more to do this winter:

- Additional work stations are being sought for a further 10 social workers to be based at Northwick Park Hospitals and discussions have started about providing similar access at other Trusts ahead of the West London Alliance pilot commencing.

- There is still a need to test 'trusted assessor' social care hospital discharges as proposed in the West London Alliance pilot. The pilot would allow the borough the hospital is located in, to discharge all patients for other Boroughs, overcoming some of the issues hospitals face when trying to support people home to a number of London boroughs.

- The Emergency Care Improvement Programme, an NHS led initiative to improve health and social care system performance, is currently working with LNWHT and system partners. A focus of this work is on processes relating to discharge arrangements and data sharing improvements. For example, they are aiming to reduce the 40% inappropriate referrals that are currently made which would increase existing capacity.

5.0 Current strategic direction for 2016/17

5.1 The current BCF schemes have all been delivered or are close to the point of delivery. While there will clearly be a need to monitor and potentially review these new services to ensure they make the impact they are planned to make, the focus is inevitably shifting to new priorities, particularly because as a system we need to develop:

- The Brent Better Care Fund (BCF) plan for 2016/17 – submission April 2016, and;

- Aligned to the Five Year Forward View, a System Transformation Plan (STP) – submission June 2016.

5.2 A joint Adult Social Care / CCG departmental team workshop has started this process of defining the new priorities, and the process will continue over the next 2 months before coming back to the Health and Wellbeing Board for sign off in March 2016.

5.3 As part of this work, there will be a number of key proposals. The first will be to align:

- the original ambition from the 2015/16 BCF priorities: to design and implement a fully integrated hospital discharge function which includes Trust, social care, CCG and housing discharge related staff, and

- the full implementation of the WLA proposal – which means that this integrated discharge team discharges all patients from the hospital whichever borough they live in.

5.4 In addition, to integrating the discharge teams, we will need to ensure the services in the community are able to respond effectively. The Integrated Rehabilitation and Reablement Service, which will go live in April 2016 is an example of a service designed to respond to a new approach to discharges with its clear focus on ensuring easy access to individually tailored support to help people to go back and live in their own home or place of residence. However, as part of the BCF planning, we will also need to identify and prioritise the other services that need to respond more effectively to this new approach to discharge, including community nursing, GP services and for those who are not able to live at home residential and nursing care homes.

5.5 Finally, it is important to note the work of the Outcome Based Review – Housing for Vulnerable People, and how it must align to the BCF planning. This OBR is being led by the Council with the involvement of the CCG to ensure that it addresses housing issues that have been identified as barriers within the health and social care system. The OBR will not report until after the deadline for 2016/17 Better Care Fund plans, but this is not expected to be a barrier to delivering significant change if it is required.

6. Mechanisms in place for joint working / dialogue

6.1 Given the pressures on the system, the complexities of the system, and the need to drive continuous improvement at the same time as designing transformational change, governance is crucial. The mechanisms set out below do not replace the core decision making processes in the individual partner agencies, but they provide the forums to tackle operational and strategic challenges. They range from:

- Daily Call - Brent and Harrow system wide conference call to deal with day to day operational pressures, and agree and escalate individual issues within and across organisations
- System Resilience Operational Group (SROG) – Brent and Harrow system wide weekly meeting of senior operational managers to oversee delivery of core services in line with operating procedures
- Systems Resilience Group (SRG) – Brent and Harrow system wide monthly meeting (national guidance requires every system to have an SRG) of strategic senior managers to manage system (pressures)
- Brent Integration Board - senior strategic Brent managers with a focus on long term transformation of services for Brent residents. It is responsible for developing and delivering the Brent Better Care Fund plan, and reports to the Brent HWBB.

6.2 There is a strong commitment across all key agencies to these meetings as the mechanism for managing the system. The strengths of this approach lie in the operational accountability it delivers. The area for improvement in this approach is ensuring there is sufficient focus on long term transformation. However, the increased focus on this agenda by the Health and Well Being Board and the process for setting the 2016/17 priorities offer a clear opportunity to address this.

6.3 The aim is to use an evidenced based approach to anticipate how and where in the system increased demand is likely to be present, and inform the planning of appropriate inter-agency responses to ensure that no part of the system is overwhelmed or unable to function.

7.0 Impact of winter pressure actions / current system position

7.1 These initiatives are starting to show some early signs of impact but there is a degree of caution given that it has been a relatively mild winter to date and winter is only half way through. Accident and Emergency performance at Northwick Park Hospital (LNWHT) has been improving in terms of 4 hour breaches and is currently above the same period last year. The focus on Delayed Transfers of Care has seen a 60% reduction in delays at LNWHT. At the end of December, the number of delays was 35 with only 2 being attributed to Brent and Harrow. These are positive improvements so far.

7.2 The performance of winter resilience initiatives are monitored monthly by the Brent and Harrow System Resilience Group. This enables early system responses to identified issues across partners within the health and care economy.

7.3 As illustrated above, there are cautious and early signs of the constructive and effective partnership working between LNWHT, Brent CCG and Brent Council, despite difficult and contentious issues that have to be resolved. The partnership operates effectively and will ensure collective learning from a range of joint initiaves in place this winter (as described above) will inform

16/17 winter plans thereby ensuring that we have a proactive rather than reactive approach to winter planning going forward.

8. Financial Implications

8.1. This paper is an overview of the system and changes, which seek to meet individual need more appropriately, individual implications to be confirmed through individual service changes.

9. Legal Implications

9.1. This paper is an overview of the system and changes, which seek to meet individual need more appropriately, individual implications to be confirmed through individual service changes.

10. Diversity implications

10.1. This paper is an overview of the system and changes, which seek to meet individual need more appropriately, individual implications to be confirmed through individual service changes.

11. Staffing/Accommodation Implications

11.1. This paper is an overview of the system and changes, which seek to meet individual need more appropriately, individual staffing implications to be confirmed through individual service changes.

Appendix
Overview of winter pressure initiatives

Background Papers
Brent Winter Plan and Better Care Fund Report – November 2015 HWBB

Contact Officers

Name: Phil Porter
Job title: Strategic Director, Community Wellbeing, Brent Council

Name: Sarah Mansuralli
Job title: Chief Operating Officer, Brent CCG

- 22 beds jointly commissioned
- 8 reablement beds + 8 residential beds available + 6 nursing bed
- Step down bed team in place managing access and exit
- Agreed criteria and processes in place
- Agreed measures/KPIs /monitoring and reports in place

- Housing officer based in hospital to support discharge, and housing escalation process
- Night sitting service (3 nights to support discharge)
- 7 day working, social and homecare capacity
- Additional Social Worker capacity to meet increased demand for assessments DTOC
- OD support to establish effective ways of working

- Check SRG plan and Trust action plan
- Emergency Care Improvement Programme

- Brent Council responsible for all hospital discharge from LNWHT (covering residents Brent, Tri-borough, Harrow, Ealing, Hillingdon)

- New model for Single Point of Access
- Single/standardised discharge/community referral form

- ASC discharge staff Co-located in the hospital
- Social Care staff operating in new way (e.g. part of ward round etc)
- Educating ward staff on appropriate referrals into ASC
- Combining all discharge functions (e.g. hospital

- Daily DTOC call
- SRG meeting
- Brent Integration Board
- Commissioning of Community beds

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Health and Wellbeing Board
Update on Priorities
January 2016

Title of Priority: Improving Mental Wellbeing throughout Life

Responsible officers: Duncan Ambrose, Brent CCG and Phil Porter, Brent Council

Key forums: North West London Like Minded Board, Brent Mental Wellbeing Board (BMWB), Mental Health Employment Task and Finish Group; Joint contract performance meeting for secondary MH services.

Summary of objectives

Indicative until the (BMWB) proposes objectives to be agreed by HWBB:

- Integrated commissioning for Mental Health across CCG, Council (including ASC, housing and public health):
  - short term (2016/17) across supported living and preventative services
  - medium term (2017/18) across all services and support
- Ensure crisis and urgent care pathways have adequate connectivity to other partner agencies, particularly the police, probation, and substance misuse services.
- Develop less restrictive, local options for people with a learning disability who have challenging behaviour related to a mental illness.
- Reduce reliance on in-patient mental health services for people who could be safely treated in the community. Build on the recovery pathway for secondary mental health service users delivered with Central North West London in 2015/16, with a focus on better connections from specialist services into the recovery pathway
- Align community and universal services as a route out, and challenge discrimination and stigma in local communities, and support those communities to deliver stable accommodation, stable employment, and stable social networks.
- Continued focus on improving access to employment and housing as a means to support people to be independent
- Improve access to psychological therapies (step 3 interventions) to supplement community-led work to raise awareness (step 1), guided self-help (step 2), and self-referral. Ensure clear links to employment services and community champions are sustained.
- Recognise the vulnerability of people with a mental illness, and ensure support for people with a mental illness keeps them safe.
- Ensure support is available to carers of people with a mental illness.

Progress achieved to date

- Implementation of a recovery focused operating model across Community Mental Health Teams
- Nov 2015 introduction of 24/7 telephone advice line as the single point of access (SPA) for patient enquiries, professional advice, referrals, and bookings; supported by a 24/7 Home Treatment and Rapid Response Team (HTRRT) for community-based mental health assessments.
- From HWBB mandate first of two MH workshops to align and jointly plan for mental wellbeing strategy
- Employment task and finish group set up to lead the implementation of key employment initiatives in 2016 (WLA MH Employment Trailblazer, Big Lottery Individual Placement and Support pilot and Motivational and Psychological Employment Support – over £1m investment in 2016)
- Integrated commissioning and overview of core secondary mental health services.
- Nov 2015 introduction of sustainable model for Liaison Psychiatry in A&E and

physical health acute wards.
- Liaison and Diversion Mental health worker in Wembley police station as part of a Ministry of Justice pilot.

Planned actions for next quarter

- Development of viable model for two-week access to treatment for first episode psychosis.
- MH Employment task and finish group to continue the work to prepare for initiatives (WLA trailblazer first project to go live in April 2016) and ensure full engagement with primary care
- Second MH strategy workshop (18 February) in preparation for first BMWB
- BMWB scheduled for 24 February – Chair Cllr Hirani, Vice Chair, Sarah Basham. Purpose - working to the HWBB, to lead a whole system response to the promotion of adult mental wellbeing
- Based on this strategy and working with the BMWB define the BCF – MH workstream
- Development of viable models of care for street triage, and community alternatives to in-patient care; include of physical health, substance misuse, and social care risk management in care planning.
- Establish operational link between Liaison and Diversion worker, substance misuse services, and the adult mental health urgent care pathway.

Risks and mitigating actions

- 'Giving Every Child the Best Start in Life' includes mental well being for children – we will need to ensure that through the HWBB we do not create gaps and we ensure these two pieces of work are aligned for a lifetime approach to mental well being
- Like Minded health initiative – this is a NWL programme aiming to provide a multi-agency platform for mental health strategy alignment. Initial links have been made to HWBB and individual partners. We need to ensure that we remain focused on the needs of Brent residents and influence and draw on the NWL work where appropriate.

Health and Wellbeing Board
Update on Priorities
January 2016

Title of Priority: Improving Mental Wellbeing throughout Life
Responsible officers: Sarah Mansuralli, Brent CCG and Phil Porter, Brent Council
Key forums: Brent and Harrow Systems Resilience Group, Brent Integration Board

Summary of objectives

Current objectives as outlined in the Brent Better Care Fund plan:

- Keeping the most vulnerable well and independent in the community – otherwise known as Whole Systems Integrated Care
- Avoiding unnecessary hospital admissions - holistic crisis response services to ensure only people who need to go to hospital go (re-design of STARRS (short term rehabilitation and reablement services))
- Sustainable hospital discharge - integrated hospital discharge services that ensures a safe discharge
- Wherever you are in the system, ensuring easy access to an Integrated Rehabilitation and Reablement services to support you to live independently.

Progress achieved to date

- WSIC – summary of key change for 16/17 (working towards codesigned model) for revalidation with GP Networks end Jan. Plans in development with LNWHT to align District Nursing teams to the model (due Feb). Opportunities to embed support for self-care (via evidence-based Patient Activation Measure & 3rd sector Care Navigators) being reviewed at workshop 3rd Feb with Networks, CVS Brent, voluntary sector, Lay Partners. Communication materials on sharing data for integrated care released & comms plan for Brent developed. Business Case for WSIC core contract (primary care) due Governing Body 3rd March for go live July 16.
- STARRS rapid response service – contract reviewed and new contract specification due to go live in April 2016
- Short term action to improve discharge outlined in the Winter Pressures paper to this HWBB
- Integrated Rehabilitation and Reablement service to go live in April 2016 - Brent ASC staff seconded to London North West Hospital Trust, working closely with re-commissioned reablement homecare providers

Planned actions for next quarter

- Continue implementation work to deliver what is outlined above
- Strategy and planning for long term BCF and health and social care integration priorities currently structured around the following headings:
    - Whole Systems Integrated Care – approval of Business Case; plan for implementation; development of Care Navigation model; PID for alignment of Home Care, LNWHT & GP Networks (so home care can deliver low level nursing tasks)
    - Urgent Care – focus on priority 3
    - Mental Health – a sub set of the Brent Mental Wellbeing Work, will need to be aligned to the BCF plan
    - Learning Disability – recognising the continued importance of Transforming Care

Risks and mitigating actions

- Focus on winter pressures and maintaining the current system means that the project resources are constrained. Resource requirements are being considered to support planning for 2016/17

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Health and Wellbeing Board
Update on Priorities
January 2016

Title of Priority: Empowering Communities to take better care of themselves

Responsible officers: Duncan Ambrose (CCG) Melanie Smith (Council)

Summary of objectives

Promote self-care and illness-prevention at an individual and community level.

Summary of key outcomes

The agreed ambitions for this priority are:

- Communities, families and individuals have a clear expectation that they will and are able to maintain their health
- Advice and information is accessible to support self-care
- Specialist resources are focused in the areas where people are unable to look after themselves

Progress achieved to date

- **Brent Equality, Engagement and Self-care Strategy Delivery subcommittee established**.
  - New Head of Equality and Engagement in post from January 2016.
- **Improving Access to Psychological Therapies (IAPT)**
  - Self-referral introduced
  - Use of on-line (smart phone app and web-based) resource made freely available to all Brent residents (www.bigwhitewall.com)
  - GPs encouraged to host IAPT, and to actively consider it for carers and people with long-term conditions to improve coping skills and resilience.
  - Links made via CVS to a range of community leaders to raise awareness
    - BAPS involved in discussions to raise awareness, and potentially host some IAPT sessions.
  - Links made to Employment and Skills team
- **Social isolation pilot**
  - Pilot project group formed
  - Plan for 720 cases per year, on track to deliver 650
  - Access improved to allow GPs to refer directly
  - Working to develop health-related outcome measures (with possible to link to Patient Activation Measure).
- **Adoption of asset based approach to needs assessment for CAMHS**
  - Dec 2015 successful bid to NHS England for additional CAMHS Local Transformation Plan funding.
  - Delivery of the plan will be overseen by a subgroup of the Brent Children's Trust Board.

- Funding identified to support on-going engagement activities (input and oversight from Brent Children's Trust Board, and Brent HealthWatch).
- Funding for a joint CAMHS Strategy Manager post agreed.

- **Diabetes Education and Self Management for Ongoing and Newly Diagnosed (DESOMND) and Dose Adjustment For Normal Eating (DAFNE)**
  - Increase in DESMOND places, locations and trainers (including lay trainers)
  - DAFNE educator team now in place, working towards further integration

- **Evaluation of Council / Diabetes UK Diabetic Champions commenced**

- **Diabetes Prevention Programme Bid**
  - Joint bid between Brent and Harrow to NHS England for wave one.

- **Learning disability health checks**
  - Good uptake, supported by advocacy services.
  - Health passports have enabled service users to have greater independence.

- **Better Care Fund**
  - The rehabilitation and re-ablement joint health and social care team work with home care providers to increase people's capability and level of functioning.

- **Sickle cell service**
  - Encouraging patients to attend the Day Care Centre when in crisis instead of attendance at A&E
  - Leaflet and poster campaign. Self-referral and drop-in numbers increasing.

- **Tuberculosis plan**
  - Successful joint bid to NHS England for latent TB screening service, starting in Q4 2015/16.

Planned actions for next quarter

- **Refresh Brent Equality, Engagement and Self-care Strategy**
  - Revise the work plan for 2016/17

- **Use of the *Patient Activation Measure*** is being developed as a fundamental part of the approach to Whole System Integration of Care.
  - *Patient Activation* describes the knowledge, skills and confidence a person has in managing their health and health care.
  - The *Patient Activation Measure* quantifies patient engagement and empowerment, and can evaluate the impact of self-care services.
  - The Patient Activation Measure is a UK validated, reliable and simple self-assessment (13 statements) to numerically describe a person's level of activation:
    - The King's Fund found that patients with **low activation** scores were more likely to attend A&E, be hospitalised, or be re-admitted; by contrast, **highly activated** patients were more likely to adopt healthy behaviours, have better outcomes, lower rates of hospitalisation, and have higher satisfaction.
  - Patient Activation Measures can improve service efficiency by tailoring the level of support provided.
  - Patient Activation Measures can improve insight in segmented, risk-stratified

populations.

- **Improving Access to Psychological Therapies (IAPT)**
  - Focused work to
    - Support people at risk of unemployment
    - Support small businesses and large employers reduce the risk of absenteeism due to anxiety/ depression/ stress/ mental illness.
    - Support people back into work using the WLA Trailblazer
    - Ultimately reduce cost to the statutory services (per person c£5k per year for Employment Support Allowance, compared to c£500 per year for IAPT).

- **Increasing support for dementia and psychosis**
  - Pilot new care models for people newly diagnosed with dementia, and those with stable psychosis.
  - Currently all secondary care mental health service users and their families have access to 'opt-in' to courses at the Recovery College for 12 months. Intention to make this 'opt-out', and increase the involvement of the voluntary sector in delivering courses.
  - The potential use of the Patient Activation Tool is being explored to target the right level of support towards the right individuals.

- **Diabetes Education and Self Management for Ongoing and Newly Diagnosed (DESOMND) and Dose Adjustment For Normal Eating (DAFNE)**
  - Pilot "ActiWeight" exercise programme for diabetic patients
  - Prepare to extend DAFNE for type 1 adolescents

- **Stage two of Diabetes Champions project**

- **Community Action Groups to be established**

Risks and mitigating actions

This priority includes a range of work streams and projects. There is no identified resource to co-ordinate.

Mitigation.
Consideration to be given to how this priority could be incorporated into existing governance and resourcing of BCF and WSIC, seeking greater alignment by adopting the 'Commissioning for Prevention Framework'


Commissioning for Prevention Framework

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