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Brent

Brent Clinical Commissioning Group

# Health and Wellbeing Board

**Thursday 24 July 2014 at 7.00 pm**
Boardrooms 3 and 4 - Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

## Membership:

| **Members:** | **representing** |
|---|---|
| Dr Sarah Basham | Brent CCG |
| Christine Gilbert | Brent Council |
| Sue Harper | Brent Council |
| Councillor Krupesh Hirani | Brent Council |
| Dr Ethie Kong | Brent CCG |
| Rob Larkman | Brent CCG |
| Councillor Ruth Moher | Brent Council |
| Ann O'Neill | Brent Health Watch |
| Jo Ohlson | Brent CCG |
| Councillor Michael Pavey (Chair) | Brent Council |
| Councillor Keith Perrin | Brent Council |
| Phil Porter | Brent Council |
| Melanie Smith | Brent Council |
| Gail Tolley | Brent Council |
| Vacancy | Brent Council |

**For further information contact:** Toby Howes, Senior Democratic Services Officer
0208 937 1307, toby.howes@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 held on 9 April 2014** 1 - 6

The minutes are attached.

**3 Matters arising**

**4 Developing the Health and Wellbeing Board: new ways of working** 7 - 12

This report reviews how the Health and Wellbeing Board is functioning and considers how its effectiveness can be further strengthened.

**5 Brent alcohol harm reduction strategy 2014 - 2017** 13 - 32

The covering report and Brent alcohol reduction strategy 2014 – 2017 is attached.

**6 Whole systems integrated care** 33 - 44

The report is attached. Sarah Mansuralli (Deputy Chief Operating Officer, Brent Clinical Commissioning Group) and Phil Porter (Strategic Director Adults, Brent Council) will present the report.

**7 Revision of the Brent pharmaceutical needs assessment** 45 - 50

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

This paper proposes how this responsibility should be discharged.

**8 Medication incidents report** 51 - 58

The report and presentation are attached. Mark Eaton (Head of Delivery and Performance for Brent, Harrow and Hillingdon Clinical Commissioning Groups) will present the report.

**9 Protocol agreement between Brent Local Safeguarding Children Board and the Health and Well Being Board** 59 - 64

There is a requirement to have clarity about the roles and responsibilities of the strategic boards in Brent. Brent Local Safeguarding Children Board has drafted a range of protocols to address these requirements which are being presented to the respective Boards.

**10 North West London Five Year Strategic Plan (draft), 2014/15 - 2018/19** 65 - 70

The report is attached. Kate Lawrence (Strategy and Transformation, NHS North West London Collaboration of Clinical Commissioning Groups) will present the report.

**11 Date of next meeting**

The next meeting of the Health and Wellbeing Board is scheduled to take place on Thursday, 30 October at 7.00 pm.

**12 Any other urgent business**

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

**Date of the next meeting: Thursday 30 October 2014**

Please remember to ***SWITCH OFF*** your mobile phone during the meeting.

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

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Brent

**MINUTES OF THE HEALTH AND WELLBEING BOARD**
**Wednesday 9 April 2014 at 7.00 pm**

PRESENT: Councillor Moher (Chair), Christine Gilbert (Chief Executive, Brent Council), Sue Harper (Strategic Director, Environment and Neighbourhoods, Brent Council) , Councillor Hirani (Lead Member Adults Health and Wellbeing, Brent Council), Dr Ethie Kong (Chair, Brent CCG), Rob Larkman (Chief Officer, Brent CCG), Ann O'Neill (Brent Health Watch), Jo Ohlson (Chief Operating Officer, Brent CCG), Councillor Pavey (Lead Member, Children and Young People, Brent Council), Melanie Smith (Director of Public Health, Brent Council) and Sara Williams (Acting Director of Children and Young People, Brent Council)

Also Present: Councillors Harrison, John and Gladbaum

Apologies were received from: Councillors Crane and HB Patel and Phil Porter (Strategic Director Adult Social Care, Brent Council)

1. **Declarations of interests**

None declared.

2. **Minutes of the previous meeting**

RESOLVED:-

that the minutes of the previous meeting held on 26 February be approved as an accurate record of the meeting.

3. **Matters arising**

None.

4. **Task Group Report on Tackling Violence against Women and Girls in Brent**

The Chair drew the Board's attention to the report submitted by the Overview and Scrutiny Task Group, noting that it was comprehensive, set out clear recommendations for action and in view of recent government initiatives, was particularly timely.

Councillor John (Chair of the Task Group) explained that the report focussed on three harmful practices; Female Genital Mutilation (FGM), Honour Based Violence (HBV) and Forced Marriage (FM). It was recognised that Brent's ethnically diverse population had religious and cultural ties to areas of the world where these harmful practices were prevalent and that these offences were considerably under reported both nationally and locally. Councillor John advised that she had presented the

report to all the relevant bodies of the Council to ensure it attracted the attention and action the subjects needed. She had met with Jo Ohlson (Chief Operating Officer, Brent CCG) to discuss how best to engage the Health services in the implementation of the task group's recommendations and had also been invited by the Brent Clinical Commissioning Group (CCG) to speak at a conference of General Practitioners (GPs). Ethie Kong (Chair, Brent CCG) advised that the Brent CCG was also undertaking work on the education and training agenda for primary care; this would encompass consideration of how best to draw together safeguarding issues, including those raised in the Task Group's report.

The Board reviewed the recommendations set out in the report and discussed referral routes for victims of the harmful practices. Melanie Smith (Director of Public Health) advised that at present, these were geared towards professionals and consideration would have to be given to how a single point of contact might work in practice and how it would be publicised. It was noted that this would be explored via the Violence against Women and Girls Strategy. Ann O'Neil (Brent Health Watch) commented that contract management had a role to play in ensuring that associated groups and providers appropriately covered these issues within their policies and practices. The discussion turned to work with Brent's schools. Councillor Pavey advised that Councillor John had written an item for the forthcoming school governors' bulletin and the issues would also be addressed via the school governors conference. Responding to a query, Sara Williams explained that PHSE (Personal, Health, Social and Economic Education) was part of the national curriculum and discussions had been held regarding increasing the health element of this. She further advised that Brent's network of designated teachers for safeguarding had recently been re-launched.

Andrew Davies (Senior Policy Officer) advised that the Assistant Chief Executive's department, had been tasked with co-ordinating the implementation of the task group's recommendations. An action plan would be developed in consultation with colleagues across the council and partner organisations. It was proposed that the Board review this action plan at its meeting scheduled for June 2014.

RESOLVED:

That the action plan, including expected outcomes and timescales, be presented to the meeting of the Health and Wellbeing Board in June 2014

5. **Shaping a Healthier Future Implementation Update**

A presentation was delivered by Rob Larkman (Chief Officer, Brent CCG) updating the Board on the implementation of the Shaping a Healthier Future (SaHF) Programme in Brent, with a focus on the recent work undertaken with respect to the Central Middlesex Hospital and the implications for Willesden Centre for Health and Care. The meeting was reminded that SaHF was taking forward the reconfiguration of North West London's hospitals to establish specialist centres of care. The programme was underpinned by an out-of-hospital strategy which aimed to reduce unnecessary hospital admissions by treating patients in primary care settings, thereby allowing hospitals to concentrate on the critically ill or those that required specialist care. In line with this, Brent CCG was implementing ambitious plans to improve primary care and patient access to services. The Board's attention was drawn to a map detailing how each hospital had been categorised under SaHF.

Business cases were currently being developed by the hospitals and these would be reviewed and subsequently submitted to the Treasury to confirm funding.

Rob Larkman outlined the recent developments regarding Central Middlesex Hospital (CMH). It was explained that CMH currently had an annual deficit of £11m and was under utilised. Considerable work had been undertaken to explore options for a long term, clinically viable and financially sustainable model for the site. This work had encompassed discussions with service providers across North West London and a range of stakeholder workshops. Three options had been considered; allow the hospital to continue as it was; close the hospital; or, add additional services. The additional services identified for CMH were outlined to the Board and it was explained that these involved the relocation and expansion of community rehabilitation beds from Willesden Health Centre. As a consequence, a range of services had also been identified for transfer to the Willesden Centre to ensure the site continued to be fully used. The presentation detailed that the evaluation agreement, made at a North West London wide workshop held in January 2014, had selected two preferred options; full utilisation of both sites, and full utilisation of CMH with partial utilisation and partial disposal of the Willesden site. The preferred option of Brent CCG remained the full utilisation of both sites and therefore, further work would be undertaken to identify other services that could be located at Willesden.

Rob Larkman concluded his presentation by detailing the required next steps and associated timeline. He explained that an outline business case for CMH was in development, with an intended deadline of the end of 2014/15 for completion and approval. It was planned that final services would be in place for 2015 onwards.

In the subsequent discussion it was noted by Anne O'Neill that CMH had always been under utilised and assurances were sought that the current planning process was sufficiently robust and future proof, particularly when considering the potential partial disposal of the Willesden site. In response, Dr Mark Spencer (Brent CCG) advised that the design of CMH had reflected an incorrect assumption that demand for Laparoscopic surgery would increase and had not predicted the significant amount of conditions that would become treatable in community settings. Jo Ohlson (Brent CCG) advised that Willesden Health Centre would make a great community hub and though the option to partially dispose of the site was being retained, all efforts were being made to increase occupation of the site. Local general practices had been approached to consider operating from the centre and a number of outpatient services would also be located at the site.

Responding to queries regarding the disposal of the Park Royal Centre for Mental Health site following the transfer of services to CMH, Dr Mark Spencer and Rob Larkman explained that some financial assumptions had been made based on advice from architects and that any funds released would be reinvested in the programme.

Anne O'Neil further commented that it was important that a focus remained on improving community engagement. It could be difficult for people to feed their views into the process due to a lack of understanding of the different groups and sub-groups in operation. She added that supporting documents had become more accessible to members of the public, but the overuse of acronyms could cause

barriers to effective engagement. Mark Spencer acknowledged that further work to improve community engagement was needed.

6. **Brent Better Care Fund Plan**

Sara Mansuralli (Deputy Chief Operating Officer, Brent CCG) drew the Board's attention to the Brent Care Fund Plan attached to the report. The Board was asked to endorse the Plan and agree to receive regular updates on its implementation. The Board had considered the draft Plan at a development session held on 12 March 2014 and changes had subsequently been made to reflect the Board's suggestions. Sara Mansuralli advised that the Brent Integration Board would be developing a performance dashboard to link into the schemes and performance trajectories set out in the plan and would provide regular updates on the delivery of the Plan and its impact on Brent's residents.

With reference to the Better Care Fund planning template, Councillor Hirani noted that that the minimum required value of the BCF pooled Budget had been lower in the draft version of the Plan. Sara Mansuralli advised that in the draft Plan it had been set as £19m but it was now known to be £22million and explained that the figure represented the value of the existing services that would be shaped and changed to deliver the Plan.

RESOLVED:

(i) that the Brent Better Care Fund Plan be endorsed.

(ii) that regular updates on the implementation of the Plan be submitted to the Health and Wellbeing Board.

7. **Any other urgent business**

Medication errors reporting

Jo Ohlson (Chief Operating Officer, Brent CCG) advised that the CCG Better Care Fund Planning Template contained reference to agreeing, in conjunction with the relevant Health and Wellbeing Board, a specified increased level of reporting of medication errors from local providers. The Board's views were therefore being sought on the preferred process for reaching such an agreement. It was explained that there was evidence to suggest that reporting of such errors nationally was below expected levels and it was recognised that it was important to encourage accurate reporting of medication errors to ensure that necessary lessons were learned and improvements in safety made.

RESOLVED:

That Brent CCG hold discussions with providers regarding expected levels of reporting of medication errors and report back to a future meeting of the Health and Wellbeing Board.

The meeting closed at 8.30 pm

R MOHER
Chair

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|---|---|
| Brent | **Health and Wellbeing Board**<br>24 July 2014<br><br>**Report from Ben Spinks, Assistant Chief Executive and Phil Porter, Strategic Director, Adults** |
| For Action | |

# Developing the Health and Wellbeing Board: new ways of working

## 1.0 Summary and introduction

**1.1** The Health and Social Care Act 2012 establishes health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. Each top tier and unitary authority had a duty to convene a health and wellbeing board by April 2013. Board members collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way. The expectation is that, as a result, patients and the public should experience more joined-up services from the NHS and local councils in the future[1].

**1.2** In Brent the Health and Wellbeing Board has been meeting for over a year. It is chaired by the Deputy Leader of the Council, with representation drawn from the Council, the Clinical Commissioning Group (CCG), and Healthwatch. NHS England are not members, but the Medical Director for North West London attends regularly.

**1.3** Following the local elections it is timely to review how the Board is functioning and consider how its effectiveness can be further strengthened.

## 2.0 Current purpose and focus of the Board

**2.1** The potential scope and remit of the Board is extremely broad. It might help to think of the Board's agenda as potentially comprising three types of item:

[1] Source Department of Health

- *Nationally mandated* – issues which national bodies, such as Public Health England, NHS England and other departments require Health and Well Being Boards to consider.
- *System leadership* - providing the critical friend role and oversight of ongoing work, providing a mandate for and sign off of relevant policies/projects that are developed elsewhere through the range of groups that already exist, for example, the Drug and Alcohol Action Team or the Safeguarding Adults Board.
- *Leadership on key issues in Brent* – taking on the really significant issues which are not being tackled already, or require wider engagement across public, private and voluntary sectors, for example dementia.

**2.2** Brent's Health and Wellbeing Board has been successful in meeting its statutory responsibilities, developing and agreeing a JSNA and health and wellbeing strategy for the borough, and considering a range of key plans and strategies, including CCG and National Health Service England (NHSE) commissioning intentions and Brent's Better Care Fund submission.

**2.3** The HWBB is developing its system leadership role. For example, the Board has had continuing oversight of the Health and Well Being action plan, which brings together all the work that is going on, across different organisations and through different groups, to deliver the Health and Well Being Strategy. It has seen, commented on and delegated responsibility on a range of issues, for example, Winterbourne View Concordat and Safeguarding Adults. This work is continuing as the Local Safeguarding Children Board/HWBB protocol on this meeting's agenda highlights, but there is still more to be done to fully clarify the role of the HWBB in relation to other partnership groups in the Borough.

**2.4** However, there is still considerable scope for the Board to do more in terms of *leadership on key issues*. The Board, in previous meetings, has expressed an ambition to not only lead the system, but also to lead on the big issues in Brent which have not been tackled previously, or have been tackled in a more limited way, to deliver a genuinely cross cutting approach, leading cultural change across partners so that we are clearly focused on improving the well being of the people of Brent and not only on delivering the statutory responsibilities of individual organisations.

## 3.0 Future focus for the Board

**3.1** Given the ongoing progress on the other two areas, this report suggests that the focus of the Board's development over the next 12 months is on the third area: *leadership on key issues.*

**3.2** In order to manage the range and number of items coming to the HWBB, it is proposed the Board should consider managing its agenda in parts A and B. It is inevitable that the Board will continue to be asked to sign-off and endorse a broad range of strategies and plans. For example, NHSE expects health and wellbeing boards to sign off of targets for the reporting of medication errors by local hospitals, which is on this meeting's agenda. Therefore, Part B would

focus on items for noting/agreement and would take the form of a more traditional meeting.

**3.3** Part A, would be the focus for each of the HWBB meetings, and would allow the Board the time to discuss and set the agenda on cross cutting issues that are important in Brent. It is proposed that Part A would not be run as a formal meeting, these issues would be considered in depth by the Board, with a limited number (typically one, maximum of two) coming to each meeting. It is proposed these would be run as workshops to facilitate discussion and agreement and would involve a wider range of people as required based on the issue. Where appropriate, Board meetings could be held in a venue relevant to the issue being discussed. Each discussion would lead to a clear set of agreed actions (with a clear action log that would be developed to track and ensure follow-up on agreed actions) and agreed performance/outcome measures, with accountability shared between partners.

**3.4** Crucial to the success of Part A will be the choice of issues. The suggestion is that any issue the Board tackles needs to meet a number of criteria:

- There is evidence that it is a priority for Brent – for example, through the JSNA
- It is not being addressed somewhere else in the system, or if it is being addressed somewhere else, there is evidence that it requires broader input and a fundamentally different approach
- Key partners are committed to working differently to achieve better outcomes – focusing on residents in Brent, rather than on our individual organisational priorities.

**3.5** An example of an issue that meets these criteria is dementia. The number of people with dementia is set to grow by 50% between 2010 and 2020. The CCG and Adult Social Care are already working to improve the support we provide through earlier diagnosis, increased investment in the memory service, more appropriate accommodation to help people to live independently, and increased support for carers. However, an effective response needs to go further and include a wider range of partners from the public sector, private and voluntary sectors, ensuring all services - from shops, to hotels, to buses to leisure centres, are dementia friendly. Early work has started on a Dementia Action Alliance, and the CCG and the Council have already signed up to this, but the HWBB could provide additional impetus and leadership to this work.

**3.6** To help focus its activities the Board should consider identifying a focused list of key issues where it has the greatest potential to drive change and improve outcomes in Brent. Depending on the number of items proposed, it might be necessary to increase the number of meetings of the HWBB.

**3.7** There are at least three ways of taking this forward:

- We facilitate these workshops ourselves, through organisations in Brent as appropriate
- We get them externally facilitated by a relevant expert, helping to inform and shape the discussion and Brent's approach, with a clear focus on expertise in the subject matter area, which brings fresh insight
- We appoint a partner to lead the facilitation across all the topics, ensuring that we have a consistent approach, and building into this

partnership wider Organisational Development objectives. In other words, the partner would facilitate individual workshops with a view to developing the Board as a whole over the next year to ensure we become greater than the sum of our parts. This approach would recognise the scale of cultural change we are trying to achieve by focusing on cross cutting issues and the different behaviours and ways of working we need to develop to deliver better outcomes for the residents of Brent. There are a number of organisations who could provide this support including the Local Government Association or the King's Fund.

## 4.0 Recommendations

**4.1** That the Health and Wellbeing Board agree to trial a number of changes to the format and focus of its work as follows:

- Focus on a priority list of key areas where a stronger partnership approach has the potential to drive change and improved outcomes.
- Develop a part A and B agenda in future, with part A comprising a limited number of items for detailed discussion and debate and part B items for noting and/or ratification.
- Agree the approach for facilitation of the part A discussions.
- Agree to hold meetings in venues related to the issue being discussed where relevant and appropriate.

**4.2** That the Health and Wellbeing Board discuss and agree a provisional list of priority areas which will form the basis of the part A work programme over the coming months.

**4.3** That the Heath and Wellbeing Board agree to introduce these changes from its October meeting, with dementia as the subject of the part A agenda.

## Appendix 1 – Health and Wellbeing Board Powers and Duties

| **Establishment and membership of health and wellbeing board** | |
|---|---|
| **Powers** | **Duties** |
| Power to appoint additional members to the board as deemed appropriate | |
| Power for two or more HWBs to exercise their functions jointly | |
| **Functions of health and wellbeing board** | |
| **Powers** | **Duties** |
| Power for HWB to request information for the purposes of enabling or assisting its performance of functions from local authority, CCG and Health Watch | Duty to prepare assessment of needs (JSNA) in relation to LA area and have regard to guidance from Secretary of State |
| Power to consult any persons it thinks appropriate in preparation of the Joint Strategic Needs Assessment (JSNA) | Duty to involve third parties in preparation of the JSNA, including Local Health Watch and people living or working in the area |
| Power to include in the Joint Health and Wellbeing Strategy (JHWS) a statement of views on how the commissioning of health and social care services, and wider health-related services, could be more closely integrated – i.e. the ability for the JHWS to look more broadly than health and social care in relation to closer<br>Integration of commissioning | Duty to prepare a JHWS for meeting needs included in JSNA in relation to LA area and have regard to guidance from Secretary of State |
| Exercise powers delegated to it by the local authority, except scrutiny responsibilities, which can't be delegated to the HWB. | Duty to involve third parties in preparation of the JSWS including Local Health Watch and people living or working in the area |
| Duty to encourage integrated working between commissioners of health services and commissioners of social care services | Duty to have regard to the NHS Commissioning Board mandate in developing the JSNA and JHWS |
| Power to encourage close working (in relation to wider determinants of health) between:<br>• the HWB and commissioners of health-related services<br>• commissioners of health services or social care services and commissioners of health-related services | Duty to consider flexibilities under the NHS Act 2006 when developing JHWS |
| | Duty to publish the JSNA |
| | Duty to publish the JHWS |
| | Duty to prepare a pharmaceutical needs assessment and publish that assessment |
| **Alignment of commissioning plans** | |
| **Powers** | **Duties** |
| Power to give its opinion to the local authority which established it on whether the authority is discharging its duty to have regard to relevant JSNA and JHWS | CCG has a duty to involve HWB in preparing or significantly revising the commissioning plans – including consulting the Board on whether the plan has taken proper account of the relevant JHWS |
| Power to write to NHS England with an opinion on the CCG commissioning plan (copy must also be supplied to the relevant CCG | Duty to provide opinion on whether the commissioning plan has taken proper account of the JHWS |
| Power to provide NHS England with opinion on whether a published commissioning plan has taken proper account of the JHWS | Duty to review how far the CCG has contributed to the delivery of any JHWS to which it was required to have regard |

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|---|---|
| Brent | **Health and Wellbeing Board**<br>**24 July 2014**<br>**Report from**<br>**Director of Public Health** |
| | Wards affected:<br>WARDS |
| **Brent Alcohol Harm Reduction Strategy 2014 - 2017** | |

**Summary**

The Brent Alcohol Harm Reduction Strategy has been developed by a wide partnership of public health, licencing and community safety within the Council, the Police, the NHS, alcohol misuse service providers and service users.

It recognises that alcohol is an integral part of British society and that when used responsibly has an important economic and social role in the borough. However it also recognises the potential for alcohol related harm.

The Strategy evidences the pattern and extent of alcohol related harm in Brent and proposes a strategic response to alcohol related harm for the population of Brent through measures to achieve three desired outcomes:

Outcome one: A healthier community

Outcome two: A safer community

Outcome three: A more responsible community


**Recommendations**

The Health and Wellbeing Board is recommended to

- Approve the Strategy
- Support the establishment of an Alcohol Harm Reduction Strategy Group with membership from public health, communications, licencing, community safety, the Police and the CCG to:
    - develop and implement an action plan to deliver the three objectives
    - monitor the impact of this action plan.

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# Brent Alcohol Harm Reduction Strategy 2014-2107

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## 1 Forward

1.1 Alcohol plays an important economic and social role in Brent when used responsibly but when used to excess alcohol can have a very damaging and detrimental effect on the lives of individuals, families and the communities in which they live.

1.2 The Brent Alcohol Harm Reduction Strategy 2014-2017 seeks to deliver a reasonable, proportionate and measured approach to tackling alcohol related harm in the borough.

1.3 Brent through the Council, the Police, the CCG and health services is committed to addressing responsible alcohol consumption and to safeguarding the health, safety and wellbeing of the whole community. In particular our collective functions of community safety, licencing, public health, health and social care, education and community support are all critical to the minimisation of the harmful effects of alcohol locally and we are now well placed to harness these services and functions effectively. The success in delivering a multi-faceted Alcohol Harm Reduction Strategy will depend on a strong multi-agency partnership with contributions from key stakeholders and the engagement of local communities most affected by alcohol related harm.

1.4 The Brent Alcohol Harm Reduction Strategy is a framework document, born of partnership engagement which will be reviewed and modified as emerging trends and new policies impact on reducing alcohol related harm.

1.5 The development of a new Alcohol Harm Reduction Strategy for Brent is timely and coincides with the Alcohol Strategy for England that has been developed by the Home Office which is the government department currently responsible for alcohol policy and licencing.

1.6 The Central Government programme on alcohol outlines the following commitments to:

- Overhaul the Licencing Act to give local authorities and the police stronger powers to remove licences from, or refuse to grant licences to, premises that are causing problems
- Allowing councils and the police to permanently shut down any shop or bar that is repeatedly selling alcohol to children, doubling the maximum fine for those caught selling alcohol to minors to £20,000
- Allowing local councils to charge more for late night licences, which will help pay for additional policing
- Banning the sale of alcohol below cost price.

1.7 The Brent Alcohol Harm Reduction Strategy 2014-17 will update, refresh and build on work that is in place locally. This Strategy seeks to bring work in community safety, treatment and licencing together in a single Strategy. It

builds on previous alcohol/crime and disorder strategies and on Drug and Alcohol Action Team (DAAT) substance misuse treatment plans.

1.8 At a time when there are severe financial constraints on public sector finances, it is imperative that existing resources are deployed in a manner which ensures that Brent's response to tackling alcohol related harm is co-ordinated and proportionate to locally evidenced need and addresses the concerns raised by our local communities. This will form the back drop to our strategy.

1.9 Alongside this, the transfer of public health from the NHS to Brent Council has given new impetus to develop this Alcohol Harm Reduction Strategy and to forge strong links between public health and partners in the Police, NHS, community safety, licencing and other key bodies to address harmful alcohol misuse in the Borough. This is also important as Brent will continue to be judged on its public health outcomes, particularly its rates for alcohol related hospital admissions.

## 2 Brent's Alcohol Strategy Evidence Base

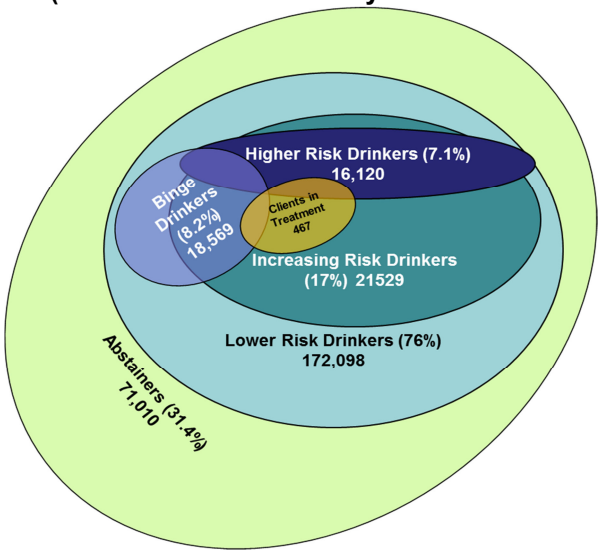
2.1 This report sets out Brent's three-year strategy for tackling alcohol misuse across the locality. The misuse of alcohol is causally related to a wide range of health problems including liver cirrhosis, heart disease, and some cancers. There are also risks to social health and well-being through increased exposure to excessive drinking, including loss of jobs, earnings and family and community dysfunction. It is also associated with a range of criminal offences including drink driving, criminal damage, a range of assaults, domestic violence as well as with many aspects of anti-social behaviour.

### What are the levels of Alcohol Consumption in Brent?

2.2 Understanding alcohol consumption in a local area is critical to assessing the local needs for public health campaigns, treatment services and for understanding the nature and prevalence of alcohol misuse. The methodology used is based on the use of synthetic estimates generated through the Local Alcohol Profiles for England (LAPE). The profiles were first introduced in 2008 and have since been updated annually.

2.3 The estimation tool assesses the proportions of the local population in the categories of: alcohol abstainers, low risk drinkers, increasing risk drinkers, higher risk drinkers and binge drinkers. Brent is below the national estimates of binge drinkers (8.2%) and those at increasing risk of drinking (16.9%). The borough also has more abstainers per head of population (31.4%) and a higher number of lower risk drinkers (76.0%) than nationally. However the area of greatest concern is that Brent seems to have a higher proportion of high risk drinkers, 7.1%, compared to 6.7% nationally. What this suggests is that Brent tends to have less alcohol users as a whole but more 'higher end' alcohol misusers. The chart below sets out the profile of alcohol consumption for the borough based on the 2011-12 LAPE estimates.

**Chart 1: Estimation Tool (Source: Local Alcohol Synthetic Estimates for England 12/13)**

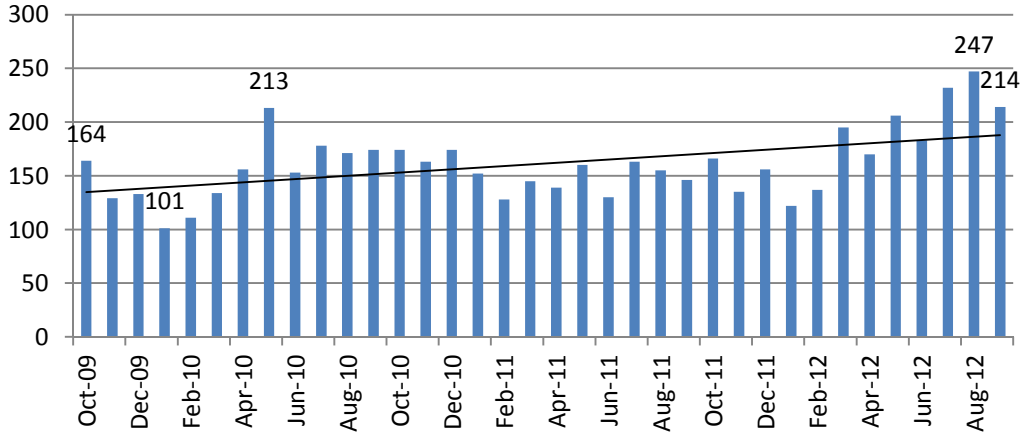



2.4 This diagram indicates that there are significant numbers of abstainers, 71,010, and low risk drinkers,172,098, in Brent. Nonetheless there are large numbers of increasing risk drinkers at 21,529 and of higher risk drinkers at 16,120. However it must be stressed that alcohol is a normal part of British society, it is legal and tolerated, and that there is a dominant culture of drinking. Clearly Brent is a diverse community and key segments abstain from alcohol. Nonetheless there is a general consistency across society that people simply do not see themselves as problematic drinkers and this is reflected in the low numbers of those people in the alcohol treatment system, in Brent this is 467.

**London Ambulance Callouts for Alcohol**

2.5 One of the most severe outcomes of problematic drinking results is the need to call an ambulance either to be seen as an emergency or to be taken into hospital. The following information has been collated from the London Ambulance Service (LAS) for 'alcohol related' ambulance callouts. In the period 01/10/12 – 30/09/12 there were 5,809 alcohol related callouts to the borough. This is significantly higher than drug overdose callouts and clearly has major resource implications for the LAS. Alcohol callouts have increased quite significantly since October 2009 and the trend line in the graph reinforces this.

**Chart 2: Brent LAS Alcohol Callouts Total Oct 09-Sep 12**

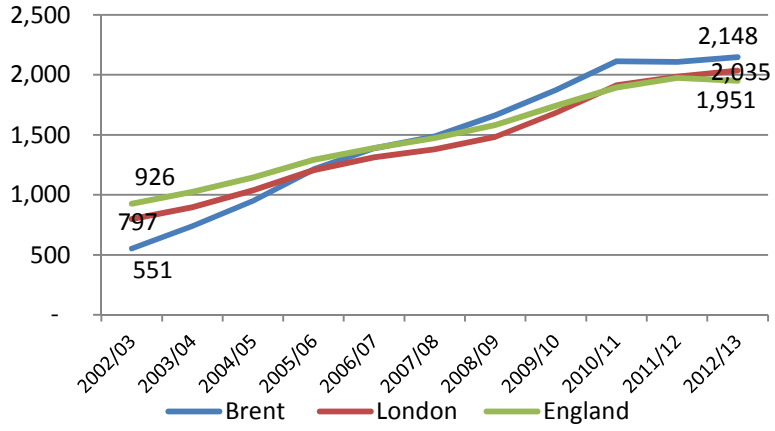



2.6 The major hotspots for alcohol callouts by the LAS in Brent are located in Willesden Green, Kilburn and Wembley Central, with lesser concentrations found in Kensal Green, Stonebridge, Mapesbury, Queens Park and Harlesden. Trends show that callouts steadily increase throughout the day until 9pm and then level off slightly before peaking between midnight and 2am. The profile of callouts shows that there are call outs from all age groups but that there is a trend that this is increasing with the older population. Seventy eight per cent of call outs were for men and 22% for women. Interestingly 4% of callouts are cases that were classified as violent.

## Alcohol Related Hospital Admissions

2.7 Alcohol related hospital admissions are another strong indicator of the problems that alcohol can have on health but also demonstrate the impact this has on health services locally. The rate of alcohol related hospital admissions[1] per 100,000 people has risen sharply in Brent between 2002 and 2013. This growth has mirrored that in England and London but currently in 2013 the Brent rate is higher at 2,148 compared to London with 2,035 and England 1,951.

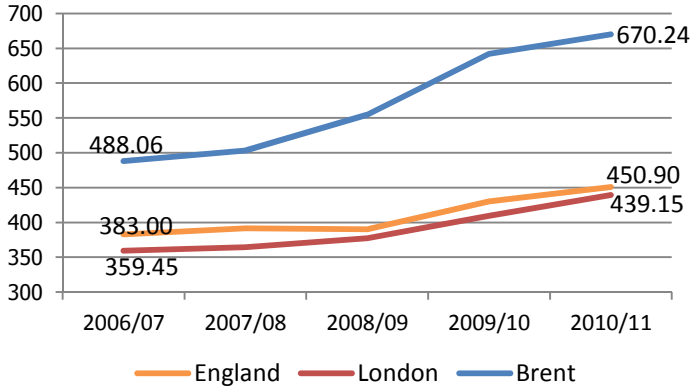
**Chart 3: Rate of alcohol related hospital admissions per 100,000 population (2002/3 to 2011/12) Source: - Local Alcohol Profiles for England**




[1] Alcohol related admissions are those where alcohol is a contributing factor.

2.8 The rates for alcohol related admissions are far higher than for alcohol specific admissions[2]. However, for alcohol specific admissions Brent has a significantly higher growth rate of 52% over this time when compared to London (45%) and nationally (36%).

**Chart 4: Rate of admissions to hospital with alcohol specific conditions per 100,000 population - (2006/7 to 2010/11) Source: NWPHO - Local Alcohol profiles for England**




## Alcohol Related Crime and Disorder

2.9 Alcohol has both a direct and indirect impact on crime and disorder in Brent. The Borough Command for Brent are fully aware of these impacts both from a crime and anti-social behaviour perspective. Therefore it sees strong potential benefits from this partnership work in terms of crime reduction opportunities, demand reduction and high harm health provision/diversion opportunities, adult safeguarding link/referrals, Integrated Offender Management pathway referrals, MARAC integration, S2S and business crime reduction initiatives.

2.10 In Brent there are 'hotspots' where alcohol use is visible and prominent and is associated with anti-social behaviour that increases the fear of crime for local communities. Police and Council officers have identified a number of hotspots in Harlesden and Willesden, as well as some in Neasden, Cricklewood, Kilburn, Wembley and along the Grand Union Canal footpath.

2.11 In terms of crimes known to the police, between 1st April 2011 and 31st October 2012 there were 851 arrests for drinking offences in Brent. Nearly three-quarters (73.5%) of arrests were as a result of a road traffic accident; and the vast majority of the remainder were drunk and disorderly charges.

2.12 Mapping analysis from the Met Police shows that there is correlation between where offences occur and the proximity to licenced premises. Moreover 59.4% of Anti-Social Behaviour (ASB) calls are within the vicinity of licenced premises in the borough. In addition there is a rise in ASB during evening hours which can be attributed empirically to a variety of factors, such as the concentration of pupils conglomerating in public areas after school, and the impact of borough night-time economy on alcohol-related disorder. This lends credence to the

[2] Alcohol specific hospital admissions are those where alcohol is a contributing factor in all cases, e.g. alcoholic poisoning.

influence of other factors in determining the prevalence of crime and ASB in the borough, such as the socio-economic demography of affected localities, the dynamics of gang related crime and its association with licenced premises.

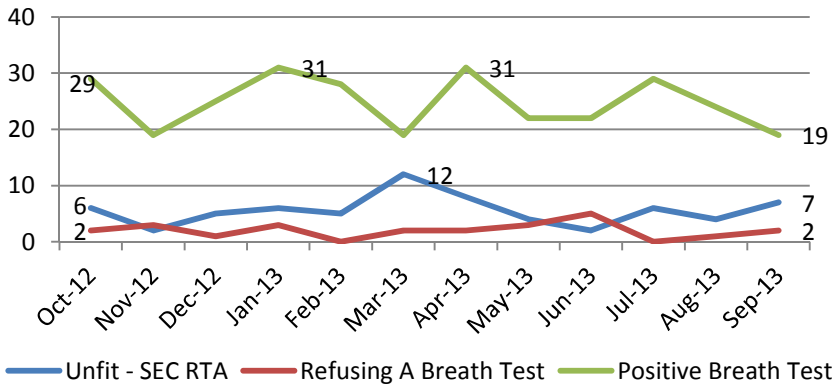
**Domestic Violence**

2.13 In Brent between 10/12 and 09/13 there were 2,196 Domestic Violence (DV) incidents recorded by the Police. Of these only 32 or 1.4% were flagged as having an alcohol related cause. However anecdotally the Police suggest that over 60% of all DV cases are where one or other party has been drinking. Based on the last rolling year period that would amount to 1,318 incidents. The Police are clear that in a majority of DV cases, alcohol has fuelled the situation.

**Drink Driving**

2.14 Drink driving is a serious crime however cases have fallen in the last 10 years as a result of repeated national drink driving campaigns. The numbers for Brent are set out in the chart below. On average there are between 20 and 30 positive breath tests per month, between 6 and 12 unfit to drive cases and 0 to 5 refusals of breath tests. Evidence from the police suggests that these cases are not necessarily always Brent residents, many are simply driving through the borough. Drink driving whilst not clearly completely addressed has diminished and this serves as testament to how other areas of behaviour and alcohol use could change and hence make our population healthier, safer and more responsible.

**Chart 5: Brent Drink Driving Offences Oct 2012-Sept 2013 NSPIS**




2.15 General alcohol related crime is set out in the tables provided through the Local Alcohol Profiles for England completed by the North West Health Observatory. This provides comparisons between Brent, London and England of rates of alcohol related crime in the context of all crime, violent crime and sexual crime. In all cases the Brent rate is above London and England rates and in the case of violent crime this gap is currently growing. However, in the case of alcohol related sexual crimes the difference is reducing. What this shows is that there is a strong case to address the impact of alcohol related crime and to ensure that local partnerships are effective in addressing this concern.

**Chart 6: Alcohol Crime Estimates per 100,000 population (2007/8 to 2011/12)**
**Source: Local Alcohol Profiles for England**

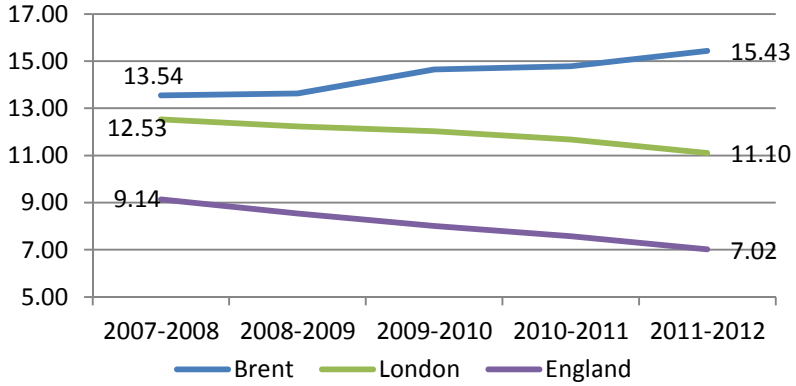



**Chart 7: Alcohol Violent Crime Estimates per 100,000 population (2007/8 to 2011/12)**
**Source: Local Alcohol Profiles for England**

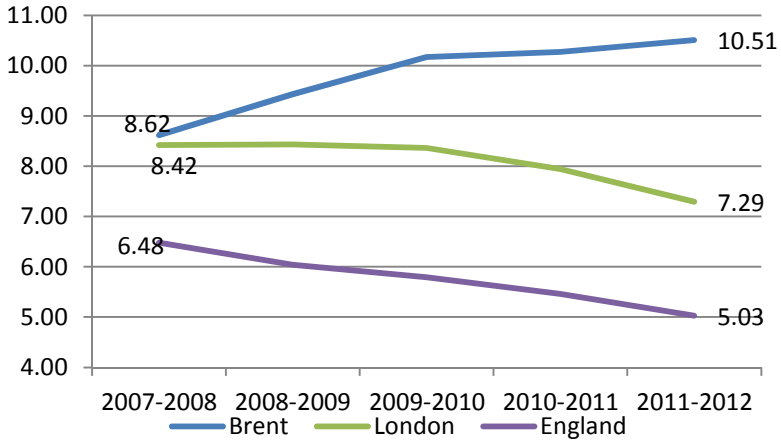
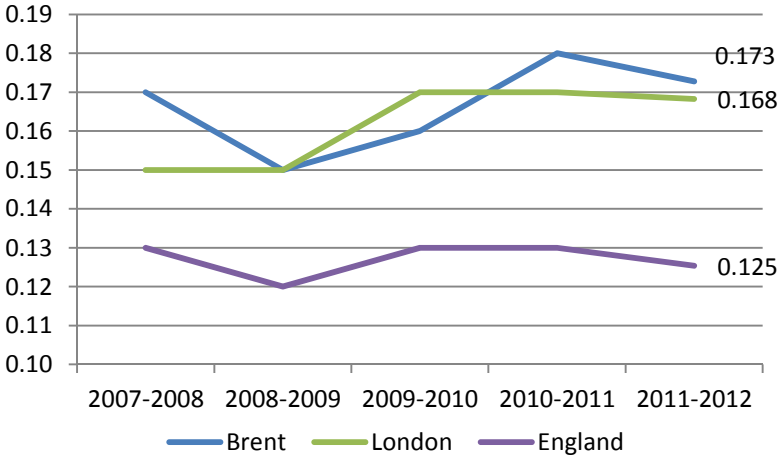



**Chart 8: Alcohol Sexual Crime Estimates per 100,000 population (2007/8 to 2011/12)**
**Source: Local Alcohol Profiles for England**




## Young People and Alcohol

2.16 Under-age drinking is clearly a concern for all communities. However the level of alcohol use by young people in Brent is low. Brent is categorised by Public Health England as a neighbourhood with the least level of harm. The Institute of Alcohol Studies (IAS) estimates suggest that 36% of 15-16 year olds are

regular drinkers (5 drinks on a single occasion in the last 30 days). This would equate to 2,476 young people in Brent. Thirty per cent of this age group report this behaviour three or more times in the last 30 days. This equates to 571 young people. However in Brent there are few reported incidents of binge drinking by young people. It is not that it does not happen but there are certainly no indicators that the problem is as great as in some other outer London boroughs with night time economies and with less diverse populations.

2.17 Alcohol Harm Reduction Strategy for England (2004) estimates between 780,000 and 1.3 million children are affected by parental alcohol problems. This equates to between 8% and 13% of the under-16 population in England. Based on 59,249 under 16s in Brent (2011 census) this equates to between 4,739 and 7,702 young people affected by parental alcohol problems.

2.18 In Brent 76% of adults receiving alcohol treatment live with children, compared to a lower rate of 52% nationally.

**Alcohol Supply Considerations**

2.19 There are 1,145 licenced premises in Brent of which 400 are open beyond 23:00 hours and 15 are nightclubs. There is a correlation between the saturation of licenced premises and the ASB hotspots as identified in the previous Police/community safety sections.

**Key Groups at Risk**

2.20 Alcohol consumption and in particular harmful alcohol consumption is not the exclusive problem of any particular community or group of people. Analysis of the treatment system suggest that there is a wide range of problematic users from different genders, all ethnic groups, all faiths and religions and from a wide age range in the community. Evidence however suggests that there are some trends which highlight a greater level of problematic drinking to be found with older people, particularly those living alone, and in migrant workers, particularly from the Eastern European community. There is also a close relationship with binge drinking with 18-25 year olds and young professionals from all communities. Essentially alcohol can potentially impact negatively on a wide range of people from a health perspective and a much wider range of the community from a crime and disorder and anti-social behaviour perspective.

**What are the attitudes and perceptions of Brent residents to alcohol?**

2.21 In March 2012 the GLA and the Regional Public Health Group published research in to the attitudes and perceptions towards alcohol consumption in London. The information set out below describes some of the key responses from residents in Brent and where appropriate compares these to London.

2.22 This survey showed that 36% of residents responding from Brent stated that they ‘never drink alcohol’. Twenty one per cent drink once a month or more, 20% drink every 1-2 weeks, 16% drink every 2-5 days and 8% drink daily. In terms of daily drinkers broken down by gender, 8.3% of Brent males drink daily compared to 10% for London, and 7.6% of Brent females drink daily compared to 5.2% in London. This suggests that there is a higher rate of daily drinkers in

the male population compared to the female, but the female population of daily drinkers is much higher than the London comparison.

2.23 The mean weekly spend for Brent is £6.25 and is lower when compared to neighbouring boroughs (Camden £16.28, Harrow £6.27, Barnet £6.55, Ealing £7.03, Hammersmith and Fulham £11.10, Kensington and Chelsea £11.94 and Westminster £15.65). The average weekly spend for daily drinkers in Brent is £18.10.

2.24 Attitudinally, 74% of respondents from Brent were concerned about levels of alcohol related crime and this concern is higher amongst infrequent and non-drinkers. Concerns over alcohol related anti-social behaviour was lower at 57%.

**What does this say about service needs in the Borough?**

2.25 This evidence points to the need for intervention in a range of areas. This is particularly important in terms of tackling the harmful effects of excessive and irresponsible drinking behaviour. In particular it reconfirms the need for treatment provision and for a holistic approach to raising awareness of safer drinking and in tackling barriers to accessing treatment. It is critical to note that most people simply do not see alcohol as a health issue and as such their reluctance to enter treatment is acute.

2.26 There is equally the need to address the effects of alcohol misuse both in terms of crime and anti-social behaviour. There are a range of specific initiatives and programmes which seek to address this, in terms of the control of the sale of alcohol, particularly with respect to licencing law. Particular targets are preventing the under aged sale of alcohol and irresponsible consumption by working effectively with licenced premises and venues where alcohol can be sold to the general public. There are also incidents of alcohol related crime and disorder. The level of concern felt by the public with regards to the effects of alcohol and its association with crime are significant and the public need to be reassured.

2.27 Therefore from a service and partnership perspective there needs to be coordination to address the health and wellbeing of the community, particularly from an alcohol harm reduction perspective, and to harness this with clear partnership approaches to address community safety and crime and disorder. In addition there is an important role for partners to build awareness of the harmful effects of alcohol and to build stronger more resilient approaches to promoting responsible social behaviour for individuals, communities, public agencies involved in health and community safety and the alcohol related industry in the borough.

## 3 Alcohol related Health services in Brent –'from awareness to treatment'

3.1 Awareness and treatment of alcohol related harm is a continuum from basic education and alcohol awareness through to alcohol screening/testing and assessment of consumption through to full blown treatment including

psychosocial interventions for addiction, detoxification, rehabilitation and aftercare. This whole range of provision is available to differing degrees within the borough and all are important components of the menu to support the health and wellbeing of our community.

3.2 Alcohol awareness activity within the borough seeks to promote an awareness of the harm that alcohol can have on the physical and mental wellbeing of individuals and the impact that alcohol can have on the wider community. This activity tends to start in schools and is maintained through various local and national campaigns.

3.3 Brent's health check programme is managed by the Council following its transfer from the PCT. The focus of health checks is critical to support the early indication of problematic conditions and to help the participant to recognise and then address lifestyle choices to support better health and well-being. Since the transfer of this contract alcohol has now been included as a specific element of the health check assessment.

3.4 Alcohol is a growing component of Brent's substance misuse treatment system. Alcohol treatment in Brent is commissioned through substance misuse treatment providers locally. The National Alcohol Treatment Management System (NATMS) reports the referral and treatment pathways for clients in the borough's treatment system.

3.5 In 2012/13 there were 320 referrals from a wide range of referral sources into the alcohol treatment system in the borough, in 2011/12 there were 249 referrals. The highest volume of referrals came from self-referrals and referrals from family or friends accounting for 158 referrals or 49% of all referrals. The next highest was health and mental health services with 37 (12%) and community based care services with 34 (11%).

3.6 There were 467 people undergoing treatment in Brent in 2012/13. In total there were 600 different interventions including psychosocial interventions (40%), structured treatment (20%), in-patient detox (8%), residential rehabilitation (8%) and brief interventions (11%).

3.7 Treatment is care plan based and there was a limited level of in treatment transfers for clients between different service providers to procure the best possible outcome. This included transfers to specialist detox units and in some cases residential detox. Sixty eight per cent finished their treatment with a successful completion (either alcohol free or occasional use) which is a high level of positive treatment outcomes. However the profile of un-planned exits for Alcohol, at 20%, is a regression on the figure in 2011/12 of only 14%.

3.8 Essentially the treatment system is performing well in Brent, there are more people coming into treatment and more are completing successfully. Nonetheless more can be done to increase access to services and to help people to better recognise the impact of harmful alcohol consumption on their health and well-being.

## 4 The roles of the range of partners in tackling Alcohol Harm Reduction

4.1 **Public Health** is now part of the Council and with this there is clear opportunity to ensure that public health priorities locally are driven across the Council in all its functions. For this alcohol strategy this has meant coordination with key departments within the Council. Additionally it is also possible for public health to influence local policy and strategy to ensure the more effective delivery of local public health outcomes and to support a cross corporate approach to key priorities. Alcohol harm reduction is no different and to this end Public Health provides:

- Awareness programmes
- Campaigns, including Alcohol Awareness week
- Commissioning of treatment
- Treatment review
- Maximising treatment outcomes to support health

4.2 **Brent Drugs and Alcohol Action Team (DAAT)** is the central point of governance over this Alcohol Harm Reduction Strategy. The DAAT Board meets quarterly and brings together the Council (including Public Health, Adult and Children's Services, Licencing and Community Safety), Police, Probation, the NHS, third sector, and service users. The DAAT's staff team is resourced through public health, whose commissioners hold weekly meetings with treatment providers to ensure that the targets for alcohol harm reduction are adhered to and that the treatment system locally is operating effectively.

4.3 **GPs** provide the first point of intervention for the vast majority of people with regards to their alcohol consumption. The use of screening tests (like Audit C) are a clear way in which drinking behaviour can be monitored and this, where appropriate, instigates a referral to structured treatment. Many general practitioners are able to support people to address their alcohol misuse through identification and brief advice (IBA) with the assistance of their nursing teams. Consideration may be given to review existing GP provision and to support enhanced services within primary care to enable it to better detect, and screen for alcohol misuse.

4.4 **Health Checks** deliver a critical service of early intervention and diagnosis of a wide range of health conditions. The health checks programme is a strong focal point of addressing people's awareness of their health needs and supporting them into treatment.

4.5 **Licencing** is a critical feature of this Alcohol Harm Reduction Strategy. Access and availability of alcohol is a key component of any approach to tackling alcohol harm reduction. Licencing and its enforcement role is focused on:

- Borough wide controlled drinking zone, preventing the consumption of alcohol in public places.
- Licencing for sale and consumption of alcohol
- Restrictions of opening hours
- Enforcement of breaches of licence conditions

- Controls to address under aged sales
- Licence review, withdrawal and closure
- Management and enforcement of major events
- Working with small and large retailers including supermarkets

4.6 **The Police** have a central role in the reduction of and response to alcohol related crime and anti-social behaviour through:

- Management of the licencing application review process, setting where appropriate specific conditions of licence
- Responding to crime and disorder and anti-social behaviour
- Accounting for alcohol related crime, including violent crime
- Targeting local hot spots for street drinkers and ensuring sensitive policing of community events and festivals
- Policing major events including sporting, performance and cultural events
- Tackling child sexual exploitation
- Responding to cases of domestic violence (including alcohol related DV)
- Referring drinkers into treatment

4.7 **Community Safety** work across a wider partnership to support:

- The analysis and review of crime and disorder hotspots
- Joint initiatives to target specific establishments where anti-social behaviour and crime have occurred
- Coordinating resources through Joint Action Groups.

## 5 Strategic Priorities

5.1 The borough's commitment to tackle alcohol misuse coupled with the National Alcohol Strategy have been triggers for this strategy. Brent DAAT/Public Health Service working in partnership with local policing, health and social care services will build on and reaffirm a long standing drive to reduce alcohol related harm. We believe this will have direct impact on individuals, families and communities through the following aim and objectives:

5.2 **Overall Aim**: To reduce the negative impact of Alcohol Related Harm for the population of Brent

5.3 Outcome One: **A Healthier Community -** Improving alcohol awareness, brief interventions, access to treatment and positive treatment outcomes.

| Objective | Measures |
|---|---|
| Increased perception of the misuse of alcohol and awareness that inform healthier choices for alcohol consumption. | • Improved awareness of the risk of alcohol harm and misuse<br>• Reducing harm to health caused by alcohol<br>• Increased awareness of alcohol use |

| | |
|---|---|
| Support for health checks and lifestyle health activity | • Increased access to brief interventions, alcohol awareness and treatment services<br>• Improving prevention and Identification and Brief Advice (IBA) |
| Accessible alcohol screening and testing (including Audit C) | • Improved referral pathways into treatment<br>• Review potential for the delivery of pre-treatment 1 day workshops |
| Improving access to structured treatment and recovery services | • Improved referrals, retention and completion of treatment<br>• Supportive rehabilitation for those who have undergone treatment<br>• Improved successful completions to structured alcohol treatment |

5.4 Outcome Two: **A Safer Community -** tackling alcohol related crime and disorder

| Objectives | Measures |
|---|---|
| A targeted response to alcohol related crime and disorder | • Responsiveness to and reductions in anti-social street drinking<br>• Reductions in alcohol related violent crime<br>• Reductions in alcohol related anti-social behaviour<br>• Reductions in alcohol related domestic violence<br>• Reductions in under-age sales and drinking<br>• Further reductions in drink driving<br>• Reduction in the hidden harm of alcohol on the lives of others<br>• Reductions in alcohol associated domestic violence |
| Reassurance for communities to enable them to feel the benefit of reductions in alcohol related crime and anti-social behaviour | • Reduced levels of community concern with respect to alcohol crime and anti-social behaviour |
| Licencing works with local alcohol industry to ensure that there is appropriate regulation in environments where alcohol is consumed. | • Proactive enforcement of licencing conditions<br>• Licencing reviews |

| | |
|---|---|
| Safeguarding Children, Young People and vulnerable | • Establish alcohol reviews through the MASH<br>• Ensure effective referral into treatment where appropriate for young people/families to address hidden harm |

5.5 Outcome Three: **A Responsible Community -** working with communities and the alcohol related industry to tackle alcohol related harm

| Objective | Measures |
|---|---|
| Increased awareness by people of the impact that their drinking has on others. | • Borough wide alcohol harm reduction campaign<br>• Support local alcohol industry to actively promote sensible drinking through effective licencing and enforcement |
| Local communities are safeguarded through effective licencing and enforcement and planning | • Maintain commitment to the controlled drinking zone across the borough, targeting key hotspots when necessary<br>• Residents benefit from the opportunity to drink responsibly in safe and social surroundings.<br>• Effective regulation of the night time economy<br>• Effective management and regulation of major events |
| Oversee and monitor alcohol harm reduction action plan by regularly reviewing partnership data, evidence and performance | • Improved partnership communication and understanding, re-enforcing the role of harm minimisation in relation to:<br>  • Community perceptions of alcohol misuse<br>  • Local service provision<br>  • Knowing/understanding the partnership messages<br>• Establishing a strong and up to date evidence base for alcohol harm reduction including health, crime and licencing enforcement data. |


Vision
To reduce the negative impact of Alcohol Related Harm for the population of Brent
A Healthier Community
A Safer Community
A Healthier Community
• Harm minimisation
• Improved access to structured treatment and recovery
• Increased awareness of alcohol use
• Support via Health Checks programme
• More alcohol testing and screening
• Improved rates of people coming into and successfully completing treatment
A Safer Community
• Target alcohol related crime
• Reduction in street drinking
• Reductions in alcohol related violence and domestic violence
• Community reassurance
• Enforcement of licencing policies
• Assessment and response to Alcohol related hidden harm and safeguarding
A More Responsible Community
Awareness campaigns, maintain controlled drinking zones across Brent, opportunity to drink responsibly in safe and social surroundings, sellers empowered to manage responsible drinking, residents benefit from responsible licencing and sales
A More Responsible Community

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# Brent Health & Wellbeing Board

# Whole Systems Integrated Care

*Brent Early Adopter – Update on Activities & Next Steps*

Date: 24th July, 2014

Version: 0.8

Contact: richardmcsorley@nhs.net / sarah.mansuralli@nhs.net

## *Purpose*

1. The purpose of this report is to update the Health and Wellbeing Board on the activities of the Whole Systems Integrated Care (WSIC) Brent Early Adopter Project, and to outline key activities in the next phase of implementation planning.

2. The report provides details of the emerging implementation plan and presents an opportunity for the Health and Wellbeing Board to comment on the proposals for Brent's WSIC early adopter project. Specifically this is an opportunity for the Board to influence the development and scope of the Early Adopter Implementation Plan. It is also an opportunity to assess the strategic fit of the WSIC Early Adopter within the wider framework of Brent's Health and Wellbeing Strategy and Brent's Better Care Fund Plan.

## *Recommendations for the Board*

3. Following the development of the WSIC Implementation Plan for Brent's Early Adopter, the Board is requested to review Brent's vision for Whole Systems Integrated Care and the Model of Care to deliver the vision.

4. To note Brent's next phase planning activities, and in particular the deadline of 31st October 2014 for submission of the Implementation Plan and the emerging changes, challenges and opportunities in health and social care services that need to be overcome to deliver whole systems integration.

5. For Board members to note the positive feedback from the Expert Panel for the process of coproduction and the WSIC Outline Plan.

6. For Board members to note the forthcoming opportunities for engagement and coproduction in the WSIC Brent Early Adopter Project and an opportunity to influence the development of the Early Adopter Implementation Plan. Specifically, the coproduction of the vision for WSIC, the Model of Care and the outcomes for measuring success of whole systems integration for the target cohort of patients.

7. Following the development of the WSIC Implementation Plan for Brent's Early Adopter, the Board is requested to review Brent's vision for Whole Systems Integrated Care and the Model of Care to deliver the vision.

8. To note that the next review point, prior to formal approval at the October Health and Wellbeing Board.

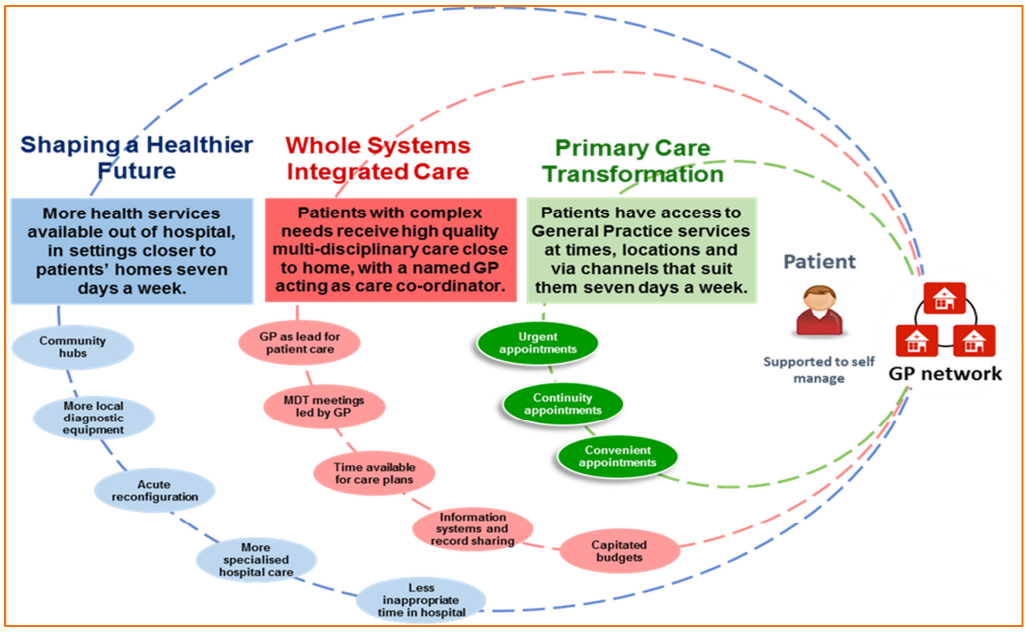
## *Introduction & Background to WSIC Vision*

9. The WSIC is the new name for the North West London Pioneer project. Brent, as part of a North West London consortium, submitted a successful bid to the national Pioneer programme in August 2013. The first phase (October 2013 – December 2013) of the NWL WSIC was the creation of the NWL toolkit (http://integration.healthiernorthwestlondon.nhs.uk/) to underpin all integration work in NWL. The second phase was the development of local, borough based, Early Adopters. Brent submitted an expression of interest to become an early adopter pilot in January 2014, and an outline plan was submitted to an *Expert Panel* on 30th May for further consideration.

10. The last update to the Brent Health and Well Being Board was in April 2014. The update was presented as part of the overarching update on the Better Care Fund plan. The WSIC Early Adopter pilot is a key component of Scheme 1 in the Brent Better Care Fund plan – *keeping people well in the community*.

11. In addition, the WSIC Early Adopter Project sits within a wider health transformation agenda, which is illustrated by the diagram below. The success of each strategy is dependent on the others and achievements in one will reinforce and amplify ambitions in the others.

*Scope of WSIC Work and fit with wider transformation agenda*



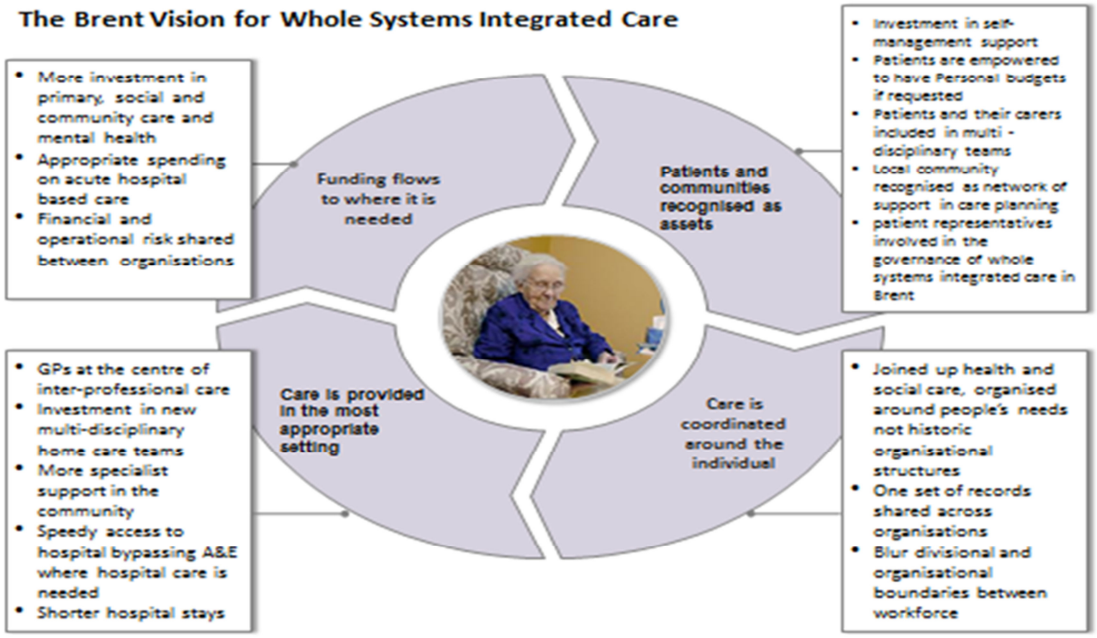

12. It is also an important part of delivering the Care Act 2014 which places new responsibilities on the Local Authority to integrate with health to achieve better outcomes for local people.

13. The Outline Plan detailing the Brent WSIC Vision, built on the good practice modeled in the first phase of the WSIC, and was coproduced through a series of workshops involving a wide range service users, clinicians and lay partners.

## *Development of WSIC Vision*

14. The WSIC vision puts the patient's or service user's needs at the heart of the design and delivery of our health and social care services. Whole Systems Integrated Care will remove the barriers and obstacles to meeting the patient's needs and coordinate delivery of their care through multi-disciplinary teams and through the introduction of 'care coordinators'.

    An overview of the Brent Vision is provided in the diagram below:




15. We will design a system that it is responsive to the needs of the people who use it, and will reflect the services and support they need to make a difference in their lives. This means challenging ourselves to think not only about traditional health and social care responses, but instead to understand the impact of other support from other sectors can have on issues such as social isolation and financial insecurity which have a significant impact on well being.

16. The patient or service user will be fundamentally central to the provision of services. Around the service user are arrayed four key overarching aspects to the WSIC Vision:

    a. Self-Care Management,

    b. Joined-up Seamless Services Coordinated around the Individual,

    c. Provision of Care in the Most Appropriate Setting,

    d. Fluid and Dynamic Resource Allocation to ensure investment is made where most appropriate for patient-centred care.

17. The NWL WSIC toolkit starts with a focus on people and outcomes. Working with clinicians, professionals, voluntary sector partners and lay partners, we segmented the population

according to need in order to create a new organising logic for a new system. This segmentation creates a clear focus on people, rather than organisations.

## Whole Systems approach to population grouping

| Age | Mostly healthy | Defined episode of care | Single LTC | Multiple LTC | Cancer | Serious and enduring mental illness | Advanced organic brain disorders | Learning disability | Severe physical disability | Socially excluded groups |
|---|---|---|---|---|---|---|---|---|---|---|
| 0-15 (Children) | ▪ The programme is currently not focused on integrated care for children<br>▪ There may be innovative care models that we could trial, but that would be the focus of a future phase | | | | | | | | | |
| 16-74 | 1 Mostly healthy adults | | 3 Adults with one or more long-term conditions | | 5 Adults and elderly people with cancer | 6 Adults and elderly people with SEMI[1] | 7 Adults and elderly people with advanced organic brain disorders | 8 Adults and elderly people with learning disabilities | 9 Adults and elderly people with severe physical disabilities | 10 Adults and elderly people who are socially excluded[2] |
| 75+ | 2 Mostly healthy elderly people | | 4 Elderly people with one or more long-term conditions | | | | | | | |

In addition, there will be several **cross-cutting themes** that should be used to prioritise the particular approach within each grouping, e.g., frailty, deprivation, behaviour, social involvement, utilisation risk, presence of a carer, a person's own caring responsibilities

1 Severe and enduring mental illness
2 For example, the homeless, people with alcohol and drug dependencies
Source: Whole Systems Integrated Care module working group

18. In Brent the initial discussion focused on all people with one or more long term conditions as partners felt these people would benefit most from the integrated approach. However, we recognised that this population group would be very large and would be difficult to manage in a transformational pilot. Therefore, the current early adopter project will initially focus on delivering whole systems integrated care for over 75's with one or more long-term conditions. The opportunity to take part in the Early Adopter project was given to all GP localities, but in the end it was Harness and Kilburn GP Networks, who volunteered to take part. Therefore, the Early Adopter project will focus on all people over 75 who have one of more long term conditions and are registered with a Harness or Kilburn GP. This equates to approximately 6500 registered patients. This will create challenges for Borough wide services, but these have been recognised and will be tackled.

19. Further work is underway to better understand the characteristics of this group; for example, analysis is being undertaken or is planned to be undertaken to evaluate the key care pathways currently used to navigate the provision of services. We are currently mapping the current landscape of services and support across all sectors to describe and understand their accessibility and settings.

20. Through this analysis of the current health and social care landscape we aim to better understand the gaps and challenges in services, and the potential obstacles and risks to

developing whole systems integrated care services. This analysis will contribute to our understanding of the necessary interventions and levers required to deliver the WSIC vision. It will also deepen our understanding of the implications and impact of the WSIC Vision. This vision will develop and evolve as the detail of the Model of Care emerges and new patient pathways are developed to capitalise on innovations in self-care management, primary care services, and new treatments in community settings and in the patient's own home.

### *Development of the Model of Care*

21. The WSIC Vision will be updated and set out in greater clarity in the final draft of the Implementation Plan. It will provide the framework in which the new Model of Care will be described and navigated. Work is commencing to flesh out the Model of Care, plot the pathways and describe the interventions which will deliver the Vision. The Model of Care will embody key principles that together will govern the approach to delivering whole systems integration.

22. For example, where appropriate we will respond proactively so patients have the information, choice and control to manage their care to best meet their needs. Through the early adopter WSIC work patients will feel empowered and given the support to better manage their own treatment.

23. But where a patient requires treatment in a health setting we will respond reactively with rapid and timely interventions to deliver seamless patient-centred care; our aim is to keep people well, as long as possible in their homes and in their communities but be there to provide urgent care when they need this.

24. To deliver the above ambitions it has been determined that the Brent model of care should include 4 evidence based principles:
    1. A Collaborative Multi-Disciplinary Team structure
    2. Care Coordination
    3. Self-Management by the Patient
    4. A Single Shared Care Plan

25. In addition to this the Brent local vision has developed emerging principles to govern integrated care models that are developed. These include:

    - Jointly commissioning for quality of life and independence outcomes
    - Single point of access to health and social care services
    - Single named coordinator/lead professional– who is best placed to care for patients
    - Single care coordination approach that is holistic and person centered to empower and enable independence, dignity and quality of life
    - Shared information and patient registration to maximize wellbeing and user experience
    - Removal of professional and institutional barriers
    - Network led to ensure equity of access and care

- Consistency and continuity of 24/7 across health and care
- Supporting carers to care and improve patient experience

26. The far reaching transformation of social and healthcare services delivered by whole systems integration will fundamentally change the way we provide health and social care services, and this will result in challenges and opportunities in the system. However, given the small size of the initial target group the impact will be limited. There is an advantage in this in that we will take the opportunity of the Early Adopter experience to consider and test the potential mitigation strategies required when WSIC is rolled out to cover other patient cohorts.

27. To illustrate how the proposed changes will make things different for the patient, consider how in the current set-up your GP will not help patients with non-health issues, and instead is likely to direct you to social services or the voluntary sector. This leaves the patient with the job of finding out the relevant contact and help they need; a responsibility that not all patients are capable of fulfilling. In the future, adult social services and Age UK would be part of the multi-disciplinary Locality Team. They would all have joint responsibility and would be working together.

28. There would not only be better understanding of what is available (avoiding unnecessary referrals), but they could also make direct referrals, direct to another member of the Locality Team who would help immediately. All of these professionals would be working together on a daily basis and they would be identifying the gaps in services and support, and would work together to commission what was needed locally based on a shared understanding of the gaps, and a shared understanding of the impact – the impact it would have on the well being of the people they support, and the impact it would have on the budget available to the locality team for its population.

29. A fundamental part of the Early Adopter process is the idea of a 'capitated budget'. This means the Locality would know how much money it has to spend on its population across all services, and could then make decisions about where to spend money, which services and support would make the greatest difference, rather than at the moment where different organisations are focus on their organization outcomes and spend money according to those organisational priorities.

30. In addition, the care coordinator role in the Locality Team would have a more explicit role in accessing support outside of the Locality Team that would have a significant impact on an individual's well being. For example, there are no plans for Housing to be part of the Locality Team, but we know that Housing has a major impact on people's well being. Therefore, there is an expectation that the Locality Team would have strong links with Housing and the Care Coordinators would help people to navigate the housing system to find solutions. They would help them to understand what may or may not be on offer, and help them to access what is on offer, rather than just saying 'you will need to speak to housing'.

## *Challenges and Opportunities*

31. Initial thinking on challenges and opportunities suggests the following potential situations arising:

- Institutional and professional challenges to organisational change such as the development of multi-disciplinary teams and creation of new job roles like care coordinators

- Service redevelopment opportunities resulting from the emergence of financial winners and losers as transformation re-routes care pathways and patients, mainly from secondary to primary care and treatment in the community and home; where the resource is attached to patients under Payment By Results Acute Trusts face a significant risk caused by reduced activity and the knock-on effect on revenue. Similarly, increased incidence of home and community treatment could result in increased costs to social care, nursing homes and individual carers. In primary care it is to be hoped that the provision of broader array of treatments historically provided in acute inpatient or acute outpatient settings will be offset by savings achieved through the cheaper unit costs of primary care interventions compared to secondary care interventions.

- With the opportunity for service redesign there is a challenge of 'efficient reallocation of resources' to reflect the changes in patient pathways. If the mechanism for redistributing costs and reallocating is weak or absent, for example a Provider Network founded without a legal basis or strong organisational support and suffering from weak leadership, then the system will not be able to react quickly enough to reallocate resource within a capitated budget to match system changes or will lack the credibility to enforce the reallocation decisions it makes.

- There are challenges and opportunities connected with data sharing and the information governance and interoperability consequences of this work. This is connected to the development of Brent's bid (as part of a larger NW London reference bid) as a 'Pioneer' for money available under the Government's Tech Fund Bid.

- This will help to ensure systems are inter-operable and we have the Information Governance and IT capabilities to link patient records. Without this capability we will not be able to either construct the capitated budget from the bottom up or monitor patient activity and associated costs. Also if Providers are unable to communicate and share patient data quickly and dynamically in realtime patient care could suffer and impact adversely on clinical outcomes and quality of life outcomes as the ability to coordinate care and implement joint care planning and decision-making is impaired or wholly absent. The mitigation to a data sharing risk is being considered now as IT and information governance products and activities have long lead-times and decisions need to be made now.

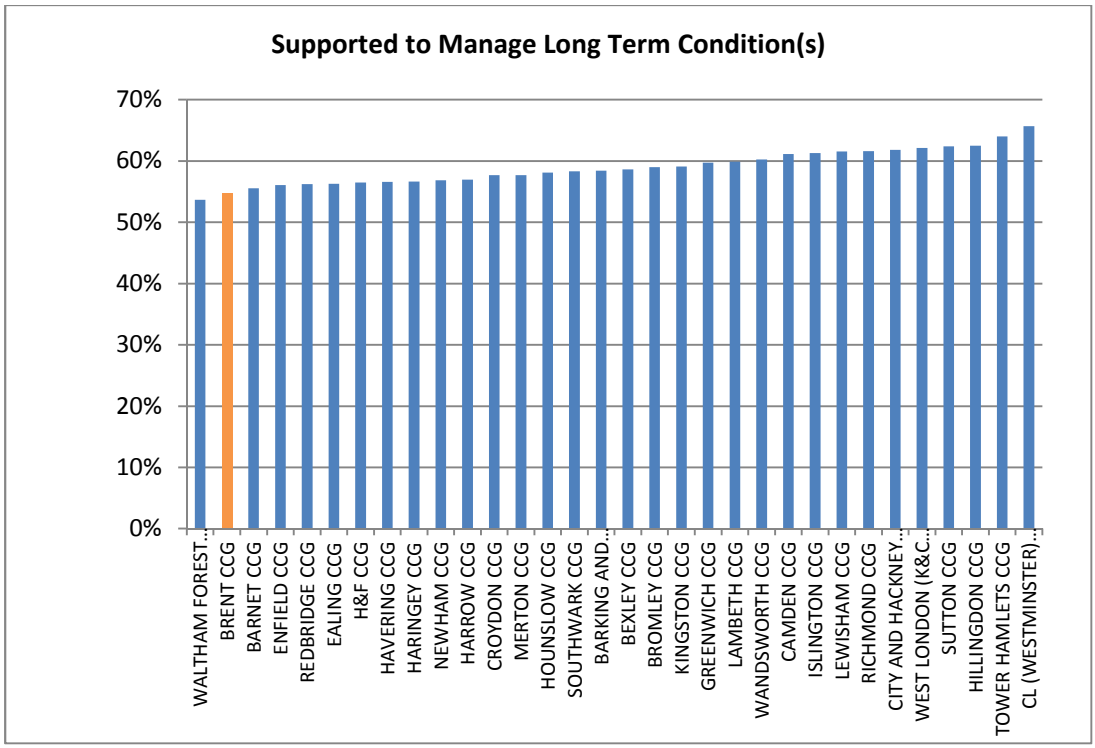
- To fully take advantage of the opportunities created through patient-centred care, safeguards for patient safety and service-user welfare will be developed as delineated roles and responsibilities are replaced by multi-disciplinary teams and shared responsibility for problems if things go wrong.

*Measuring success and the impact on service users and providers*

32. The success of the Model of Care will be evaluated through the measurement of key outcomes and key performance indicators. Central to this evaluation will be quality of life outcomes. Measures of quality of life are the best indicators of service-user priorities; improvement in these outcomes will denote improvement in service-users' quality of life and as a result service-user satisfaction. Improvement will therefore demonstrate we have delivered the WSIC Vision and contributed towards the delivery of key Health and Well-being ambitions.

33. For example, Brent currently is rated very low by patients in terms of feeling 'supported to manage long term conditions'. We aim to change this so Brent is amongst the top performers and patients report a very high level of satisfaction and confidence with the support offered to them to manage their long term condition.

**Chart: Feeling Supported to Manage Long Term Conditions**




34. The ultimate aim of whole systems integration is to improve patient's quality of life. Whilst we are planning further work to develop patient related outcomes, initial engagement shows that for over 75s quality of life means:

a. Living independently
b. Meeting personal goals
c. Being at home
d. Feeling safe
e. Having enough to eat
f. Opportunities to maintain choices
g. Feeling in control
h. Ability to direct support
i. Being listened to
j. Not feeling isolated

35. The WSIC early adopter Outline Plan we have co-developed sets out the vision for delivering improvements in these quality of life indicators. The goal of delivering improvements in these outcomes highlights the case for change and the key drivers that together denote the importance and priority of this work.

36. Success will also be measured by performance and professional related outcomes and in particular financial savings. Whole systems integrated care will provide patient-centred seamless care in settings convenient to the patient and which will deliver the best clinical outcomes. In practice this means planned care, reductions in expensive emergency admissions, reductions in avoidable admissions and readmissions, and the transfer of treatments from secondary care to primary care resulting in reduced bed-days and length of stay.

37. Whilst the primary objective of WSIC is improvement in patient related outcomes, the impact of the implementing the new Model of Care will be a reduction in costs for both health and social care services. Further work is required to evaluate costs associated with the new Model of Care and plan the realisation of benefits to the patient and to organisations along the care pathway. Once the Model of Care has been developed and costs associated with its interventions have been mapped, we will understand the relative affordability of the WSIC Early Adopter Project in comparison to the current care landscape for the target patient cohort.

38. A benefits realisation plan will be developed to plot the trajectory of cost and benefits. Experience and previous pilots always show that costs of integrated care programmes are incurred near the beginning of the programme lifecycle and there is a gap before financial savings are realised in provider organisations. For some interventions, requiring specialist training and a learning curve, such as some self-care management techniques it is to be expected that there will be long lead-times before benefits are accrued. Other interventions could be relatively 'quick-wins', for example innovations that directly reduce emergency admissions. We will plan the implementation of the Model of Care to ensure as far as possible that the system experiences speedy realisation of benefits to offset initial costs.

### *Expert Panel Evaluation of Brent's Outline Plan*

39. The last update to the H&WB Board described the contents of the Early Adopter Outline Plan. The document sets out the local vision, initial planning on critical elements of the new system such as the model of care and planning to prepare full business cases and an implementation plan.

40. The Outline Plan was reviewed by an 'Expert Panel', who the Brent partnership presented to on the 12th June, 2014. The Expert Panel comprised of industry leaders and innovators, senior directors from NHS England, the Chair of Monitor and a patient representative.

41. The Expert Panel comprised of industry leaders and innovators, senior directors from NHS England, the Chair of Monitor and a patient representative. The panel included integrated care trailblazers from the USA (the Chief Medical Officer from ChenMed, Dr. Greg Tanios, and the Chief Executive of Kaiser Permenente, Mr. Hal Wolf), the NHS England Director of Primary Care, a senior GP with experience of implementing integrated care solutions and the Chair of Monitor and a patient representative with a perspective of true patient-centred care.

42. The Brent Partnership jointly presented to the panel, which showed we have a shared vision and explained the challenges of the work from all perspectives. This had the impact of reinforcing the fact that we are all equally committed to the work and are all enthusiastic supporters of patient-centred care.

43. The Panel, who had previously read the Outline Plan, gave our presentation a warm reception and displayed real enthusiasm for our vision which they said was well articulated and conveyed a deep understanding and support for developing integrated services that were designed around the service-user to best their needs. Special mention was made of Brent's commitment to consulting and engaging with different resident and service-user groups, and commended our approach to co-production which they stated was evident in the way we developed the Outline Plan and how it featured prominently in our vision and presentation.

44. The next phase of 'Implementation Planning' continues our journey of engagement and coproduction. We reiterate our local commitment to finding and using representation from grassroots organisations and lay members, including the general public. We wish to engage a diverse wide range of people whose views are representative of all the local issues faced by service-users in Brent.

## *Next Steps and Implementation Planning*

45. There will be a number of opportunities to engage with the coproduction of the Implementation Plan and particularly the development of the new Model of Care. We will be implementing the necessary structures and processes to ensure alignment of all Brent engagement work and to ensure adequate communication of progress, including regular updates on key programmes of work. This will include regular updates on WSIC Early Adopter Phase 2 Implementation Planning for the H&WB Board where appropriate.

46. Of particular interest to the H&WB Board will be the development of the WSIC Early Adopter Vision and the new Model of Care to deliver the vision. Members will also have a special interest in the development and selection of outcomes to measure success. The Board will have opportunities through coproduction to influence the development of the Vision and Model of Care.

47. To ensure the Vision and Model of Care fit within the broader aims of the Health and Wellbeing Strategy and within the wider transformation agenda in Brent and NW London, including the Better Care Fund, it is proposed that before the 31st October deadline a final draft of the WSIC Brent Early Adopter Implementation Plan will be submitted to the Board to explain the Vision, the Model of Care and the outcomes chosen to measure success. A early version of the Benefits Realisation Plan will also be shared to provide a high-level view of the cost/benefit trajectory.

48. Subject to approval by the H&WB Board the Implementation Plan will then be submitted to meet the 31st October deadline. The headline timeframe to develop key components of the Implementation Plan is described below. The development of deliverables will be managed by a Task & Finish working group for each workstream who will report to the Brent WSIC Steering Group, which is accountable to the Better Care Operational Board.

49. Key Milestones and Activities for the next period:

| Workstream deliverables | Activities | Timeframe |
|---|---|---|
| Vision<br>Model of Care<br>Outcomes | Map existing care pathways and integrated care initiatives | July-August |
| | Sharing of 'best practice' | August |
| | Develop NW London-wide Outcome Framework | August-September |
| | Coproduction workshops to develop interventions (including external preparatory work) | August-September |
| | Testing with patients | September |
| Costs & Benefits | Costing Tool Available<br>First draft Benefits Realisation Plan | End August<br>October |
| Operational Strategy | Development of Capacity & Demand Planning | End September |
| Provider Network | Convene Accountable Care Partnership (NWL) | End July |
| Multi-Disciplinary Teams | NWL Clinical Reference Group: Provide job descriptions | End August |
| Workforce | Facilitate discussion with national stakeholders | Start end July |
| Data Protocols | Provide data in correct format<br>Decision on preferred contracting vehicle | End July<br>Mid-September |
| Information Governance & Information Technology | Data warehouse available (including ability to access PID with correct IG Protocols) | October |
| Finance / Commissioning | Provider & Commissioner dashboards<br>Linked dataset and Capitated budget values | End September<br>End October |
| Organisational Development | Design OD Programme & present delivery options (NWL) | Start September |

END

| | |
|---|---|
| Brent | **Health and Wellbeing Board**<br>24 July 2014<br><br>**Report from the Director of Public Health** |
| For decision | Wards affected:<br>ALL |

# Revision of the Brent Pharmaceutical Needs Assessment

## 1.0 Summary

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

This paper proposes how this responsibility should be discharged.

## 2.0 Recommendations

The Board is asked to

- Agree the establishment of a task and finish PNA Steering Group
- Agree the terms of reference for this PNA Steering Group which form appendix 1 to this report.
- Delegate to the PNA Steering Group the task of overseeing the conduct, consultation and publication of the revised Brent PNA.

## 3.0 Detail

PNAs are used by the NHS to make decisions on which NHS funded services need to be provided by local community pharmacies. PNAs are also used in

decisions as to whether new pharmacies are needed in response to applications by businesses.

The responsibility for producing, consulting on and publishing PNAs previously rested with PCTs. The Health and Social Care Act 2012 transferred this responsibility to Health and Wellbeing Boards

NHS England has the responsibility to commission pharmaceutical services. The responsibility for using PNAs as the basis for making decisions about applications to provide pharmaceutical services transferred from PCTs to NHS England under the Heath and Social Care Act 2012.

The development and updating of PNAs is subject to the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013: http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/ ("the Regulations").

The existing PNA for Brent (available on the Council website http://www.brent.gov.uk/your-council/partnerships/health-and-wellbeing-board/) was produced by the PCT in 2011. The Regulations require that the Health and Wellbineg Board publish revised PNA by 1st April 2015. Further revisions will be required within three years of publication of a PNA .

Section 8 of the Regulations requires consultation with specific organisations and groups allowing them a minimum of 60 days for making their response to the consultation.

In order to revise the PNA and publish the same, it is recommended that a Steeing Group is established which will oversee the production, consultation and subsequent publication of the PNA. The proposed terms of reference are appended to this paper.

Director
Dr Melanie Smith
Director of Public Health
Assistant Chief Executive's Office
Melanie.smith@brent.gov.uk

Appendix 1.

**Brent Phamaceutical Needs Assessment Steering Group**
**Terms of reference**

Purpose

To direct and oversee the production of and consultation on a revision of the Brent Pharmaceutival Needs Assessment (PNA) in order to enable the Health and Wellbeing Board to approve this for publication by 1st April 2015.

Context

If a person wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list. Pharmaceutical lists are compiled and held by the NHS Commissioning Board, now known as NHS England. This is commonly known as the NHS "market entry" system.

Under the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations ("the 2013 Regulations"), a person who wishes to provide NHS pharmaceutical services must generally apply to NHS England to be included on a relevant list by proving they are able to meet a pharmaceutical need as set out in the relevant PNA.

The Health and Social Care Act 2012 established HWBs. The Act also transferred responsibility to develop and update PNAs from PCTs to HWBs. Responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list transferred from PCTs to NHS England from 1 April 2013.

The NHS Act 2006 (the "2006" Act), amended by the Health and Social Care Act 2012, sets out the requirements for HWBs to develop and update PNAs and gives the Department of Health (DH) powers to make Regulations.

**128A Pharmaceutical needs assessments**

(1) Each Health and Well-being Board must in accordance with regulations:

(a) assess needs for pharmaceutical services in its area, and

(b) publish a statement of its first assessment and of any revised assessment.

(2) The regulations must make provision:

(a) as to information which must be contained in a statement;

(b) as to the extent to which an assessment must take account of likely future needs;

(c) specifying the date by which a Health and Well-being Board must publish the statement of its first assessment;

(d) as to the circumstances in which a Health and Well-being Board must make a new assessment.

(3) The regulations may in particular make provision:

(a) as to the pharmaceutical services to which an assessment must relate;

(b) requiring a Health and Well-being Board to consult specified persons about specified matters when making an assessment;

(c) as to the manner in which an assessment is to be made;

(d) as to matters to which a Health and Well-being Board must have regard when making an assessment.

"*Healthy lives, healthy people*", the public health strategy for England (2010) says: "Community pharmacies are a valuable and trusted public health resource. With millions of contacts with the public each day, there is real potential to use community pharmacy teams more effectively to improve health and wellbeing and to reduce health inequalities." This will be relevant to local authorities as they take on responsibility for public health in their communities.

Community pharmacy is an important investor in local communities through employment, supporting neighbourhood and high street economies, as a health asset and long term partner

<u>Responsibilities</u>

- The Steering Group will oversee the production of a revision of the Brent PNA in accordance with the 2013 Regulations.

- The Group will ensure that the PNA is of high quality, specifically it will ensure that the PNA:

o includes pharmacies and the services they already provide. These will include dispensing, providing advice on health, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users.
o looks at other services, and services available in neighbouring HWB areas that might affect the need for services in its own area.
o examines the demographics of Brent's population, across the area and in different localities, and their needs.
o looks at whether there are gaps that could be met by providing more pharmacy services, or through opening more pharmacies. It should also take account of likely future needs.
o contains relevant maps relating to the area and its pharmacies.
o is aligned with other plans for local health and social care, including the Joint Strategic Needs Assessment (JSNA).

- The Group will ensure consultation in accordance with the Regulations

- The Group will ensure the findings of the PNA are presented to the Health and Wellbeing Board once published.

Membership

Consultant in Public Health: Adults and Health Intelligence. Chair
Brent Council PH analyst
LPC nominee(s)
CCG nominee(s): medicines management, primary care
Health watch representative
NHS E representative
Health Watch representative

To attend as required:
Brent Council Senior Category Manager (Public Health Procurement)
Brent Council Consultation Officer

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## 1. Introduction

1.1 This paper sets out the proposed approach that Brent CCG will adopt to address Domain 5 of the CCG's 14/15 Quality Premium and the targets associated with three key providers relevant to Brent CCG.

1.2 The aim of this paper is to give the Health & Wellbeing Board the opportunity to discuss and comment upon the proposed targets.

## 2. Background

2.1 Domain 5 of Brent CCG's 14/15 Quality Premium sets out a requirement for the CCG to work with key providers to increase the number of medication related incidents that are reported with the aim of capturing more of the estimated 80% of medication incidents that go unreported. The long term aim of this action is to reduce the overall risk to patients through improving the controls that are put in place following the subsequent investigation

2.2 It has been proposed, and accepted by NHS England, that Brent CCG work in concert with both Harrow and Hillingdon CCG's in delivering this element of the Quality Premium.

2.3 The BHH CCGs have identified four key providers to focus upon: Imperial, NWLHT, CNWL and The Hillingdon Hospital. Only the first three are relevant to Brent CCG and therefore it is only these three that are presented to the HWBB for consideration. In addition, the targets for Imperial are written into the contract so they will be managed slightly differently to the other two providers we have put forward for consideration.

2.4 Prior to the presentation of this paper to the HWBB we have gained agreement on the targets and approach with NHS England, the Exec Committees of each of the three BHH CCGs and with the providers themselves.

## 3. Proposed Approach

3.1 The Quality Premium requires CCGs to use the data from the National Reporting and Learning System (NRLS) and to baseline providers against the latest data from this system (currently this being the data for the six months to September 2013).

3.2 Providers that are below the average for their cluster are to be required to increase to at least the average whilst those above the average are asked to maintain their position as a minimum. With the exception of Imperial, we are asking all providers to increase the rate of medication related incidents that they report.

3.3 The approach proposed also requires the named providers to demonstrate that they have a robust approach to reporting incidents, to put together a

communications programme to encourage people to report incidents and also to undertake a risk review associated with the medication elements within three major pathways. Finally, providers are also asked to demonstrate an increase in the number of reported incidents.

3.4 Through this approach we will capture more of the unreported incidents and also put in place additional controls within three major pathways within each provider therefore improving the overall quality and safety of the services delivered.

## 4. Additional Information

4.1 The baseline and targets associated with each of the three providers relevant to Brent CCG are shown in the attached presentation.

4.2 The programme will be managed for Brent CCG by Carole Mattock (Head of Quality for the BHH CCGs) and Mark Eaton (Head of Performance and Delivery for the BHH CCGs) with the support of Brent CCG staff.

## 5. Next Steps

5.1 The HWBB are invited to review the proposed targets, discuss the proposed approach and provide comment as appropriate.

# Increasing Medication Incident Reporting Rates

## 15% of the Quality Premium

**Carole Mattock, Head of Quality & Safety**
**Mark Eaton, Head of Delivery & Performance**

# Background

Domain 5 of the 14/15 Quality Premium includes an opportunity for Brent CCG to ultimately improve safety by increasing the rate of reporting for medication-related safety incidents within key providers.

The Quality Premiums are dictated to CCGs by NHS England (NHSE) but the mechanism for monitoring performance and demonstrating that the improvements have been delivered is proposed by the local CCG.

To achieve Domain 5 of the Quality Premium Brent CCG will be working with both Hillingdon and Harrow CCGs to deliver improvements in four specified providers (THH, NWLHT, Imperial and CNWL). Only CNWL, Imperial and NWLHT are relevant to the work being undertaken by Brent CCG so only their information is included within this document. The targets for Imperial Hospital are managed through the contract rather than the quality premium hence the different wording for the targets for this provider.

This paper is presented for approval by the HWBB of the targets for CNWL, Imperial and NWLHT The targets for these providers has already been agreed by NHS England and also by the Executive Committees of the three BHH CCGs.

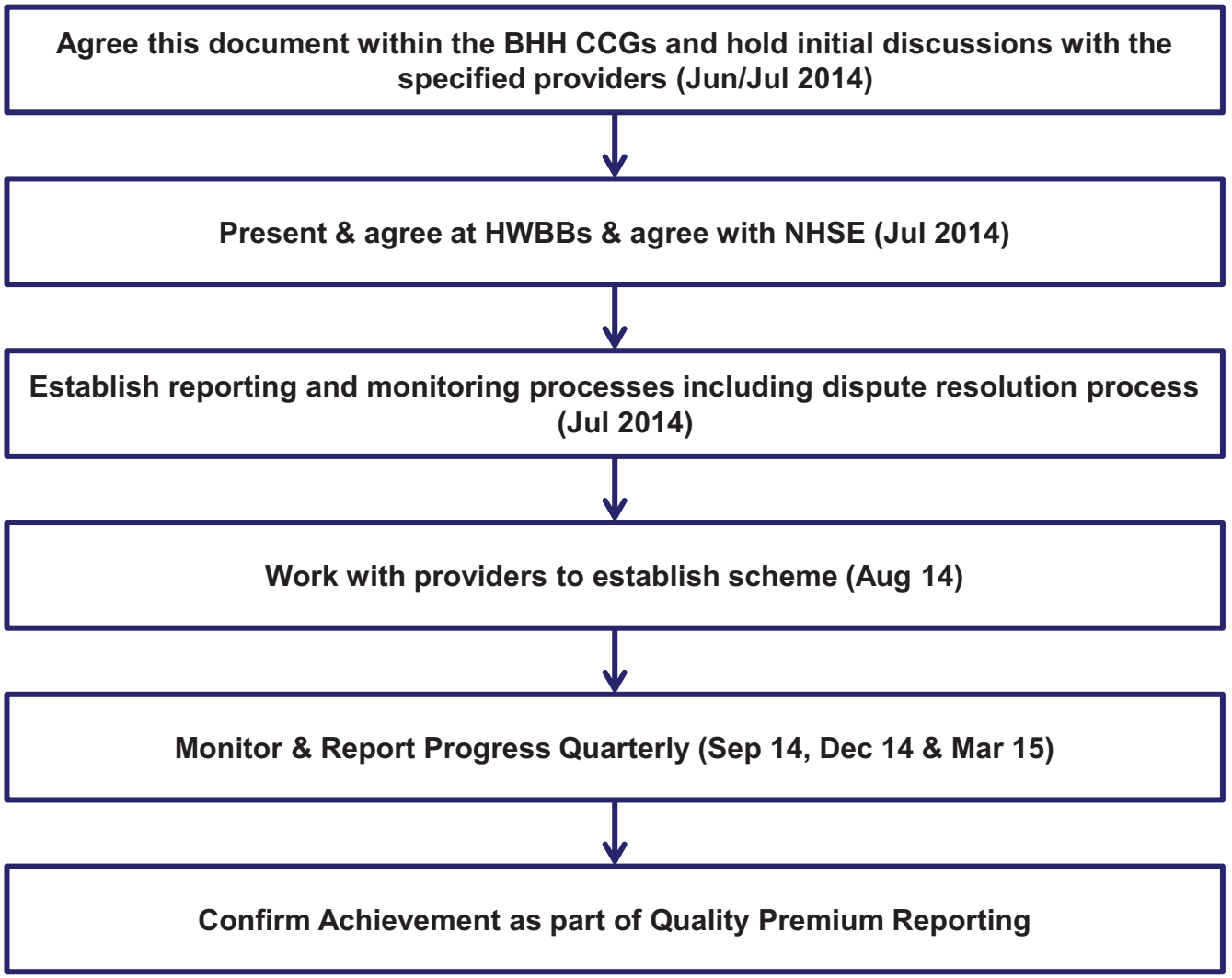
The providers are asked to achieve four things as part of this project:

- Demonstrate that they have a robust reporting process that is compliant with the NHS's NRLS reporting system.
- Put together a communications programme to encourage people to report more of the many unreported incidents that are felt to exist.
- Risk assess three major pathways to identify where medication incidents can occur and to put together plans to improve them.
- Demonstrate an increased reporting rate for medication incidents for Q3 and Q4 of 14/15.

There is a concern by NHSE that areas of poor performance within a provider organisation may be masked by the provider's overall reporting rate. To provide assurance that this is not the case providers are to be asked to produce a quarterly report for presentation at their CQG meetings that demonstrate not only an increase in the rate of reporting but also that the spread of reporting is equitable across the organisation.

This programme will be managed and monitored by Carole Mattock (BHH Quality & Governance Team) and Mark Eaton (Head of QIPP) on behalf of Brent CCG.

# High Level Implementation Plan



# CNWL Targets & Baseline Information

The BHH CCGs propose to work with CNWL to deliver Domain 5 of the Quality Premium. The following is a summary of the baseline information and proposed improvements in performance.

| CNWL |
| --- |
| **Baseline Information**<br>(Six Months to Sep 13)<br>- Total Incidents Reported: 3,660<br>- Medication Incidents: 383<br>- Medication Reporting Rate: 10.5% |
| **Comparison To Similar Organisations**<br>The comparison to similar organisations suggests that CNWL should be reporting medication related incidents at a rate of around 8.8% of all incidents. Therefore they are currently reporting at a rate 1.7% above that of comparable organisations. |
| **Proposed Target for December 2014**<br>Increase Medication Related Incidents reporting to more than 430/six months whilst maintaining this at a rate above 8.8% of all incidents reported. This represents a 12.2% increase in the overall reporting rates. |

# NWLHT Targets & Baseline Information

The BHH CCGs propose to work with NWLHT to deliver Domain 5 of the Quality Premium. The following is a summary of the baseline information and proposed improvements in performance.

| NWLHT |
| --- |
| **Baseline Information**<br>(Six Months to Sep 13)<br>- Total Incidents Reported: 2,062<br>- Medication Incidents: 255<br>- Medication Reporting Rate: 12.4% |
| **Comparison To Similar Organisations**<br>The comparison to similar organisations suggests that NWLHT should be reporting medication related incidents at a rate of around 10.6% of all incidents. Therefore they are currently reporting at a rate 1.8% above that of comparable organisations. |
| **Proposed Target for December 2014**<br>Increase Medication Related Incidents reporting to more than 300/six months whilst maintaining this at a rate above 10.6% of all incidents reported. This represents a 17.6% increase in overall reporting rates. |

# Imperial Targets & Baseline Information

The BHH CCGs propose to work with Imperial to deliver Domain 5 of the Quality Premium. The following is a summary of the baseline information and proposed improvements in performance.

| NWLHT |
| --- |
| **Baseline Information**<br>(Six Months to Sep 13)<br>- Total Incidents Reported: 5,937<br>- Medication Incidents: 769<br>- Medication Reporting Rate: 13% |
| **Comparison To Similar Organisations**<br>The comparison to similar organisations suggests that Imperial should be reporting medication related incidents at a rate of around 11.3% of all incidents. Therefore they are currently reporting at a rate 1.7% above that of comparable organisations. |
| **Proposed Target for December 2014**<br>Maintain Medication Related Incidents reporting rates at a rate equivalent to 1.5% above the average for the cluster. |

**Health and Wellbeing Board**
**24 July 2014**

# Protocol agreement between Brent Local Safeguarding Children Board and the Health and Well Being Board

**Summary**

1.1 There is a requirement to have clarity about the roles and responsibilities of the strategic boards in Brent. Brent LSCB has drafted a range of protocols to address these requirements which are being presented to the respective Boards.

## 2.0 Recommendations

2.1 That the Health and Well Being Board accept the protocol.

## 3.0 Detail

3.1 Brent Local Safeguarding Children Board (LSCB) has drafted governance arrangements with partners, including the Health and Well-Being Board (HWBB) to assess whether they are fulfilling their statutory responsibilities to help (including early help) protect and care for children and young people.

3.2 The protocol agreement between the LSCB and the HWBB is one of a number of protocols that have been drafted to identify the respective responsibilities of the strategic boards in Brent; these include the Safer Brent Partnership and the Safeguarding Adults Board.

3.3 The protocol between the HWBB and the LSCB specifically addresses the responsibilities of both boards and identifies how they can work effectively together.

3.4 Local Safeguarding Children's Boards will now be reviewed, conducted under 15(A) of the Children Act and there is an expectation that clear governance protocols are in place.

**Contact Officers**

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Brent lscb
local safeguarding children board
Keeping children safe is everyone's responsibility

## Relationship between Brent Local Safeguarding Children Board (LSCB) and the Brent Health and Wellbeing Board (HWB)

# Protocol agreement between Brent LSCB and Brent Health and Wellbeing Board

**June 2014**

| | Brent Safeguarding Children Board (LSCB) | Brent Health and Wellbeing Board (HWB) |
|---|---|---|
| Function | Brent LSCB key objectives are compliant with those set out in Working together to Safeguard children 2013, these are ;<br>• To co-ordinate what is done by each person or body represented on the Board to safeguard and promote the welfare of children in Brent,<br>• To ensure the effectiveness of what is done by each such person or body for those purposes (s14(1) Children Act 2004).<br><br>Safeguarding and promoting the welfare of children is defined as:<br>• Protecting children from maltreatment<br>• Preventing impairment of children's health or development<br>• Ensuring children are growing up in circumstances consistent with the provision of safe and effective care<br>• Taking action to enable all children to have the best outcomes.<br><br>The Board is required to develop policies and procedures for Safeguarding and promoting the welfare of children and young people in its area. These include:<br>• Thresholds for intervention<br>• Training for people who work with children<br>• Recruitment and supervision of people who work with children<br>• Investigations of allegations against people who work with children<br>• Safety and welfare of children in private fostering<br>• Cooperation with neighbouring authorities | The Brent Health and Wellbeing Board (HWB) role is to improve the health and wellbeing of the population of Brent and reduce health inequalities; Health and Wellbeing Boards were established by the Health and Social Care Act 2012. Their responsibilities include:<br><br>• Assessing the needs of the local population and lead the Joint Strategic Needs Assessment (JNSA) and the development of a Joint Health and Wellbeing Strategy<br>• Promoting integration and partnership working between the NHS, social care, education and public health ensuring the best use of resources including pooled budgets and joint commissioning arrangements<br>• Maintaining an overview of account for improvement in and attainment of key public health outcomes in the NHS, Public Health (Local Authority), and Adult Social Care Outcome Frameworks.<br>• Considering the wider determinants of health, including housing, education and the environment and the existing public health functions within the local authority to ensure an integrated response to tackling health and wellbeing priorities and inequalities.<br>• The (H&WB) have a formal role in authorising Clinical Commissioning Groups and in their annual assessment.<br><br>It will also:<br>• Ensure that the JSNA and JHWS inform and underpin the Corporate Plan in Brent, and wider Council strategies |

| | Brent Safeguarding Children Board (LSCB) | Brent Health and Wellbeing Board (HWB) |
|---|---|---|
| Relationship | Brent LSCB will:<br>• Take responsibility for monitoring actions to improve safeguarding including action plans arising from Serious Case Reviews and Management Reviews.<br>• Not be accountable for the operational work of local individuals and organisations. Each LSCB partner retains their own existing lines of accountability for safeguarding and promoting the welfare of children by their services<br>• Hold partner organisations to account on matters of safeguarding in all its activities, ensuring appropriate challenge if there are concerns regarding performance or emerging from management information<br>• Undertake audits and feedback results to the HWB, advising on what is working, what we are worried about and what we can do to address concerns.<br>• Cascade learning from Serious Case Reviews and Management Reviews and monitor impact on outcomes for children.<br>• Identify gaps in service for health and social care commissioners to consider as part of its commissioning process<br>• Present the Brent LSCB Annual Report to the Brent HWB. | The HWB has an important role in the support of the work of existing and new commissioning structures. These groups may have existing reporting lines into other bodies (e.g. The CCG Governing Body) but the HWB should be an avenue of consultation, engagement and oversight where appropriate.<br><br>The HWB will ensure joint working across partners by;<br>• Consulting Brent LSCB on issues which affect how children are safeguarded and their welfare promoted<br>• Taking note of recommendations and identified areas for improvement made by Brent LSCB and report back to Brent LSCB on subsequent progress<br>• Inviting the Chair of Brent LSCB to attend the HWB Board meetings, as needed<br>• Ensuring that messages and information provided by Brent LSCB are appropriately disseminated within organisations commissioning and providing health and social care services.<br>• Taking an overview of the Brent LSCB's activities as part of its monitoring arrangements, where the work of Brent LSCB falls within its framework including presentations of the Brent LSCB Business Plan and Annual Report and that of the Child Death Overview Panel Annual Report. |
| | **Both bodies will**<br>• **Have an on-going and direct relationship, communicating regularly Work together to ensure that where action is taken there is no duplication of work**<br>• **Ensure they are committed to working together to ensure there are no unhelpful strategic or operational gaps in policies, protocols, services or practice** | |

| | Brent Safeguarding Children Board (LSCB) | Brent Health and Wellbeing Board (HWB) |
|---|---|---|
| **Implementation** | • The chair of Brent HWB and Brent LSCB will attend respective Board meetings as necessary. They will receive all written reports as appropriate. When attending respective meetings they will engage in discussions, seek clarity and ask questions, but will not be part of the decision making process<br>• Brent LSCB will be involved in the development of the HWB strategy. It will be consulted about the needs assessment and contribute to the setting of priorities. Brent LSCB will take responsibility for the oversight and evaluation of the multi-agency safeguarding elements of the strategy<br>• At each review of the HWB strategy, both Boards will receive a formal report of progress against targets<br>• Relevant issues arising from Brent LSCB meetings will be considered within the agenda-setting process for the HWBB and vice versa<br>• 4 monthly meetings will be held between respective business unit managers to ensure on-going communication between, and connectivity of, relevant areas of business progressing through Boards. This will also help to avoid duplication of work and gaps in policies and services and ensure an aligned agenda-setting process between Boards. Minutes of Board meetings will be shared to assist this process | |
| **Leader & Chief Executive** | The Leader of the Council and Chief Executive have a responsibility to ensure that both bodies are well led, managed and effective. As part of this role, the Leader and Chief Executive will consider the Brent LSCB annual report regarding the effectiveness of arrangements for safeguarding children in Brent, including the effectiveness of governance and partnership arrangements in this regard. | |
| **Families** | The primary function of the HWB relates to commissioning, joint planning and collaborative working and both boards will develop and monitor an agreed suite of performance information, including national and local, and quantitative and qualitative indicators<br><br>In addition the following options may be initiated when required:<br>• Either Chair making a formal written request of the other for information or consideration of an area of concern<br>• Either Chair making a request of the other for an item to be placed on either Board meeting agenda to address a particular area of concern<br>• Either Chair requesting of the other a meeting between Board Chairs (and other relevant representatives) to consider and agree a way forward regarding issues that have not been resolved by the above<br>• Where an area of concern cannot be resolved within the above framework, a resolution meeting will be held between Board Chairs, the Director of Children's Services and Brent Council's Chief Executive. | |



**Brent LSCB Chair Signature:**  **Brent HWB Chair Signature:** **Date: 11th July 2014**

| NHS Brent Clinical Commissioning Group | **Health & Wellbeing Board 24 July 2014** |
|---|---|
| For Information and Discussion | |
| **Briefing paper to Brent Health & Well-being Board: *North West London Five Year Strategic Plan (draft), 2014/15 – 2018/19*** | |

## 1. Aim/purpose of the Plan

1.1 NHS England has asked each local health economy to develop genuinely transformative strategic plans to meet the strategic challenges facing the NHS, as part of this year's planning process set out by NHS England in *Everyone Counts: planning for patients 2014/15 to 2018/19 (*NHS England, 20 December 2013; http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid.pdf).

1.2 Clinical Commissioning Groups (CCGs) were asked within which larger health economy 'unit of planning' they wanted to prepare their strategic plan. The eight CCGs of NWL (Brent, Central London, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow and West London) chose to prepare a joint plan across the eight CCGs, as this is consistent with the significant strategic planning that has already taken place across the region, particularly through the *Shaping a healthier future* (SaHF) programme.

1.3 The North West London Strategic Plan is therefore a shared five year strategic plan across the eight boroughs of NWL. It is supported by the operational and financial plans at CCG, provider and NHS England Area Team level, and also aligns with the Better Care Fund plans at the Health & Wellbeing Level. It provides the narrative that describes how the planned activity levels and financial position will be achieved across the eight CCGs of NWL.

## 2. Process for developing the Plan

2.1 A NWL Strategic Planning Group (SPG) has been set up to oversee production of the 5 Year Strategic Plan. The SPG includes CCG Chairs, representative Directors of Adult Social Care and Public Health, lay members, and NHS England.

2.2 The NWL Strategic Plan ***builds entirely on the existing strategic plans and transformation programmes*** that have been developed across NWL, including the *Shaping a healthier future* acute reconfiguration, Whole Systems Integrated Care, and the Health and Well-being Strategies (HWBS) of each Borough.

2.3 The Plan ***is solely a bottom-up consolidation of existing plans into a single document***, with the addition of NHS England's direct commissioning plans (e.g. specialised services, screening, immunisations and primary care). All existing plans have been subject to extensive patient and public involvement (see Appendix A for the further details).

2.4 The Plan is structured so as to address the 'Key Lines of Enquiry' set out in the NHS England strategic plan template, using the guidance provided in '*Everyone Counts: Planning for Patients 2014/15 to 2018/19*'[1] (see http://www.england.nhs.uk/ourwork/sop/templates/ for both).

2.5 The first draft of the Plan was submitted to NHS England on 4th April 2014, while a second draft of the Plan was submitted on 20th June, updated based on feedback received from NHS England and from a wide range of stakeholders across NWL.

2.6 The draft Plan has been reviewed and commented on by CCG Governing Bodies, Health & Wellbeing Boards, providers, lay partners, and others. It remains a 'live' document that will continue to be revised over the next few months.

## 3. What the NWL Five Year Strategic Plan means within Brent

3.1 The North West London Five Year Strategic Plan sets out the ambitions and objectives for health care across the eight CCGs (Clinical Commissioning Groups) of North West London – of which Brent is one. It is drawn up in partnership with NHS England, who directly commission a number of services, including primary care and specialised services. The plan sets out how and where we will be working with our local partners, including Local Authorities and lay partners, and other CCGs in North West London, to deliver changes.

3.2 The plan describes key changes we want to make in order to achieve our ambitions for improved care, patient experience and health outcomes in Brent. In summary these areas of change are:

## 4. Health Promotion, Early Diagnosis and Early Intervention

4.1 The priorities drawn from Brent's Health and Well Being Strategy, which include:

- Giving every child the best start in life
- Helping vulnerable families
- Empowering communities to take better care of themselves
- Improving mental wellbeing throughout life
- Working together to support the most vulnerable adults in the community

4.2 Dementia – early diagnosis and early intervention pathway

4.3 Improve uptake of screening and immunisations (NHS England)

## 5. Out of Hospital Strategy including Primary Care Transformation

[1] NHS England, "Everyone Counts: Planning for Patients 2014/15 to 2018/19", 20 Dec. 2013. http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

5.1 This includes strengthening out of hospital services to meet growing demand for care that hospitals cannot manage,

5.2 The development of primary care centres to offer a flexible range of out of hospital services in South Kilburn and Kingsbury,

5.3 Better care closer to home, e.g. outpatient services provided in the community (cardiology, ophthalmology, MSK and gynaecology).

5.4 Access, convenience and responsiveness of primary care through developing GP networks to extend the primary care offer to patients.

## 6. Whole Systems Integrated Care and Better Care Fund

6.1 This includes a system of preventative care that is tailored to specific population groups and puts the patient at the centre of care.

6.2 In Brent, we will pilot this as a Whole Systems Integrated Care early adopter with an initial focus on those who are 75 year olds plus with one or more long term conditions. This will test the effectiveness of a proactive approach to care management of these patients within Kilburn and Harlesden networks.

6.3 We will also deliver the 5 schemes within our Better Care Fund Plan which include:

- Keeping the most vulnerable well in the community - Bringing services together to help people manage their health and remain healthy and active in the community.
- Avoiding unnecessary hospital admissions - When a crisis happens we want to ensure the support available means people don't have to go into hospital.
- Effective multi agency hospital discharge - We want to ensure that people are discharged as soon as possible and that support is available in the community or at home in order to continue their recovery.
- Mental Health Improvement - Implement a 'Recovery Pathway', which supports people with a severe and ensuring mental health illness to lead independent lives in the community.

## 7. Transforming Mental Health Services

7.1 This includes enabling more people with stable mental health conditions to be supported in the community, by their GPs and specialists as required.

7.2 Psychiatric liaison services to ensure timely access to urgent mental health care in hospitals.

7.3 Increasing access and capacity for people to enter into psychological talking therapies (IAPT).

7.4 Reviewing the provision for out of hours child and adolescent mental health services.

7.5 Improving services for people with learning disabilities in line with annual self-assessment across health and social care and the Winterbourne review recommendations.

## 8. *Shaping a healthier future* (SaHF) acute reconfiguration

8.1 This includes ensuring that there is high quality and sustainable acute health care in North West London that is organised in a way that maximises the clinical and estates assets available in the area, centralising where necessary and localising where possible.

8.2 Meeting the London quality standards, which include the national standards for 7 day services, based on the review by the Medical Director of NHS England, Sir Bruce Keogh, for urgent care, which seek to reduce the variation in patient outcomes which occur at the weekends and out of hours.

## 9. Improved quality and safety of care

9.1 The plan further sets out the need to maintain a focus on essentials during this period of significant change across health and care services. In particular, there will be a focus on maintaining quality, access and performance, ensuring that the CCG responds effectively to:

- Recommendations arising from the Francis, Berwick and Winterbourne View reports
- The need to improve patient experience
- Ensuring compassion in practice values are embedded in all services that deliver care
- Maintaining staff satisfaction
- Ensuring high quality safeguarding services
- The need for better access to care

## 10. Measuring our Success

10.1 The way we will measure our success will be based on the targets we have set for improvement within our outcome ambitions, which are national measures that have baselines and a target for improvement:

- People living longer and not dying prematurely
- People with Long Term Conditions maximising their quality of life
- People recovering from illness or injury resuming their lives
- People having a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm (i.e. people experiencing a safe care environment)

10.2 In addition, the plan demonstrates how the financial challenge arising from the following will be managed over the 5 year period in the light of:

- Population growth

- Increased care needs associated with an aging population with chronic health conditions
- Physical condition of health buildings/estates

## 11. Involvement of the Brent H&WBB

11.1 To note the updated draft of the North West London Five Year Strategic Plan, and to provide comments and input.

11.2 To note next steps:

11.3 Further guidance from NHS England on expectations with regards to future submissions of the Strategic Plan after the 20th June is awaited.

11.4 CCGs and Health & Wellbeing Boards are encouraged to review and input further into the updated draft, which remains a 'live' document to which further amendments will be made after the 20th June submission, regardless of guidance received.

11.5 Any comments and questions can be sent by e-mail to Kate Lawrence, from the NWL Strategy & Transformation team, at kate.lawrence1@nhs.net. If a separate meeting to discuss the Plan in more detail would be helpful then this can be arranged.

11.6 Once the NHS England guidance about future submissions is received, formal sign-off processes and timescales will be agreed.

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