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Brent

Brent Clinical Commissioning Group

Health and Wellbeing Board

Wednesday 14 June 2017 at 7.00 pm
Conference Hall - Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

Membership:

Members		Substitute Members
Councillor Hirani (Chair)	Brent Council	Labour:
Dr Ethie Kong (Vice Chair)	Brent CCG	Farah, Miller, Southwood and Tatler
Councillor Butt	Brent Council	
Councillor Colwill	Brent Council	Conservative:
Councillor McLennan	Brent Council	Davidson and Kansagra
Councillor M Patel	Brent Council	
Dr Sarah Basham	Brent CCG	
Rob Larkman	Brent CCG	
Dr Sarah Mansuralli	Brent CCG	
Carolyn Downs	Brent Council	
Phil Porter	Brent Council	
Dr Melanie Smith	Brent Council	
Gail Tolley	Brent Council	
Julie Pal	Healthwatch Brent	

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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

Notes for Members - Declarations of Interest:

If a Member is aware they have a Disclosable Pecuniary Interest* in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent and must leave the room without participating in discussion of the item.

If a Member is aware they have a Personal Interest** in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent.

If the Personal Interest is also a Prejudicial Interest (i.e. it affects a financial position or relates to determining of any approval, consent, licence, permission, or registration) then (unless an exception at 14(2) of the Members Code applies), after disclosing the interest to the meeting the Member must leave the room without participating in discussion of the item, except that they may first make representations, answer questions or give evidence relating to the matter, provided that the public are allowed to attend the meeting for those purposes.

***Disclosable Pecuniary Interests:**

(a) **Employment, etc. -** Any employment, office, trade, profession or vocation carried on for profit gain.

(b) **Sponsorship -** Any payment or other financial benefit in respect expenses in carrying out duties as a member, or of election; including from a trade union.

(c) **Contracts -** Any current contract for goods, services or works, between the Councillors or their partner (or a body in which one has a beneficial interest) and the council.

(d) **Land -** Any beneficial interest in land which is within the council's area.

(e) **Licences-** Any licence to occupy land in the council's area for a month or longer.

(f) **Corporate tenancies -** Any tenancy between the council and a body in which the Councillor or their partner have a beneficial interest.

(g) **Securities -** Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

****Personal Interests:**

The business relates to or affects:

(a) Anybody of which you are a member or in a position of general control or management, and:

- To which you are appointed by the council;
- which exercises functions of a public nature;
- which is directed is to charitable purposes;
- whose principal purposes include the influence of public opinion or policy (including a political party of trade union).

(b) The interests a of a person from whom you have received gifts or hospitality of at least £50 as a member in the municipal year;

or

A decision in relation to that business might reasonably be regarded as affecting, to a greater extent than the majority of other council tax payers, ratepayers or inhabitants of the electoral ward affected by the decision, the well-being or financial position of:

- You yourself;
- a member of your family or your friend or any person with whom you have a close association or any person or body who employs or has appointed any of these or in whom they have a beneficial interest in a class of securities exceeding the nominal value of £25,000, or any firm in which they are a partner, or any company of which they are a director
- any body of a type described in (a) above.

Agenda

Introductions, if appropriate.

Item Page

1 Apologies for Absence

For Members of the Board to note any apologies for absence.

2 Declarations of Interests

Members are invited to declare at this stage of the meeting, any relevant personal and prejudicial interests and discloseable pecuniary interests in any matter to be considered at this meeting.

3 Minutes of the Previous Meeting 1 - 6

To approve the attached minutes of the previous meeting on 28 March 2017 as a correct record.

4 Matters Arising (If Any)

To address any matters arising from the minutes.

5 Brent Health and Care Plan Update 7 - 16

The purpose of this report is to provide the Health and Wellbeing Board (HWB) with a further update on the progress of the delivery of the Brent Health and Care Plan following the first update report in January 2017.

6 Frailty Integrated Service 17 - 24

The purpose of this report is to provide the Health and Wellbeing Board (HWB) with an update on progress on the Older People's Acute Liaison Service (OPALS) business case for Northwick Park Hospital.

This is one component of the Unified Frailty Pathway and part of Delivery Area (DA) 3 - the Older People's services workstream of the Northwest London Sustainability and Transformation Plan (NWL STP). It also forms a key workstream of the Brent Health and Care Plan (the Brent Plan).

7 Pharmaceutical Needs Assessment (PNA) 25 - 30

The Brent Health and Wellbeing Board published its first PNA by April 2015 in accordance with the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (the Regulations). The

Regulations stipulate that HWBs will need to publish a revised assessment within three years, which is by 01 April 2018.This paper proposes how this responsibility should be discharged.

8 Date of Next Meeting

The next scheduled meeting of the Health and Wellbeing Board is on 5 October 2017.

9 Any Other Urgent Business

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

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

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

Brent

MINUTES OF THE HEALTH AND WELLBEING BOARD
Held on Tuesday 28 March 2017 at 7.00 pm

MEMBERS PRESENT:

Councillor Hirani (Chair), Dr Ethie Kong (Vice-Chair of Health and Wellbeing Board; Chair and Co-Clinical Director, Brent Clinical Commissioning Group), Dr Sarah Basham (Assistant Chair, Brent Clinical Commissioning Group), Councillor Butt, Councillor Colwill, Carolyn Downs (Chief Executive, Brent Council), Sarah Mansuralli Ian Niven (Head of Healthwatch Brent, substituting for Julie Pal) Councillor M Patel, Phil Porter (Strategic Director, Community Wellbeing) Dr Melanie Smith (Director of Public Health, Brent Council), Gail Tolley (Strategic Director, Children and Young People)

Also Present: Dr Amanda Craig (Network Chair for Kilburn NHS Brent Clinical Commissioning Group), Ralph Elias (Head of Planning & Programme Management Office, London North West NHS Trust), David Finch (North West London Medical Director, NHS England), Fana Hussein (Head of Primary Care Delivery, NHS Brent Clinical Commissioning Group), Sarah McDonnell (Assistant Director-Primary Care Brent Clinical Commissioning Group), James Walters (Divisional General Manager, London North West Healthcare NHS Trust), Helen Woodland (Operational Director, Social Care, Brent Council)

1. **Apologies for Absence and Substitutions**

Apologies for absence were received from Councillor McLennan, Julie Pal (Chief Executive of Healthwatch Brent, Ian Niven was substituting on her behalf) and Rob Larkman (Chief Officer, Brent Harrow and Hillingdon Clinical Commissioning Groups).

2. **Declarations of Interests**

(i) In relation to Agenda Item No.7, Dr Ethie Kong (Vice Chair of the Health and Wellbeing Board; Co-Clinical Director, Brent Clinical Commissioning Group) declared that she currently worked at a Personal Medical Services (PMS) contracted GP practice; and

(ii) In relation to Agenda Item No.7, Dr Sarah Basham (Assistant Chair, Brent Clinical Commissioning Group) declared that she currently also worked at a Personal Medical Services (PMS) contracted GP practice.

3. **Minutes of the Previous Meeting**

It was **RESOLVED that** the minutes of the previous meeting held on 24 January 2017 be approved as an accurate record of the meeting.

4. **Matters Arising (If Any)**

There were no matters arising.

5. **Brent Health and Care Plan Update**

Phil Porter (the Council's Strategic Director, Community Wellbeing) gave an overview of the report and the attached Brent Health and Care Plan document (Appendix 1). He emphasised that the focus of the document was on the development of Brent's own Local Health and Care Plan, which, although aligned in content, was separate to the wider North West London regional Sustainability and Transformation Plan (STP). He noted that the document had been refocused and reformatted to clearly spell out Brent's overarching five year strategy and implementation plans to improve the health and wellbeing of Brent's residents.

Members welcomed the report and accompanying appendix, praising the successful collaborative work which had taken place to get to this point. The Chair noted that there was generally an absence of local plans that sit under the development of regional STPs and that this had provided an important opportunity to clearly define what health and social care outcomes Brent were looking to achieve locally. He stated in the absence of a local plan there was a danger that the North West London STP would dictate what local areas had to do and it was therefore important for Brent to have its own local plans.

RESOLVED that the Brent Health and Care Plan, as a public-facing document, be endorsed by the Board.

6. **Brent Health and Care Plan: Older People's Services Update**

Helen Woodland (the Council's Operational Director of Social Care) introduced the report which provided the Board with an update on the progress of delivery area three within Brent's Health and Care Plan: *Joining Up Older People's Services.*

The Board heard that this delivery area was focused particularly on bringing together existing services and identifying potential gaps on the frailty pathway. Helen Woodland stated that the aim was ultimately for a more coherent pathway across the different types of community and acute care settings. Members heard a brief overview of the achievements to date this year which included: the role of the Whole Systems Integrated Care model; the Integrated Reablement and Rehabilitation Service (IRRS); Effective Hospital Discharge and West London Alliance's Integrated Discharge Initiative - as set out within the report. Helen Woodland outlined that the plans for the upcoming year would focus on community aspects such as joining up the Whole Systems Integrated Care and social prescribing project; expanding the remit of the Short-Term Assessment, Rehabilitation and Reablement Service (STARRS); and developing a more advanced model of care within care homes to continue to ensure that less people are admitted to hospital in the long term.

James Walters (Divisional General Manager, London North West Healthcare NHS Trust) emphasised the importance of this work stream by outlining that approximately 50 per cent of the acute bed base at the London North West Healthcare NHS Trust was now occupied by those over 65 years old. He also mentioned that approximately 25 per cent of the bed base was occupied by those over 80 years old. He outlined that whilst 'frailty' services were not just centred on care of the elderly, the key element factor to be factored into service planning was

the longer recovery time for elderly patients. He explained some of the key elements to STARRS model and its role in preventing unnecessary admissions to hospital by providing a rapid response service to patients both at home and Accident and Emergency (A and E). He also mentioned the emerging importance of Older Persons' Assessment and Liaison (OPAL) teams in linking STARRS and specific rehabilitation and reablement services to reduce the length of stay in Acute Medical Units (AMU). He concluded that it was widely felt that care could be provided better by continuing to align services and bring health and social care elements closer together.

A Member of the Board asked for further detail on the savings identified from the Whole Systems Integrated Care initiative (within paragraph 4.5.1 of the report) and whether additional investment into this model of care, if possible, could generate even greater savings in future. Sarah Mansuralli (Chief Operating Officer, Brent CCG) confirmed that these were 'real' savings and that the STARRS model had been instrumental in this. She also outlined that the CCG had done work with GE Healthcare Finnamore which looked at the scope for greater care and care management services in the community. She said that the research had found that there remained a lot of patients that were not being reached that could benefit from this type of rapid response service. Discussions continued on the potential for investment in this type of scheme and the need to develop a collaborative 'quid pro quo' business case in cooperation with the different CCGs and Local Authorities in North West London to incentivise investment. It was felt that a unified approach across the NHS and social care was essential to make further progress with this type of integrated care model. It was agreed that a proposal for implementation and investment which took this into account would be brought to the next meeting of the Board.

Questions also arose on whether examples of best practice were being tracked and whether there were innovative examples which could further improve service design. It was mentioned that the joint venture between Epsom and St Helier Hospital Trust and the Surrey Council was an interesting example to be assessed. James Walters responded that best practice examples were being monitored and that the evidence base for helping to shape frailty services continued to grow.

RESOLVED that:

(i) The progress of delivery area three of the Brent Health and Care Plan, Joining Up Older People's Services, be noted; and

(ii) A report which provided a proposal for implementation and investment on the frailty integrated service, as described in paragraph 4.5.1 of the report, be brought to the next meeting of the Health and Wellbeing Board.

7. **Personal Medical Services (PMS) Review**

Sarah McDonnell (Assistant Director, Brent Clinical Commissioning Group) introduced the report which provided the Board with an update on the PMS Contract Review currently being undertaken locally by the CCG upon instruction from NHS England.

Sarah McDonnell gave the Board some background on the review which began nationally in February 2014, before being paused in 2016 and recommenced in 2016 with new arrangements to see it be completed locally. She noted that there were currently 11 PMS Practices in Brent holding an approximate £1.25million in premium funding between them. The principle behind the review was for the premium funding to be released from these 11 practices and redistributed across the 62 GP practices in Brent to ensure that services for patients are consistent and equitable. The Board heard that to achieve this, with minimum disruption to services, there would be a 0 to 4 year transition period for PMS practices and that a transition path alongside future commissioning intentions was currently being developed with a wide variety of stakeholders involved. She added that the financial and legal implications were likely to be focused on impact assessments, because of the desire to mitigate against potential negative impacts on services and patients. Dr Melanie Smith thanked the CCG for having included the Public Health team in the development of transitional arrangements and future commissioning intentions currently being drawn up.

Questions arose for an indication on the priorities of the commissioning intentions and when the timescales would allow for a meaningful update to the Board. Sarah McDonnell responded that a number of different areas were being looked at to inform the commissioning intentions, but that it would be driven by what was deemed the most important for addressing health needs. She noted that equity of access for patients, regardless of their registered GP practice, would be a defining intention. On timescales, she outlined that there was a significant risk to these across London and that it would be best to update the Board when key decisions had been made. She said that it remained the intention to have the final commissioning intentions decided from the end of April.

A question was asked on whether there was any risk of practice failure as a result of the premium funding being withdrawn. Sarah McDonnell stated that this was very unlikely and was being mitigated against through the transition plans. She also noted that there were a number of PMS practices involved in work to improve resilience and that the CCG would be reaching out further to other practices over the next financial year.

RESOLVED that the progress of the PMS review be noted.

8. **Children's Trust Update**

Gail Tolley (the Council's Strategic Director of Children and Young People) introduced the report which provided the Board with an update on the work of the Children's Trust in the last six months and how this aligned with the work of the Health and Wellbeing Board and the North West London Sustainability and Transformation Plan. She noted that a key feature of the trust was its strong partnership working and the report aimed to show the positive dividends from this in a number of different areas. She drew the Board's attention in particular to the work of Child and Adolescents Mental Health Services (CAMHS) transformation projects and how these would continue to be a clear focus for monitoring going forward. Gail Tolley concluded her overview by extending an invite to Board Members to any meeting of the Children's Trust in future.

A Member of the Board raised the work mentioned on CAMHS and questioned whether this had had any identifiable effect on waiting list reductions. Dr Sarah Basham responded saying that it had and that it was positive that waiting lists for mental health services for children and young people had come down to be more in line with other Boroughs in North West London. She continued that it was hoped that it would be reduced further to be in line with the national level from May onwards. Gail Tolley also mentioned that there is a forthcoming Scrutiny Task and Finish Group on CAMHS which had begun positively and already made good progress since its inception.

Questions also arose on the National Childhood Obesity Plan and how Brent's specific actions in this area were delivering positive outcomes. Dr Melanie Smith stated that it was pleasing that recent data suggested that children who had been overweight at reception were now achieving normal weight by age ten. She stated that schemes such as the 'Daily Mile' in Brent primary schools and the Junior Citizens Scheme which aimed to make children 'sugar smart' would assist with this further in the future.

RESOLVED that:

(i) The work of the Children's Trust from October 2016 to March 2017 be noted; and

(ii) A development session for Health and Wellbeing Board Members on Brent's childhood obesity initiatives be arranged before the next formal meeting of the Board.

9. **Review of Healthwatch Brent Enter and View Reports**

Ian Niven (Head of Healthwatch Brent) introduced the report which provided the Board with information on the 'Enter and View' visits undertaken by Healthwatch Brent from September 2015 to March 2016. He stated that during this period Healthwatch Brent visited five residential care homes in announced visits and that the report provided a summary of these visits.

The Board heard some additional background on the visits which involved both announced and unannounced visits from staff and volunteer lay-people to health and social care settings for adults. This was designed to be a means of reviewing the quality of care for patients from their friends and relatives. Ian Niven noted that this helped to inform the work of Healthwatch Brent as a mechanism for promoting an independent voice for Brent residents on their experience of local health and social care services. It was explained that Healthwatch Brent worked closely with the Care Quality Commission (CQC) to inform the conduct of these visits.

Members questioned the scope for the visits in the future including: varying the location in the Borough of where they take place; more interaction and reflections from residents; and linking the purpose of the visit with an area aligned to the priorities on the Brent Health and Care Plan. Ian Niven stated that it had been a coincidence that all of the five care homes visited were in Wembley, and that they had been chosen because largely to assess any difference in care between different sized care homes. He stated that residents' views were the prime focus of Healthwatch's Brent's work and that the individual Enter and View Reports on the

Healthwatch Brent website went into more detail on residents' observations, rather than the summary version presented before the Board. He also agreed that a closer alignment of the work of Healthwatch Brent and the local Health and Care Plan would be beneficial.

RESOLVED that:

(i) The report be noted; and

(ii) The establishment of a central portal for all Brent inspections which can be accessed publicly (including, for example: Enter and View report, CQC reports, annual Brent Council customer feedback reports) would be considered.

10. **Any Other Urgent Business**

There was no other urgent business to be transacted.

The meeting was declared closed at 7.59 pm

COUNCILLOR KRUPESH HIRANI
Chair

Brent NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 14 June 2017 **Report from the Chief Operating Officer of Brent Clinical Commissioning Group and the Strategic Director of Adults and Community Well Being Brent Council**
For information / decision/ noting	Wards Affected: ALL

Update on the Brent Health and Care Plan

1.0. Summary

1.1. The purpose of this report is to provide the Health and Wellbeing Board (HWB) with a further update on the progress of the delivery of the Brent Health and Care Plan following the first update report in January 2017.

1.2 In Brent the delivery of the Health and Care Plan is overseen by the STP delivery board, co-chaired by the Strategic Director Community Wellbeing Brent Council and Chief Operating Officer Brent CCG and membership include all Brent STP work stream leads from the health and care system.

1.3 The STP delivery board has the key responsibility of overseeing delivery of the six Health and Care plan work streams which are the Brent big ticket items. It provides strategic and operational direction and ensures appropriate links to NWL STP delivery areas.

1.4 The STP delivery board is accountable to HWB, and provides regular updates to the HWBB and seeks steer on the direction of travel. Going forward, the aim is to focus in detail on one specific work stream at each meeting with a summary overview of the remaining work streams. This report details the progress on big ticket item five, Transforming Care – Supporting People with learning disabilities in sections 3.26 to 3.30.

2.0. Recommendations

2.1 The Health and Wellbeing Board are requested to note the progress report on delivery of the Brent Health and Care plan.

3.0. Detail

STP Governance

3.1 In order to deliver a plan as ambitious as the STP, it is essential that robust governance arrangements are in place to drive delivery. An STP Delivery Board in Brent has been established and mirrors the successful Children's Trust model of governance**.**

3.2 The board reports to HWB and oversees six subgroups responsible for delivery of the Health and Care plan work streams and aligning with the five NWL Delivery Boards as required.

3.3 The STP delivery board meets every two months and has representation from the Council, CCG, NHS provider organisations, Brent CVS, and HealthWatch Brent. It also includes representation from the Council and CCG communications and engagement leads to facilitate ongoing communications and engagement throughout the delivery of the Health and Care plan.

Health and Care Plan Programme Management

3.4 The six Health and Care plan work streams have designated Senior Responsible Officers (SROs) with responsibility for the delivery of the work streams.

3.5 The work streams are being supported by a joint CCG and Council Health and Care Plan Programme Team which currently consists of the Director of Integration and two interim senior programme managers supporting the SROs across the six work streams. In addition there are two interim project managers in place to lead on the operational delivery of Better Care Fund projects under the Frailty work stream.

3.6 The Health and Care plan programme team is overseen by the STP Executive Group providing strategic steer to the Health and Care plan work streams, and influencing the delivery of the work streams

Health and Care Plan Leadership Development

3.7 There is a strong commitment from leaders in Brent Health and Care system to implement the Health and Care plan including support of the HWB. However there is widespread acknowledgement that delivering the Health and Care plan is highly complex and requires system collaboration and leadership at different levels and across range of organisations. It is recognised nationally that this will require a different set of skills, resources and approaches by local leaders.

3.8 Similar to other footprints, in Brent and NWL the focus until late last year has been on planning, moving into the delivery phase over the last few months has identified a shared concern about the system's ability to implement the plans. It is becoming apparent meaningful delivery of the Health and Care plan will require us as leaders and organisations to work together in different ways.

3.9 At the NWL sector level there is recognition that to achieve the ambitious objectives set out in our STP and have a sustainable legacy, the development of effective system leadership across health and care organisations needs to be accelerated. NWL Strategy and Transformation team have commissioned leadership and change management programmes under the Change Academy umbrella at three levels:

a) **Systems leadership programme** aimed at STP leadership team, e.g. the NWL Joint Health and Care Transformation Board, Delivery Area 1-5 programme boards and Provider Board. This is an initial programme based on the evidence that collaborative system leaders who broker meaningful partnership and relinquish the rights over parts of their territory, deliver sustainable change. The Systems leadership programme aims: to improve collaborative working and partnership behaviours across health and care through board observation-based diagnostics and practical support; and facilitate systems leaders to lead networks instead of individual organisations which requires a different mind-set and leadership behaviour. This is being led by Prof Rebecca Malby from London Southbank University. Prof Malby has a track record in systems innovation, organisational change and leadership development in UK.

b) **Joint Commissioning for outcomes across health, social care working with service users to define "value**". This is aimed at lead commissioning managers and operational managers to get to grips with new ways of working and break down barriers between different commissioners and ultimately between commissioners and providers in line with the STP ambition to move towards accountable care. This means moving away from the current provider/commissioner divide and the development of services based purely on volume and activity to deliver care based on outcomes. COBIC and Optimedis who have significant experience of delivering this elsewhere have been engaged as delivery partners.

c) The High Performing Care Programme (HPCP) and Senior System team development (SSTD)-

HPCP – aimed at team managers it will deliver system change through high performing teams across health, social care and voluntary sector with carers/service users, using improvement methodology underpinned by data.

SSTD – to enable change to occur across the whole system, the senior leaders who line manage/sponsor the HPCP team members will need to improve collaborative working and address challenges in a boundary-less fashion. The programme includes coaching and action learning with access to leadership events. This programme is being facilitated by GE Finnamore.

3.10 Brent STP Executive Group have been proactive in submitting expressions of interest to participate in all the three programmes:

We have negotiated with NWL team to engage Prof Malby to facilitate a bespoke systems leadership development programme for Brent STP Delivery Board. The first session on 08 June has been scheduled to co-design a workshop focused on securing a shared approach to change within Brent Health and Care plan. This will initiate a process of addressing accountability and governance processes for networked systems change.

Brent STP team has also been successful in being recruited to the first cohort of Commissioning for Outcomes Programme. Key commissioner and provider leads and clinical lead are committed to participate and focus will be on mental health system. This programme will provide practical support for the mental health work stream members to start the process of developing network of care.

Finally, recognising the importance of supporting our health and care teams to lead on integrated care, we put forward two teams to participate in High Performing Care Programmes related to Delivery Area 3 – which is our newly formed integrated reablement and rehabilitation service and the second related to Delivery Area 4, the learning disability health and care teams which are not integrated but plan to be an integrated team by October 18. This will give a much needed focus to our front line teams and their sponsors to facilitate integration, develop the skills and capacity to deliver sustainable change.

STP Delivery Board Update

3.11 The STP delivery board with its newly constituted membership and terms of reference focused on delivery has met a few times since transitioning from planning to delivery phase.

3.12 The focus of the board in the last quarter of 16/17 has been to ensure that the scope, outcomes and deliverables of the six work streams are fully agreed across partner organisations and reflect the outcomes of various engagement events that were held in September and October 2016. All the six work streams have completed scoping documents which articulate key deliverables and outcomes.

3.13 The STP delivery board chairs have since had focused meetings with all the work stream SROs and lead commissioners to agree implementation plan for each of the work stream and key milestones to achieve the key deliverables articulated in the scoping documents.

Health and Care plan work streams update

3.14 All the six work streams are now established and regular meetings are held to ensure oversight of the work programme and ensure key stakeholder engagement. Regular updates on the programme of work, risks and

challenges are discussed and milestones are agreed at work stream meetings.

Work stream 1 Prevention

3.14 This work stream has now been set up with key stakeholders and continues to build on the existing initiatives on workplace based health and wellbeing initiatives and making every contact count.

3.15 The main focus of this work stream has been to align with Delivery Area 1 priority of reducing alcohol related A&E admissions. A key priority across NWL has been to agree and develop an acute based service model. Brent has been leading on this with NWL team with the objective of being an early implementer site for Northwick Park Hospital and subsequently at Ealing Hospital. The service model has been agreed with A&E operational and clinical leads. In addition, robust work on data analysis and setting a clear baseline has been completed to enable measuring of impact and return on investment. The next steps are to complete a joint business case for Brent and Harrow for investing in the service. The business case will propose the development of an alcohol care team to be based at A&E for the acute LNWHT site at Northwick Park with cover offered to the Urgent Care Centre at Central Middlesex Hospital. The service will be measured on reduction in admissions and re-admissions. It is expected that the team will be in place by October subject to successful investment decision.

3.16 This work stream is also progressing the development of social prescription service. The objective is to use social prescription as a means to reduce social isolation and reduce inappropriate use of health services e.g. A&E admissions, ambulance call outs, GP appointments and statutory services. A business case that includes demonstrable outcomes and return on investment is being developed. The next steps entail building an operational model for service delivery that will incorporate the Care Navigator service and Social Isolation Brent Initiative.

3.17 The smoking cessation project is in early stages. As is the case nationally, the numbers of people accessing smoking cessation are falling in Brent as smoking prevalence falls and e-products are widely available. A review is being undertaken of existing smoking cessation services. This will include lessons from CNWL going smoke free as part of the business case development. Engagement to be agreed to enable implementation of CO4 initiative.

Work stream 2 New Models of Care

3.18 This work stream has been in development over a number of years and builds on Whole Systems Integrated Care (WISC). Providers and commissioners co designed the first phase of WISC in 2015 as a precursor to an Accountable Care Partnership delivery model. However, this work is largely commissioner led in view of the need to develop the provider landscape to respond to the challenge of delivering care in this manner.

3.19 This work stream now moving to the phase of being a key enabler to the other Health and Care plan work streams in particular older people, mental health and transforming care. As these work streams progress, it is becoming apparent that services across health and care system are operating in silos, driven by disjointed commissioning and perverse contractual incentives. The Models of Care work stream therefore needs to leverage existing Brent Health and Care plan programmes and address the common barriers to integrated working. This work stream will essentially be a vehicle to enable a care partnership jointly accountable to achieve common system wide outcomes, supported by single commissioning arrangements within an agreed pooled budget.

3.20 The next steps are to identify existing programmes that can be developed as a network of care around specified client groups, such as Older People's care network, Mental Health care network and Learning Disability care network. Further details and programme of work to implement this will be brought to future HWBB meeting.

Work stream 3 Frailty

3.21 This work stream is aligned with Delivery Area 3 and has two distinct but interlinked elements – acute frailty model and out of hospital community provision. The out of hospital element is being developed and implemented through the Better Care Fund (BCF) Plan. The plan has three interlinked schemes that incorporate admission avoidance initiatives; effective hospital discharge delivered by integrated health and care teams with a strong focus on reablement and a fundamental cultural shift to implement Discharge to Assess (D2A); and Enhanced health care in care homes and joint commissioning. The next steps on this work stream are detailed in a separate report to the HWBB.

Work stream 4 Mental Health and Wellbeing

3.25. This work stream is well established with monthly meetings scheduled and consists of three interlinked projects:
Crisis Response: developing a crisis response that recognises and prevents escalation of crisis in order to decrease the number of people who are submitted to an in-patient setting. A baseline has been determined regarding current crisis activity and in-patients admissions data, to understand the client cohort who has in-patient admissions due to crisis. The next stage is to agree a system wide operating model that can recognise and effectively respond to escalating crisis, particularly for people in mainstream accommodation.

Community support with a recovery focus: A stocktake has been completed regarding the commissioned and directly provided services supporting people with mental health needs. This has demonstrated that there are in excess of 30 different types of services commissioned from a range of providers. It is a highly complex system to navigate, and although there are links and collaborative relationships, the system needs to be joined up and

integrated. The next stage is to develop an operational delivery model aligned with whole Systems Integrated Care that can be commissioned to achieve systems outcomes for people with mental health needs and develop a network of care. The Commissioning for Outcomes programme will enable the commissioners and provider leads to start this process.

Primary Care: Brent CCG have undertaken a capacity and capability assurance of the preferred primary care provider, Brent Care Ltd to confirm that they can deliver the required service and expected outcomes for complex but managed mental health needs, which includes a DEPOT and non-complex Dementia service. Brent Care Ltd are partnering with secondary mental health provider CNWL to deliver the service and Local Medical Council has been engaged to support Brent care ltd to ensure that its GP members are not committing to deliver a service for which they do not have capabilities. Although the Depot and Dementia service is currently provided by CNWL, the intention is for services to transfer to Brent care Ltd from 01 October 2017.

Transforming Care Programme (TCP)

Supporting People with Learning Disabilities

3.26. The work stream is aligned to NWL TCP and has four interlinked programmes of work.
Individuals in placements: securing suitable support closer to home for people with learning disabilities who are in in-patient settings.
Integrated Health and Social Care team: bring together the health and care teams to form a single integrated team to support people with learning disabilities.
Market management: developing a joint commissioning action plan to increase the range, scope and quality of support available in the community for adults with learning disability and/or autism.
Transitions: Developing an all age offer in order to decrease the impact of transition between childhood and adulthood for people with learning disabilities.

The progress in each of these four areas is detailed below.

3.27. Individual in placements

This work area is well established with the NHS continuing health care team co-ordinating Care and Treatment Reviews for adults with Learning disability in in-patient settings.
There is a monthly multi-stakeholder meeting that oversees progress of individuals in in-patient settings.
Currently there are three Brent Commissioned people in in-patient settings and eight people whose care is commissioned by NHS England as specialist commissioner. In line with the TCP requirements, all the 11 individuals have either had their Care and Treatment review or have been scheduled. The objective of these reviews is have a comprehensive assessment of individual care and treatment needs including discharge planning if appropriate. Of the

three individuals who have had reviews, two of them are being supported to be discharged into community settings.

3.28. Integrated Learning Disability Team

The STP steering group agreed that creating an integrated health and social care team would improve outcomes for people with learning disabilities, reduce handoffs and optimise use of resources.

A task group has been established to identify and implement the operational changes required to create an integrated team that works collaboratively and innovatively with people who have a learning disability to increase their independence and decrease their reliance on formal organized services.

The operational task group successfully applied to the Change Academy programme to support this transformation process and attended the first workshop on 10 and 11 May. The group will receive coaching support and attend further workshops for six months.

A commissioner task group has been established to consider the current contracting arrangements and resource allocation for existing services and the NWL service specification for Learning disability services. The lead CCG commissioner has undertaken a pricing review with CNWL and established the current staffing resource that could be allocated to a ring-fenced Brent integrated LD service.

The Council has applied to the NWL data warehouse to gain access to the Whole System Integrated Care (WSIC) data in order to conduct a needs assessment of people with Learning disabilities in Brent. Analysis of this data will be used to inform the overall system resource required to provide support that improves the outcomes for people with LD, whilst optimising use of resource across the Brent system.

Commissioning options have been reviewed to inform the structure of an integrated LD team. Integrated and lead commissioning arrangements of the team will enable a single commissioning function to meet statutory responsibilities. However, a pooled placements expenditure and service delivery budget has the potential to generate transformational system sustainability as resources can then be allocated based on client need, rather than funding source. Agreement from the Council and CCG will be required to pursue such a commissioning arrangement. If agreed, the commissioning arrangement will need to be supported by risk and benefit arrangements.

The next step is to develop system wide outcome measures and options for lead commissioning and pooled funding arrangements to achieve joint health and social care ambitions. These joint outcome measures will also be the basis of developing a learning disability network of care.

3.29. Market Management

A joint health and social care strategy for people with LD and/or Autism is being finalised. The strategy describes a joint health and social care aim to improve co-ordination and quality of services for people with learning disabilities and/or autism with challenging behaviour. The strategy aims to facilitate system wide change that enables more people to live in the community, with the right support, closer to home.

A task group has met to consider the general accommodation needs of people with learning disability and/or autism and is now mapping the existing provision in order to identify the gaps in the market and the market management actions required to address these gaps.
The next step will be to consider the wider support needs of people with Learning disability and/or autism in order to identify the gaps in provision. This will form the basis of the joint health and social care commissioning action plan.

3.30. Transitions

An ideas paper on Transitions has been discussed and agreed in principle by Brent Council. Changes to the Children and Young people with Disability services and the Transitions service have been considered. These changes are intended to improve operational processes in order to create greater equity, effectiveness and consistent practice for children and adults with Learning Disability.
There is council agreement to align with the Education, Health and Care (EHC) process and greater integration with health services would facilitate joined up planning, assessment and delivery of care. This will make best use of resources.
The next stage will be to form a combined health and social care task group to consider the benefits of integrated health and social care service delivery and the necessary changes required to achieve this.

3.31. Central Middlesex Hospital Hub Plus

This work stream identifies Central Middlesex Hospital (CMH) site as a major place-based opportunity, with the potential to accelerate integration and joint working for the benefit of local residents. Potential benefits span across all five delivery areas of the NWL STP.
It has two broad strands of work; the first is estates-focused aimed at realising location and facility related opportunities and the second concentrates on service and service user driven opportunities, including the employment creation, learning opportunities as well as integrated models of support and care.
The work stream is led by LNWHT and supported by STP team. An initial project plan has been developed to focus on three main deliverables in the short term:

Identify opportunities, to leverage the Park Royal location to address health, social care or drivers of health and well-being. This will be done through engaging a consultant in early July to assess the current site usage and potential opportunities

A strategic vision for the Park Royal site following stakeholder engagement

Prototype, a community hub at CMH (following Brent council's successful Harlesden Hub model) over the summer period.

4.0 **Finance Implications**

4.1 There are no specific strategic financial implications in this update report.

5.0 Legal Implications

5.1 Whilst this document is an update on the on-going project, from an adult social care perspective, it is important to ensure that throughout the project, the requirements of the Care Act 2014 in terms of promoting wellbeing, preventing, reducing or delaying needs are complied with, as well as the recently released 2017-19 Integration and Better Care Fund Policy Framework prepared by the Department of Health and the Department for Communities and Local Government so that we continue to meet our statutory obligations so that our actions do not leave the local authority open to legal challenge**.**

6.0 Diversity Implications

6.1 The STP aims to address the whole health and care system to enable a rebalancing towards prevention, early intervention; supporting independence and wellbeing. It aims to engage and empower the diverse communities of Brent and the wider health economy across NW London to improve health and wellbeing outcomes and patient experiences.

6.2 Detailed Equality Assessments will be undertaken for each of the work stream plans to ensure that equalities issues are addressed or mitigated as part of the implementation process.

7.0 Staffing / Accommodation Implications (if appropriate)

N/A

Background papers

a) Brent Health and Care Plan accessed via

https://www.brent.gov.uk/media/16405520/16-07-13-brent-stp-chapter-draft.pdf

b) The North West London Sustainability & Transformation Plan accessed via https://www.healthiernorthwestlondon.nhs.uk/documents/sustainability-and-transformation-plans-stps

c) The NHS Five Year Forward View, accessed via https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Contact Officers

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Brent NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 14 June 2017 **Report from Operational Director Adult Social Care and Deputy Chief Operating Officer London North West Healthcare NHS Trust**
	Wards Affected: ALL

Unified Frailty Pathway/ OPALS Business Case

1.0. Summary

1.1. The purpose of this report is to provide the Health and Wellbeing Board (HWB) with an update on progress on the Older People's Acute Liaison Service (OPALS) business case for Northwick Park Hospital.

This is one component of the Unified Frailty Pathway and part of Delivery Area (DA) 3 - the Older People's services workstream of the Northwest London Sustainability and Transformation Plan (NWL STP). It also forms a key workstream of the Brent Health and Care Plan (the Brent Plan).

The business case additionally forms part of the recovery action plan for the A&E performance targets, with phasing for breach reduction to begin from September 2017.

2.0. Recommendations

2.1 The Health and Wellbeing Board is invited to comment on the programme of work and note progress.

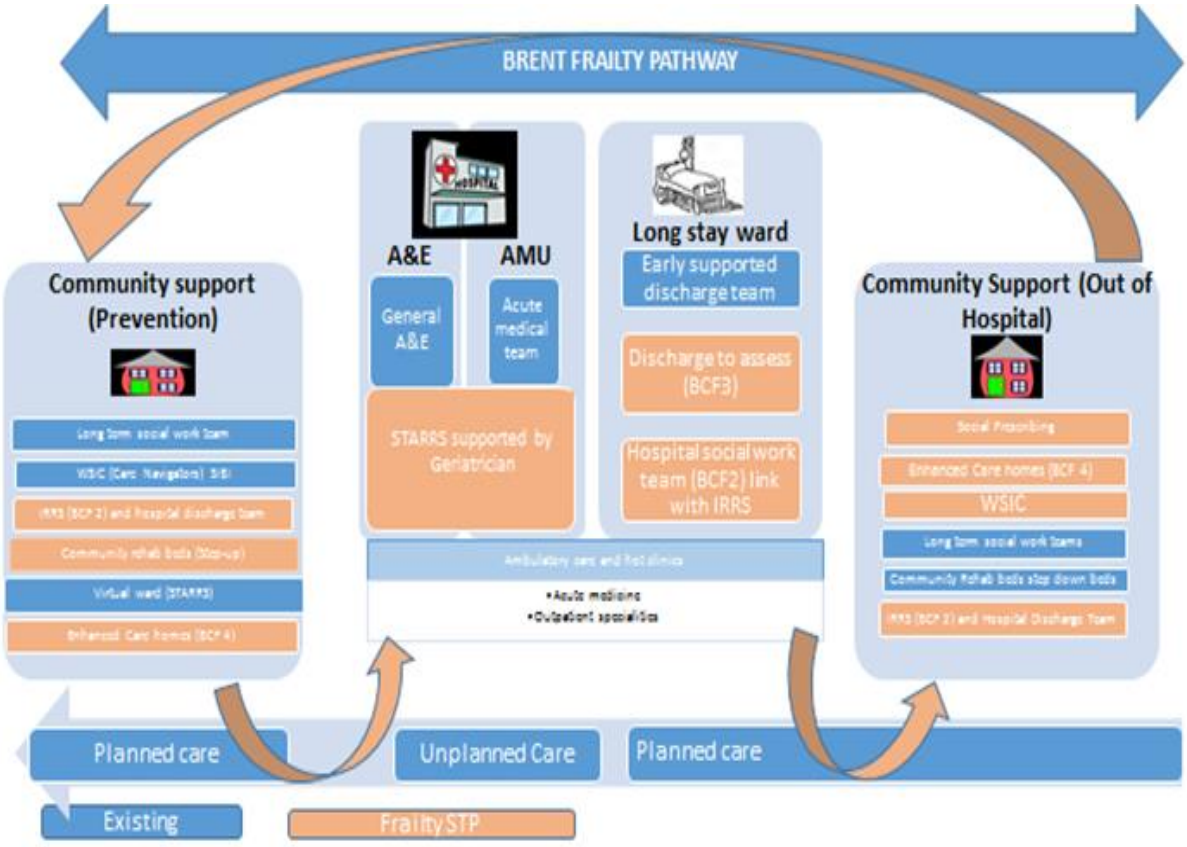
3.0 Background

3.1 Sustainable Transformation Plans (STP) are being developed on geographic "footprints" which bring together a number of CCGs, local authorities and NHS providers (mental health, acute and community). Brent is part of the North West London (NWL) STP footprint. Brent HWB members are actively involved in the NWL STP, but the board has also recognised the need for a local Brent focus. The Brent Health and Care Plan, which localises the NWL STP, has therefore been developed.

3.2 At its March meeting, the HWB endorsed the high level plan for the Older People's Workstream and requested ongoing updates to include costs and benefits for the different elements of the Older People's Service workstream, acknowledging that this workstream was particularly complex and wide ranging, and that different elements of the overarching pathway were at different stages of development.

3.3 Improving outcomes for Older People is one of the six big ticket items and a key priority of the Brent Plan, and also one of the five Delivery Areas of the NWL STP.

3.4 The Frailty pathway agreed by the Brent STP Board is illustrated below:



3.5 Due to the scale of the work required to deliver the whole frailty pathway, work has been separated into four workstream to deliver meaningful change across in and out of hospital services. This approach will not create silo working but it is expected to be concurrent ensuring that key planks of STP, BCF, A&E breach reduction and business as usual plans deliver the transformational change required so a fully functioning frailty pathway is in place in Brent by 2020. The four workstreams are summarised below:

3.5.1 Workstream 1 – Long Stay Wards & Improved Discharge

For this phase of work the assumption is made that patients with frailty have moved through the emergency system from A&E, assessment units and transferred into the general wards.

The Better Care Fund 16/17 & the revised 17/18 schemes are at the heart of delivering changes within this phase of work. Brent CCG/LA and LNWHT went live with an 8 week pilot (May 2017) to deliver a 'discharge to assess' model of care which aims to reduce the length of stay and the number of DTOC's on the Northwick Park site.

Patients under this model will be transferred home with a rapid OT assessment and an immediate package of care in place to support the necessary needs. Any equipment requirements will be dealt with rapidly so that care is wrapped around the patient at home whilst they wait for their relevant assessments.

The cohort of patients that this model will impact on will be older people (65+) of which some will have frailty.

The Brent system already has an Integrated Rehabilitation and Reablement Service (IRRS) in place which supports transfer of patients home and if patients still need to remain under the care of a medical team we have Early Supported Discharge which is under the remit of STARRS.

The elements under this scheme have been delivered and the focus is to ensure that they are embedded and expanded where appropriate and feasible.

3.5.2 Workstream 2 – A&E and AMU

This aspect of the frailty model is the focus of the OPALS business case and specifically on quicker, more multi-disciplinary assessment at the 'front-door' of the hospital (Emergency Department). The OPALS pilot run in 2015/16 tested the initial case for change and highlighted the financial opportunity (length of stay reduction).

The CCG has already commission a Rapid Response service through STARRS which is expected to manage a range of patients at home, some of which would be patients with frailty. This is expected to accelerate during 2017/18 along with the presence they have in A&E to ensure patients are identified and managed accordingly.

The OPALS service proposed in the business case is expected to span across A&E and the short stay assessment units.

3.5.3 Workstream 3 – Community Support (Prevention)

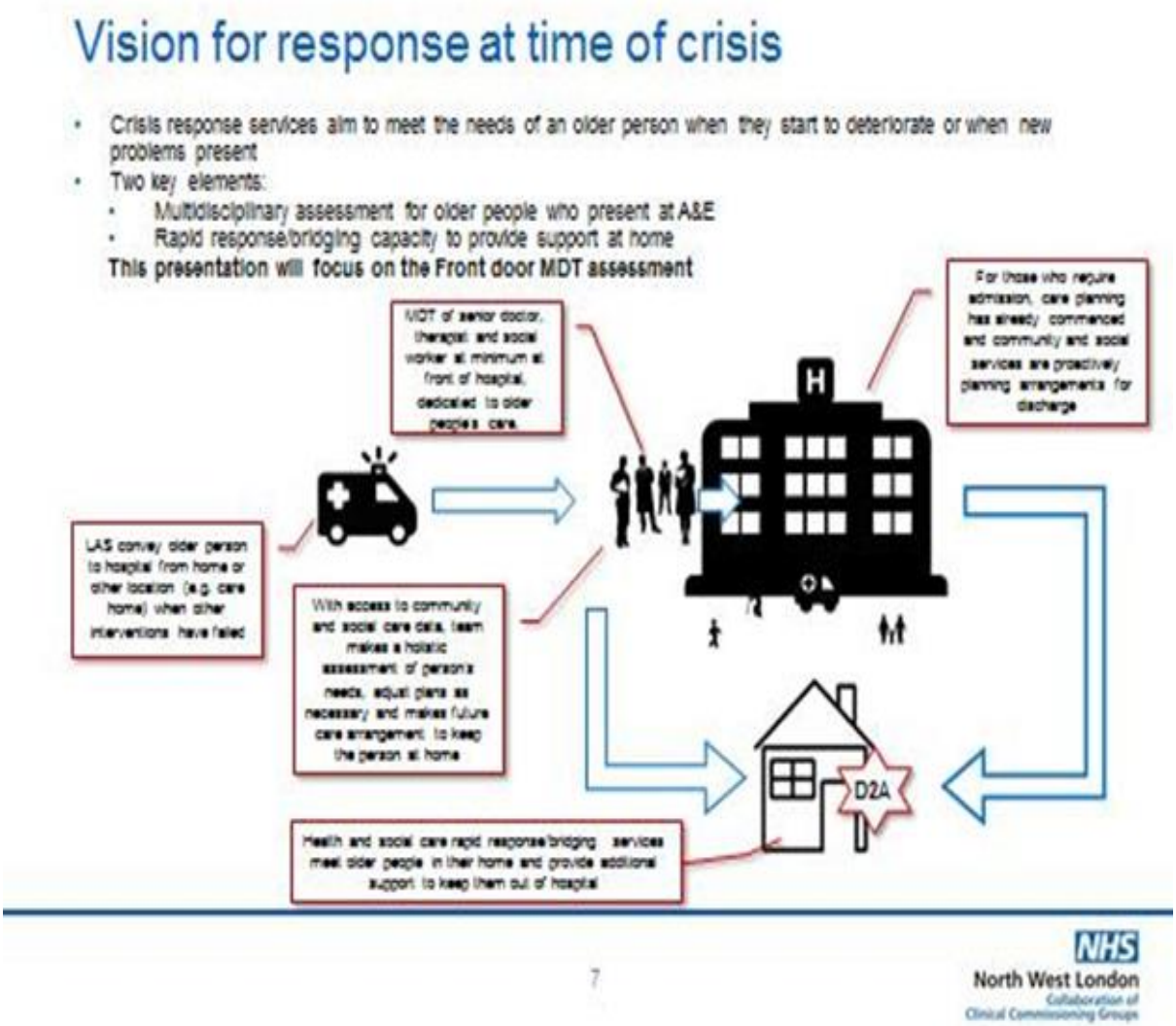
This is a critical area to ensure that we are doing everything we can to avoid patients moving upstream into the urgent and emergency care system. Whole

Systems Integrated Care (WISC) and the Enhanced model for care homes are the key components within this workstream.

3.5.4 Workstream 4 – Community Support (Out of Hospital)

Once patients have had an unplanned episode of care in the hospital this phase aims to ensure that the infrastructure in the community can maintain patients as there is a risk that as a result of a change in baseline they are likely to be readmitted in the future.
Services which impact on other phases within this pathway are included here such as IRRS, Early Supported Discharge and Community nursing, all of which will deliver a service to manage patients in the community.

3.6 This report concentrates on developments around the Workstream 2 – A&E and AMU aspects of the pathway, specifically the business case that has been developed in relation to the development of the OPALS service for Northwick Park Hospital. The diagram below sets out how the pathway will interact with existing services:



4 Background to OPALS business case

4.1 Despite the numerous initiatives delivered as part of an overarching out of hospital strategy, an increasing number of older people are attending hospital through an urgent and emergency route, accessing urgent health and social care services.

Over the past 12 months LNWHT (London Northwest Hospitals Trust) has reported a 6% increase in admissions for 65+ and a 10% growth in admissions for 85+. Evidence at a local level suggests that older people who attend an emergency department are;

I. more likely to be admitted into an acute bed
II. have a longer length of stay and occupy more bed days compared to the other patient groups.

A patient who is 85+ has a length of stay of 9.9 days at LNWHT compared with a 4.5 day average across all age groups.

4.2 Based on Brent CCG SUS data (Secondary User Data), the cost of non-elective emergency admissions for older patients at LNWHT during 2015/16 was £15.6m and in 2016/17 the cost had increased to £16.7m (all providers). At LNWHT the activity has remained relatively flat with total non-elective admissions 3661 for 16/17 compared with 3538 in 15/16.

4.3 Doing nothing is no longer an option and large scale transformation within the short term has a number of challenges. Therefore, as part of this frailty business case the transformational change is articulated as a phased approach to address the local requirements. By 2020/21 the expectation is for the Brent system to have completed the necessary deliverables to achieve the overarching ambition of a 'unified frailty model'.

4.4 For the LNWHT recovery of the A&E performance trajectory, a fully operational frailty model within the acute trust by Sept 2017 is critical to ensure that breaches are reduced. The submission to NHS England and NHS Improvement committed to a reduction of 1302 A&E breaches over a six month period from September 2017.

4.5 The focus of this business case at Northwick Park, will address the issue of older people with frailty once they have entered the Emergency Department and who are likely to end up in a bed for a period of time which can cause unnecessary harm and deterioration, should a prolonged length of stay materialise for whatever reason.

4.6 The aim of this business case is approval for an enhanced model of care for the Northwick Park site which will ensure that there is a focus on assessment and treatment of frail elderly patients in the full Emergency patient flow. The design of this model is based on the OPALS pilot which included patient

feedback. NWL also have an Older Peoples Reference Group which has informed this business case.

5 Detail of the proposed model

5.1 The proposal is to create both an OPALS mutli-disciplinary team and a frailty pathway that will allow for early identification and assessment of people who would benefit from earlier, targeted assessment and a dedicated team to co-ordinate and manage their care. Evidence suggests that this will support frail elderly people to avoid admission to long stay wards and to be supported back home with a better chance of avoiding re-admission.

5.2 In order to successfully establish a team for NWP site which will aim to cover all frailty patients on site it is anticipated that the following staff will be required to deliver the initial 5 day service:

- 1.4 x WTE consultants
- 1 x Band 7 therapy team leader (team needs dedicated leadership) and 1 x band 6 and 1 band 5 therapists
- 4 x Junior Drs - 1 x registrar, 2 x SHOs/clinical fellows and 1 x F1 (required to cover annual and study leave)
- 1.5 x discharge co-ordinator (this role was central in ensuring success of pilot and needs to have leave cover built in)
- 1.5 advanced nurse practitioners (ideally 3 x WTE working across acute wards and Emergency Pathway)
- 1.5 x Social Worker (holiday and sickness cover can be provided through the existing Hospital Discharge Team)
- 1 x Occupational Therapist (cover to be provided by IRRS)
- 0.5 x Housing/adaptations advisor.

Whilst some elements of the workforce can be made available through internal reconfiguration of staff it is expected that a number of these roles will require recruitment.

5.3 Further discussion is taking place regarding whether there is a need for input from a pharmacist and a transport co-ordinator.

5.4 The OPAL team will aim to assess patients within 24 hours of admission and discharge/transfer 75% of those patients within 48 hours. The aim will be to move this model to a 7 day service within 12 months.

5.5 ED department at NPH will establish a frailty area on Carroll Ward to facilitate comprehensive geriatric assessment and admission avoidance for the frail elderly identified using the frailty screening tool.

5.6 The OPAL team will interface and in-reach into this area aiming to see patients within 2 hours of referral to avoid admission if appropriate, overall management

of patients in this area will remain the responsibility of the ED team led by a consultant and advanced nurse practitioner (Leicester model).

5.7 If the OPAL team deem that the patient requires admission then they will be referred via the acute medical team and then triaged to the appropriate clinical team for ongoing treatment.

5.8 The team will work to the agreed complex discharge planning process with shared responsibility between the acute trust, community services and social care:

- Older people should only be discharged from hospital with adequate support and respect for their preferences
- Information must be shared between the relevant services whenever there is a transfer of care between individuals of services
- An expected discharge date should be set within 2 hours (14 hours overnight) following admission into a bedded unit
- Sharing of information on local voluntary sector organisations, accessing financial support and reablemenent services.

6 Finance Implications

6.1 The resource implications will need to be fully worked through prior to business case approval for Jun 2017. The cost of this service is estimated at £397k per annum with identified savings of c. £550k. However, there remains significant opportunity to increase this level of savings through this model of care.

Sign-off will also be required by the contract and finance teams to ensure that the assumptions made on Payment by Results activity shifts are valid.

7 Legal Implications

7.1 No implications have been identified at this stage. This will be reviewed as work progresses towards implementation.

8 Diversity Implications

8.1 The Brent and Health Care plan aims to address the whole health and care system to enable a rebalancing towards prevention, early intervention, supporting independence and wellbeing. It aims to engage and empower the diverse communities of Brent to improve health and wellbeing outcomes and patient experience.

8.2 Detailed Equality Assessments will be undertaken for each of the workstreams to ensure that equalities issues are addressed and or mitigated as part of the implementation process.

9 Staffing / Accommodation Implications (if appropriate)

9.1 Staffing implications are listed as above. Further implications will be assessed once work is completed to identify what existing resource can be contributed towards the team.

Contact Officers

a) Phil Porter - Strategic Director of Adults and Community Wellbeing, Brent Council

b) Sarah Mansuralli - Chief Operating Officer, NHS Brent Clinical Commissioning Group

Brent NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 14 June 2017 **Report from the Director of Public Health**
For decision	Wards affected: ALL
Revision of the Brent Pharmaceutical Needs Assessment	

1.0 Summary

1.1 S128A National Health Service Act 2006, amended by s206 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. The Brent Health and Wellbeing Board published its first PNA by April 2015 in accordance with the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (the Regulations). The Regulations stipulate that HWBs will need to publish a revised assessment within three years, which is by 01 April 2018.

This paper proposes how this responsibility should be discharged.

2.0 Recommendations

2.1 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

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

3.2 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

3.3 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.

3.4 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").

3.5 The existing PNA for Brent (available on the Council website https://www.brent.gov.uk/media/16402268/brent-pna-pharmaceutical-needs-assessment-2015.pdf) was produced by the HWB in 2015. This has been updated by the publication of supplementary statements as changes have been made to pharmacies within Brent. The Regulations require that the Health and Wellbeing Board publish a revision within three years of publication of a PNA.

3.6 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.

3.7 In order to revise the PNA and publish the same, it is recommended that a Steering 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.

4.0 Financial Implications

4.1 There are no specific strategic financial implications from this report.

5.0 Legal Implications

5.1 The Health and Social Care Act 2012 established HWBs. The Act also amends s128 National Health Service Act 2006 transferring responsibility to develop and update PNAs from PCTs to HWBs.

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.

5.2 Regulations 3-9 and Schedule 1 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the requirements for PNAs.

5.3 Specifically Regulations 5 and 6 cover the date by which the HWB's first PNA must be published and the arrangements for revising the PNA. The local authority must ensure the PNA Steering Group and those it reports to are aware of and adhere to the requirements.

6.0 Equality Implications

6.1 The Council is required under section 149 of the Equality Act 2010 when exercising its functions, to have due regard to the need to eliminate discrimination, harassment and victimisation and other conduct prohibited under the Act, to advance equality of opportunity and to foster good relations between those who have a protected characteristic and those who do not share that protected characteristic. This is the Public Sector Equality Duty (PSED). The protected characteristics covered under the Act are age, disability, gender, gender reassignment, marriage and civil partnership (only in respect of eliminating unlawful discrimination) pregnancy, maternity, race (this includes ethnic or national origins), religion or belief (this includes lack of

belief) and sexual orientation. Due regard means giving relevant and proportionate consideration to the duty, in that whenever significant decisions are being made or policies developed consideration must be given to the impact/affect that implementing a particular policy or decision will have in relation to equality before making that decision.

6.2 Brent is one of the most diverse boroughs in London and in the UK. Evidence suggest that there is strong correlation between health inequalities and the levels of diversity in the population. For example, certain ethnic minority communities are exposed to a range of health challenges, from low birth weight and infant mortality through to higher incidence of long-term limiting illnesses such as diabetes and cardio vascular disease. Brent pharmaceutical services need to reflect the needs of the borough's diverse communities while providing a broad range of services to the entire population.

6.3 When conducting the Pharmaceutical Needs Assesment (PNA) review, the PNA Steering Group must pay due regard to the PSED and all relevant protected characteristics, including socio-economic groups.

7.0 Staffing/Accommodation Implications (if appropriate)

7.1 See paragraph 3.7 for details

Background Papers (if any)

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

Appendix 1.

Brent Pharmaceutical Needs Assessment Steering Group
Terms of reference

Purpose

To direct and oversee the production of and consultation on a revision of the Brent Pharmaceutical Needs Assessment (PNA), on behalf of the Health and Wellbeing Board, in order the revised PNA to be published by 01 April 2018.

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 01 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 Wellbeing 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 Wellbeing Board must publish the statement of its first assessment;

(d) as to the circumstances in which a Health and Wellbeing 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 Wellbeing 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 Wellbeing Board must have regard when making an assessment.

Responsibilities

- 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
Healthwatch representative
NHSE representative