Brent / NHS Brent Clinical Commissioning Group	**Brent Health and Wellbeing Board** 14 July 2021
	Report from the Strategic Director for Community and Wellbeing

Brent Health and Wellbeing Board Governance, ICP delivery vehicles and highlights update

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt:	Open
No. of Appendices:	Appendix 1– Governance structures 2021/22 Appendix 2 – BHWB work plan 2021/22 Appendix 3 – Health inequalities and diabetes
Background Papers	/
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1.0 Purpose of the Report

1.1 This report outlines the Brent Health and Wellbeing Board (BHWB) governance structures and the delivery vehicles of the Integrated Care Partnership (ICP) (see Appendix 1).

1.2 The report aims to bring into focus the changing landscape in health and seeks to engage Brent Health and Wellbeing Board input to future ways of working.

2.0 Recommendations

2.1 To note the delivery mechanisms of the Integrated Care Partnership Executive Committee (ICPEC), and the membership and priorities of the four executive groups.

2.2 To discuss the BHWB arrangements within this context and provide strategic direction to officers as required. Key considerations could include:

- Purpose and focus e.g. to allow for annual or bi-annual public engagement
- Membership e.g. to enable delivery of statutory responsibilities

2.3 To agree the draft work plan of the BHWB for 2021/22 (see Appendix 2).

3.0 Detail

The Brent Health and Wellbeing Board

3.1 Health and Wellbeing Boards (HWBs) are a statutory forum where political, clinical, professional and community leaders come together to improve the health and wellbeing of their local population. HWBs have a statutory duty to produce a joint strategic needs assessment and a joint health and wellbeing strategy for their local population.

3.2 As well as its statutory role, the **Brent Health and Wellbeing Board** (BHWB) ensures system leadership across commissioners and providers working in Brent.

3.3 Current legislation states that health and wellbeing boards must include:

- At least one elected representative
- A representative from the Clinical Commissioning Group (CCG)
- The local authority directors of adult social services, children's services and public health
- A representative from the local Healthwatch

3.4 Beyond this minimum membership, other interested local stakeholders may also be invited to hold membership. These may include representatives of third-sector or voluntary organisations, other public services, or the NHS. The BHWB currently has a wider membership than statutorily defined, made up of voting and non-voting members.

3.5 Current BHWB membership is as follows:

Full members (voting):

- Cllr Farah (Chair), Brent Council
- Cllr McLennan, Brent Council
- Cllr Nerva, Brent Council
- Cllr M Patel, Brent Council
- Cllr Kansagra, Brent Council
- Sheik Auladin, Brent Clinical Commissioning Group (CCG)
- Dr M C Patel (Vice Chair), Brent CCG
- Dr Ketana Halai, Brent CCG
- Jonathan Turner, Brent Borough Director, CCG
- Healthwatch Brent

Full members (non-voting):

- Carolyn Downs, Brent Council
- Phil Porter, Brent Council
- Dr Melanie Smith, Brent Council
- Gail Tolley, Brent Council
- Mark Bird, Brent nursing and residential care sector
- Simon Crawford, London North West University Healthcare NHS Trust
- Robyn Doran, Central and North West London NHS Foundation Trust
- Janet Lewis, Central London Community Healthcare NHS Trust

3.6 There will be impacts on HWBs in the upcoming Health and Care Act, and officers will ensure we retain flexibility to respond to any new or changed statutory duties.

3.7 The draft work plan for the BHWB for 2021/22 has been compiled and is attached in Appendix 2. Consideration has been given to require standing items within the context of the new Integrated Care System (ICS) arrangements (detailed in subsequent

sections) and statutory focus relating to the emerging Joint Health and Wellbeing Strategy.

The Children's Trust

3.8 The **Brent Children's Trust** (BCT) is a statutory strategic partnership body made up of commissioners and key partners. The primary functions of the BCT include commissioning, joint planning and collaborative working to ensure that resources are allocated and utilised to deliver maximum benefits for children and young people in Brent

3.9 The BCT meets every two months to review progress against the priority areas of focus and address any emerging local and national issues. The BCT, through its Joint Commissioning Group (JCG), oversees five groups tasked with implementing specific priorities across the partnership.

3.10 The BCT, JCG and transformation groups have consistent attendance with representation from Brent Council and Brent Clinical Commissioning Group (CCG). Other key stakeholders also attend the JCG, which includes three school head teachers who have been active members since September 2017.

3.11 The BCT has identified a number of priority areas of focus for April 2021 to March 2022 as a result of emerging issues supported by local and national data:

a. Working with parents and carers to positively impact on children's health and wellbeing with specific focus on:
    1. Healthy weight in childhood
    2. Oral health
    3. Childhood immunisation
b. Special Educational Needs and Disabilities (SEND) – with a focus on early intervention and prevention in light of the major national review into support for children and young people with SEND to be launched in 2021.
c. Children and Young People's Mental Health and Wellbeing – with a continued focus on the delivery of the transformation plan.
d. Integrated Disabled Children and Young People Service 0-25 - with a focus on Stage 2, the integration of health and local authority provision, which was paused in 2020 due to Covid-19 Pandemic.
e. Transitional safeguarding between CYP and Adult Services - with a focus on adolescent safeguarding.
f. Young Carers - with a renewed focus on raising awareness of young carers across the partnership.

The Integrated Care System and local governance arrangements

3.12 On 11 February 2021, the Department of Health and Social Care published the White Paper 'Integration and innovation: working together to improve health and social care for all, which sets out legislative proposals for a Health and Care Bill. The White Paper groups proposals under the following themes:

- Working together to integrate care
- Reducing bureaucracy
- Improving accountability and enhancing public confidence
- Additional proposals to support public health, social care, and quality and safety

3.13 At the heart of the changes is the proposal to establish Integrated Care Systems (ICS) as statutory bodies in all parts of England. ICSs will be made up of two parts – an 'ICS NHS body' and an 'ICS health and care partnership'. The dual structure is a new development and recognises the two forms of integration that are needed to adopt a

population health approach aimed at improving the health and wellbeing of local populations: integration within the NHS (between different NHS organisations) and integration between the NHS and local government (and wider partners).

3.14 The ICS health and care partnership will be responsible for developing and performance managing a plan to address the system's health, public health and social care needs, which the ICS NHS body and local authorities will be required to 'have regard to' when making decisions. The membership of the partnership and its functions will not be set out in legislation – instead, local areas will be given the flexibility to appoint members.

3.15 The White Paper also recognises the importance of 'place', which is a smaller footprint than that of an ICS, often that of a local authority. This is the Integrated Care Partnership (ICP) level. The Department states that it has decided against giving place a statutory underpinning although it is explicit that there will be an expectation that ICS NHS bodies delegate 'significantly' to place level. The development of place-based partnerships will therefore be left to local determination, building on existing arrangements where these work well.

3.16 ICSs will be expected to work closely with Health and Wellbeing Boards (HWBs) and required to 'have regard to' Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. As stated, the future of HWBs in terms of any statutory changes introduced by the Health and Care Bill is currently unknown.

3.17 The new structures for collaboration and integration will be supported by a range of other measures, including:

- A duty to collaborate across the NHS and local government
- A shared duty on all NHS bodies to pursue the 'triple aims' of the NHS Long Term Plan (better health and wellbeing, better quality health care and ensuring the financial sustainability of the NHS)
- A duty on NHS trusts and foundation trusts to 'have regard to' the system's financial objectives
- The legislation will also be amended to assist organisations by enabling decisions to be taken by joint committees and to facilitate increased 'collaborative commissioning' across different footprints, for example, by enabling NHS England to share some of its direct commissioning functions with ICSs.

3.18 The Government has indicated that the Health and Care Bill would be prioritised, with a plan for changes to be implemented in 2022. This changing landscape provides the context for this paper and decision making within.

<u>The North West London Integrated Care System (NWL ICS)</u>

3.19 The **NWL ICS** is already functioning in shadow form and many of the structures that have been set up under the single CCG arrangements will prepare the system well for the anticipated legislative changes. The NWL ICS is led by an independent Chair and an interim Chief Executive has been appointed. The ICS is likely to be coterminous with the North West London borough boundaries currently in existence. The ICS is expected to come into force in a statutory sense by April 2022.

3.20 New operational guidance was issued in March 2021 and confirms the priorities of the ICS to be:

- Improving outcomes in population health and healthcare
- Tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development.

The NWL ICS current priorities are:

- Recovering elective care and addressing the backlog of other unmet care needs
- Strengthening out of hospital care, with focus on prevention and management of long term conditions and improving outcomes for people with mental health needs, learning disabilities and autism
- Improving the workforce experience, best use of estate and driving innovation
- Ensuring fair allocations of resources

The Integrated Care Partnership Executive Committee

3.21 The **Integrated Care Partnership Executive Committee** (ICPEC) (formerly known as the Quartet) is the place-based partnership for Brent within the NWL Integrated Care System (ICS). The ICPEC meets fortnightly, and leads on the integration and systems working in order to improve delivery. Members are:

- A Strategic Director representing Brent Council
- A Director of mental health services (the Independent ICP Director)
- A Director representing community health services
- A Director representing local acute services
- Clinical Chair of Brent area CCG

3.22 The ICPEC has set its priorities and established four further executive groups as follows:

- Health inequalities and vaccination
- Primary Care Network (PCN) development
- Community and intermediate health and care services
- Mental health and wellbeing

3.23 The executive groups oversee the integration of the health and care systems their area of focus, with the following aims:

- System recovery post Covid19
- To provide senior operational oversight over key programmes relating to joint programmes of work between the council and NHS partners
- To monitor the progress of key milestones and actions across joint programmes
- To oversee the allocation of resources for joint programmes, and advise when reallocation is required.
- To provide a key point of escalation for joint programmes, and escalate risks and issues to the IPCEC if required
- To assimilate and appraise proposed interventions for joint programmes
- To manage the brokerage of dependencies for joint programmes when escalated

Executive groups

3.24 The **health inequalities and vaccination executive** (HI&VE) will initially focus on the following priorities:

- Increasing the take up of vaccination and testing amongst BAME and disadvantaged communities
- Increasing engagement, utilisation and awareness of services in communities
- Reducing variation of impact from long term conditions between communities

3.25 The membership of the HI&VE is as follows:

- MC Patel (Co-Chair), Borough Clinical Lead
- Robyn Doran (Co-Chair), Independent ICP Director, CNWL
- Shazia Hussain, ACE, Brent Council
- Martin Kuper, Medical Director, LNWH
- Ralph Elias, Head of Planning, LNWUHT

- Melanie Smith, Director of Public Health, Brent Council
- Tom Shakespeare, Director of Integration, Brent Council
- Isha Coombes, Programme Director, NWL CCG
- Philippa Galligan, Director, CNWL
- Subash Jayakumar, GP
- Janet Lewis, Director of Operations, CLCH
- Judith Davey, Healthwatch

3.26 HI&VE meets monthly. Terms of reference (ToR) have been drafted and agreed.

3.27 The **PCN development executive** (PCNDE) has as its priorities the following:

- Supporting development and maturity of PCNs and empowering them to innovate and be proactive in delivering services to meet population health needs
- Ensuring variations in care are highlighted and addressed at the earliest opportunity with relevant infrastructure to improve health outcomes
- Support PCN leadership development
- Ensure resilience and self-sustainability of PCNs and PCN practices in delivering primary care services in line with national and local directives

3.28 The membership of the PCNDE is as follows:

- MC Patel (Co-Chair), Borough Clinical Lead
- Janet Lewis (Co-Chair), Director of Operations, CLCH
- Jonathan Turner, Borough Director, NWL CCG
- Fana Hussain, Assistant Director of Primary Care, NWL CCG
- Dr John Licorish, Public Health Lead, Brent Council
- Dr Sadiq Merali, clinical representative
- Dr Dhanusha Dhamarajah, clinical representative
- PCN managerial leads

3.29 PCNDE meets monthly. Terms of reference (ToR) have been drafted and agreed.

3.30 The **community and intermediate health and care services executive** (CIHCSE) is focused on the following priorities:

- Improving the coordination and alignment of community and intermediate health and care services
- Establish clear interface between PCNs, community services and council services, including addressing the challenges of cross border service provision in North West London
- Evaluate impact of Covid19 on community health and intermediate care services, and establish joint programme of work to improve services and pathways in response
- Establish and embed a core minimum standard and offer to care homes, including sufficient care home capacity and infrastructure

3.31 The membership of the CIHCSE is as follows:

- Janet Lewis, Director of Operations, CLCH (Co-Chair)
- Simon Crawford, LNWHUT (Co-Chair)
- Isha Coombes, Programme Director, NWL CCG
- Jonathan Turner, Borough Director, NWL CCG
- Gill Vickers, Interim Director Adult Social Care, Brent Council
- Tom Shakespeare, Director of Integration, Brent Council
- Marie McLoughlin, Public Health Lead, Brent Council
- Basu Lamichhane, Chair of Care Homes Forum
- Dr Dhanusha Dharmarajah, PCN Director, Brent
- Jo Kay, Healthwatch

3.32 CIHCSE meets monthly. Terms of reference (ToR) have been drafted and agreed.

3.33 The **mental health and wellbeing executive** (MHWE) current priorities are:

- Increase engagement, utilisation and awareness of mental health support services in communities
- Reduce variation in mental health care and support for the local Brent communities
- Support people with mental illness to access employment opportunities
- Ensure housing and accommodation provision is accessible and reflects identified needs locally
- CYP/Transitions – ensure the additional needs and identified gaps as a direct result of the pandemic are addressed and aligned to the Children's Trust Board priorities
- Align identified areas of mental health inequalities from this work stream to HI&VE

3.34 The membership of the MHWE is as follows:

- Robyn Doran (Co-Chair), Independent ICP Director, CNWL
- Phil Porter (Co-Chair), Strategic Director Community and Wellbeing, Brent Council
- Sarah Nyandoro, NWL CCG
- Philippa Galligan, Director, CNWL
- Dr Nigel De Kare-Silver
- Dr Mohammad Haidar
- Danny Maher, VCS representative
- Marie McLoughlin, Public Health, Brent Council
- Brian Grady, Children and Young People, Brent Council
- Ala Uddin, Employment Lead, Brent Council

3.35 The MHWE meets monthly. Terms of reference (ToR) have been drafted and agreed.

3.36 The health and care transformation team are responsible for programme management support to the executives. All groups have agreed to review their ToRs at six monthly intervals to ensure they remain relevant and up to date.

3.37 The ICPEC executive groups have a clear focus on adults, with some focus on transitional arrangements. This recognises the successful Brent Children's Trust (BCT) in place, and links have been made across the work programmes of the ICPEC and the BCT (the Independent Director of the ICPEC attends the BCT to provide system accountability) and whole system oversight is considered by the ICP Board. The BCT may require change to ensure collaboration as may be prescribed in the emerging legislation. Details of the ICP Board are covered in a subsequent section.

3.38 Healthwatch provide key input at the executive group level as representatives of patient and community voices. Healthwatch is not involved in the ICPEC or ICP Board in order to preserve their independence and ability to provide challenge and scrutiny at the BHWB, of which they are a statutory member. Should statutory duties change in the new health and care legislation, the role of Healthwatch can be reviewed.

3.39 An example of successful systems working undertaken by the ICPEC executive groups is detailed in Appendix 3.

<u>The Integrated Care Partnership Board (ICPB)</u>

3.40 The **ICP Board** (formerly known as the Septet) meets to ensure progress of the ICPEC, and membership includes the ICPEC members plus the:

- Chair of the Brent Health and Wellbeing Board (BHWB) (voting member of BHWB)
- Lead Member for Public Health, Culture and Leisure (voting member of BHWB)

- Chief Executive of Brent Council (non-voting member of BHWB)
- Strategic Director for Children and Young People, Brent Council (non-voting member of BHWB)

Community and Wellbeing Scrutiny Committee

3.41 The BHWB ensures systems working, accountability and delivery. It does not diminish the role of the Community and Wellbeing Scrutiny Committee (C&WSC). Indeed the revisions should enable scrutiny increased system oversight as roles and responsibilities across the system will be clarified and coherent.

Strategic partnerships

3.42 The changes in health and care legislation will affect other strategic partnerships. The CCG is named explicitly in the Care Act 2014, the Children and Social Work Act 2017 and Working Together to Safeguard Children 2018 statutory guidance as a strategic partner for safeguarding children and adults (with equal responsibility to local authorities and the police). A letter sent from Ministers for child safeguarding in late June 2021 indicates that current CCG responsibilities will pass to the ICS Chief Executives.

3.43 Early conversations are happening and the ICPEC will consider responsibilities across the strategic partnerships – the Brent Safeguarding Adults Board (BSAB), the Brent Safeguarding Children Partnership (BSCP) and the Brent Community Safety Partnership (BCSP). This will then enable joint decisions with the strategic partnerships moving forward to ensure statutory duties are meaningfully discharged.

3.44 The ICP Independent Director and the ICPEC will ensure that there is appropriate representation from the ICP providers at the BSAB, and the ICP Independent Director has agreed to join the BSAB Executive. The NWL ICS is represented at the BSAB through the Safeguarding Adults leads. The BSAB has sought assurance that not only will ICS and ICP be represented at the BSAB, but also that adult safeguarding issues are on the agenda at the ICPEC, ICPB and the NWL ICS.

4.0 Financial Implications

4.1 There are no financial implications within this report.

5.0 Legal Implications

5.1 Health and Wellbeing Boards (HWBs) were formed under the Health and Social Care Act 2012. Their original purpose was to improve the health and wellbeing of the local population by providing a forum for health leaders (including those from NHS, local government and public health) to come together and agree health priorities and actions for the area. HWBs have a statutory duty to work alongside the Clinical Commissioning Group (CCG) to produce a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS) for the local population.

5.2 More recently there has been a growing movement towards more integrated care. The Department of Health and Social Care (DHSC) published the legislative proposals (White Paper) for a Health and Care Bill in February 2021. The proposals in the White Paper were a combination of: Proposals developed by NHS England (NHSE) to support the implementation of the NHS Long Term Plan. They form the main essence of the document as the NHS England/ Improvement engagement paper ‘Integrating Care’ proposes significant changes for both regional ‘Integrated Care Systems’ (ICS) and local place based partnerships for health and care ‘Integrated Care Partnerships’

(ICP). The central theme in the NHS's Long Term Plan is the importance of joint working with colleagues in local government and elsewhere, on the basis that neither the NHS nor local government can address all the challenges facing whole population health on their own. Additional proposals in the white paper relate to public health, social care, and quality and safety matters, which are dependent on legislative change.

5.3 A number of policy changes requiring action are set out with a timetable, which includes key milestones at April 2021 (shadow arrangements) and April 2022 (implementation).

5.4 As the proposals and governance structures develop and legislative changes are implemented, guidance from legal services will be sought.

6.0 Equality Implications

6.1 Health and Wellbeing Boards must also meet the Public Sector Equality Duty under the Equality Act 2010. S149 of the Equality Act 2019 provides that the Health and Wellbeing Board must, in the exercise of its functions, have due regard to the need to:

a) Eliminate discrimination, harassment and victimisation
b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it

6.2 The Public Sector Equality Duty covers the following nine protected characteristics: age, disability, marriage and civil partnership, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

6.3 The Statutory Guidance states "*this is not just about how the community is involved but includes consideration of the experiences and the needs of people with relevant protected equality characteristics (as well as considering other groups identified as vulnerable in JSNAs) and the effects decisions have, or are likely to have on their health and wellbeing*".

Report sign off:

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