Brent

MINUTES OF THE HEALTH AND WELLBEING BOARD
Held on Tuesday 24 January 2017 at 7.00 pm

PRESENT:

Councillor Hirani (Chair), Councillor Colwill, Carolyn Downs (Chief Executive, Brent Council), Rob Larkman (Chief Officer, Brent, Harrow and Hillingdon Clinical Commissioning Groups), Sarah Mansuralli (Chief Operating Officer, Brent Clinical Commissioning Group), Julie Pal (Chief Executive, Healthwatch Brent), Councillor M Patel, Phil Porter (Strategic Director of Community Wellbeing, Brent Council), Councillor Southwood (substituting for Councillor Butt), Dr Melanie Smith (Director of Public Health, Brent Council)

Also Present: Councillor Mahmood

1. **Apologies for Absence and Substitutions (where applicable)**

   Apologies for absence were received from Councillor Butt, Councillor McLennan, Dr Ethie Kong (Vice Chair; Co-Clinical Director, Brent Clinical Commissioning Group) and Gail Tolley (the Council's Strategic Director of Children and Young People).

2. **Declarations of Interests**

   There were no declarations of interest from Members.

3. **Minutes of the Previous Meeting**

   RESOLVED that the minutes of the previous meeting held on 6 October 2016 be approved as an accurate record of the meeting and signed by the Chair.

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

   There were no matters arising.

5. **Sustainability and Transformation Plan (STP) Update**

   Phil Porter (the Council's Strategic Director of Community Wellbeing) introduced the report which provided an update on key STP related developments in Brent since the last meeting of the Board. He outlined that the governance structure for the STP in Brent was now in place and that the Delivery Board had been established. This structure, he said, had successfully mirrored the Children's Trust Model of Governance. He also drew the Board's attention to the System Leadership Development Programme, which had been commissioned by the Delivery Board for its members. He noted that the nature of delivering the STP meant that individuals involved had taken on new challenging roles, which bridged both health and social care and it was important for the sector in the long-term to support them in developing leadership skills. Mr Porter concluded by updating the Board on each of the six STP work streams as specified within the agenda pack.

Members commented on the distinctions and separations between both the local and regional aspects that informed the STP. It was noted that it would be very important to continue to find the balance between key priorities of the North West London (NWL) wide STP and the local Brent plan. The Chair mentioned that the need to look at Brent's unique local needs meant that sometimes the health and social care outcomes that the Borough wanted to deliver would not necessarily match the NWL wide plans. Members acknowledged this and stated that it was vitally important that the two elements complemented each other. It was noted that it was positive that there were elements to the NWL STP which had been directly informed by Brent's Local Plan. A Member commented that the structure of the Local Plan had helped to create an interface and forum from which health and care priorities could be taken from the ground up to help shape the wider regional plans.

The Healthwatch representatives present welcomed both the Council and the Clinical Commissioning Group (CCG) having built resident voices in to the strategic planning for the delivery of the Local Plan. The resident engagement events across the Borough, which had been mentioned at the last meeting of the Board were praised as being a very positive step. The Chair welcomed this and outlined that it was essential to continue to engage with residents to understand what their priorities were before planning to tackle these issues both locally and at NWL level. It was noted that, sometimes, residents can found it difficult to relate to what the STP is and that the local work had often been referred to as the 'Brent Health and Care Plan' to make it more accessible and understandable.

RESOLVED that the progress on the delivery of the NWL Sustainability and Transformation Plan and the Local Plan in Brent be noted.

6. **Sustainability and Transformation Plan (STP): Update on Delivery Area One - Prevention**

Dr Melanie Smith (the Council's Director of Public Health) introduced the report, which provided the Board with an update on prevention, as one of six work streams of the Brent Local Plan. Dr Smith stated that it was important there continued to be a focus on areas that the Board could collectively influence to enable it to make an impact in reducing the number of people having to use expensive clinical services. She noted the successful seminar for Board Members which had taken place in December 2016 to consider the challenges and opportunities for the Local prevention priorities of alcohol abuse, tobacco use and social isolation. The Board heard that a business case for seven day alcohol care teams in acute care settings (such as hospitals) had been submitted to the NWL STP programme, which had been identified by Public Health England as an effective method of improving the pathway to alcohol treatment services from health and social care. It was noted that this had also incorporated the need to measure the impact of investment in alcohol prevention given the current pressures on acute care. Dr Smith commented that it was pleasing that analytical aspects had not being overlooked and were also being considered as part of the proposal.

With regard to prevention of smoking, a Member of the Board questioned how successful prospective Public Health England (PHE) apps (technological applications downloaded to mobile phones), that encouraged people to stop smoking, were likely to be. Dr Smith responded that it was well established that

people used apps to assist behaviour change. She stated that early studies on the PHE app had suggested that it was effective at maintaining cessation rather than just being effective at getting people to stop smoking in the short-term. It was also noted that the Brent Local Plan included a broader focus on other uses of tobacco (such as shisha and chewing tobacco) which had been positive and expanded further on the cessation work being done at NWL level. It was felt that Brent was one of few public sector organisations looking at these wider concerns rather than just being focused on tobacco smoking.

A Member also questioned whether any of the work on prevention had caused a fall in diabetes rates in the Borough. Dr Smith outlined that diabetes levels had not reduced and said that there was a more widespread problem in Brent of diabetes going undiagnosed, and that would need to be addressed first. She noted that this was a long term issue and therefore it was more likely that in the near future diabetes diagnoses would actually rise before falling as more people are identified and diagnosed to receive the care they need.

RESOLVED that the developments in the prevention priority of the Brent Local Plan be noted.

7. **Clinical Commissioning Group (CCG) GP Member Practices - Option to Move to Delegated Commissioning Arrangement**

Sarah McDonnell (Assistant Director of Primary Care, NHS Brent CCG) introduced the report, which provided the Board with an overview of the ongoing consultation between NWL CCGs and GP Member Practices on expanding the scope of CCG commissioning arrangements. She explained that GP Member Practices had moved to Level 2, joint commissioning arrangements, in recent years and had now been asked to vote on whether to move to Level 3, delegated commissioning arrangements. The vote was specified to take place between 30 January and 13 February, with the result announced to be on 17 February 2017.

The Board heard that if the GP Member Practices voted in favour of a move to delegated commissioning arrangements, this would mean that CCGs would be newly responsible for functions previously carried out by NHS England (NHSE) and therefore would take on the accompanying statutory duties. Ms McDonnell ran through the separation of functions between the CCG and NHSE, which would take place (specified in paragraph 1.2 of the report) and noted that around half the CCGs in England had already taken up Level 3 commissioning and that NWL CCGs had begun a process of due diligence to plan accordingly, centred on three specific workstreams (governance; workforce; finance and legal) should the Member practices vote in favour. Ms McDonnell explained the benefits and risks to the move, which had been considered (outlined in paragraphs 3.9 and 3.10 of the report) and noted that a key risk identified was the CCG's capacity in terms of staff and resources, and that a transition plan would have to be drawn up to accommodate this.

Members of the Board discussed the potential problem of a lack of capacity at NWL CCGs to be able to enable this change and whether there had been any additional resources earmarked to address this in the near future. Sarah Mansuralli (Chief Operating Officer, NHS Brent CCG) responded that it was unlikely that there would

be any additional resources specifically for NWL CCGs and that this problem would still be prominent in 2018/19 which informed the need for a transitional plan.

There were additional questions arising on whether Brent CCG would be championing the Level 3 arrangements if the capacity issues were not as prevalent and whether it was felt likely that the Members Practices would vote in favour of delegating commissioning at this stage. Both Sarah McDonnell and Rob Larkman (Chief Officer, Brent, Harrow and Hillingdon Clinical Commissioning Groups) emphasised that it was incumbent on the CCG to remain impartial and merely lay out the benefits and risks clearly, allowing Members to vote without a steer one way or the other. Sarah Mansuralli added that it was also essential that the CCG retained its good relationship with GP practices and managed the results regardless of which way the vote went.

It was thought that NHSE's expectation had been that all CCGs would implement delegated commissioning functions within the next few years. It was questioned whether this would be a future source of frustration for Members Practices if they chose to vote against a proposal on Level 3 delegated commissioning for it to be implemented at a later stage regardless. Sarah Mansuralli acknowledged this point and stated that the CCG was supportive of Members Practices taking a view on this. She stated that either way it would manage and act accordingly to ensure there were no adverse effects on the relationship between the CCG and Members Practices.

RESOLVED that the upcoming consultation of GP Member Practices on whether to move to level 3 delegated commissioning arrangements from 1 April 2017 be noted.

8. **NHS Brent Clinical Commissioning Group (CCG) Commissioning Intentions 2017-19**

Jonathan Turner (Assistant Director of Planned Care and Service Transformation, Brent CCG) introduced the report which provided the Board with an overview of the Commissioning Intentions for NHS Brent CCG for the financial years 2017/18 and 2018/19.

Mr Turner explained that the Commissioning Intentions had now been structured in a way which reflected the STP and specified how projects were taken forward locally under the STP's key delivery areas. He noted that the Appendix within the agenda pack was the final version which had been approved by the CCG's Governing Body on 11 January 2017 having incorporated all additional comments from Board Members. Mr Turner outlined that the Commissioning Intentions were designed to assist addressing the triple aim of closing the gaps associated with health and wellbeing; care and quality gap; and funding and efficiency as proposed in the NHS' Five-Year Forward View. He drew Members' attention to the need for the CCG to deliver approximately £12 million of savings each year over the next five years, as this would shape how services were being commissioned and designed in order to keep up with rising patient demand. He also described how the Commissioning Intentions aligned with the five STP delivery areas themes, which underpinned activity across the delivery areas and the bespoke engagement events which had been undertaken in forming the Commissioning Intentions (detailed in paragraphs 3.7 to 3.10 of the covering report).

Members commented that the Commissioning Intentions were very positive and it was good to see how they reflected the overall priorities within the STP. A Member of the Board questioned why the detail on Children's Acute and Community Services had come under the Commissioning Intentions for Delivery Area 1 of the STP (Radically upgrading prevention and wellbeing). Sarah Mansuralli said that it was a priority for the CCG to ensure that its integrated services to reduce health and care inequalities from childhood. A Member commented on focus being placed on parenting programmes and how there had been a vast number of different parenting programmes seemingly working independently of each other. It was felt that there needed to be a focus on drawing these different programmes together to improve health outcomes. Sarah Mansuralli agreed and stated that she understood that the Children's Trust was due to address this.

Sarah Mansuralli thanked all of the colleagues present who had taken time to comment on the initial draft version.

RESOLVED that:

(i) The changes made to the CCG's Commissioning Intentions, which had been approved by the CCG's Governing Body on 11 January, be noted; and

(ii) The final Commissioning Intentions for Brent, which included health and care priorities for service development, be endorsed.

9. **Local Services Strategy**

Tom Shakespeare (Head of Health and Wellbeing, West London Alliance) introduced the report, which provided the Board with an update on the Local Services and Out of Hospital Strategy, which had been developed at North West London level. He noted that the Strategy had been developed particularly around Delivery Area 3 ('achieving better outcomes and experiences with a focus on older people') of the NWL STP Plan. The aim was to build on previous work to design an integrated pathway of care, which spanned the entire health and social care system. Social care was specified as being fundamental to the Strategy being successful and that a new social care model had been developed as a crucial element to this. Mr Shakespeare concluded by outlining that the Strategy had been recommended for approval by the Joint Health and Care Transformation Group and that business cases were currently being developed in order to bid for resources to put the Strategy into action.

Members agreed that the Local Services Strategy was an integral part of the wider STP Plan and was the essential next step on the pathway after improved hospital care. It was felt that if the different elements of primary care, secondary care, intermediate care and care in community settings could successfully be brought together under this model, then it would provide a strong basis to deliver the STP Plan. The creation of different 'hubs' within the model was discussed as a means to give patients easier access to additional community services and ensure that personalised care would be delivered. An example included the proposed 'Harlesden Hub', which aimed to bring together community and Council services, a key element of which was housing for vulnerable people. Members agreed that it

was important to draw out the next level of detail to attain what was achievable from the Strategy.

RESOLVED that:

(i) The draft Out of Hospital and Local Services Strategy be noted; and

(ii) Support for the strategic direction of the Local Services Strategy, be endorsed.

10. **Healthwatch Brent - Community Chest Update**

The Chair invited Julie Pal (Chief Executive, Healthwatch Brent) to introduce the report. Julie Pal first thanked the Chair and the Board for their tribute to her colleague Nicola Mills at the start of the meeting. She outlined to Members that Healthwatch Brent had created a £20,000 Community Chest to provide grants to local groups and organisations for a range of different activities and projects, which aimed to engage with some of Brent's most vulnerable and marginalised communities. This had helped to gather a broad range of resident experience in using different health and social care services and it was felt that this would be valuable in helping to shape service design in these areas to ensure it was accessible for all in the future.

In welcoming the report, a question was asked on the scope of the activities which had received grants and whether they had all promoted health and wellbeing. Ian Niven (Head of Healthwatch Brent) stated that on the whole they did, and that each organisation had presented their request for funding with a positive vision for the residents in their area. He added that a key element to the chest was to have encouraged applications from an array of different types of community group to try and reach groups of people who did not usually engage with organisations such as Healthwatch. The work being done alongside Central and East European organisations regarding the use of urgent care services was specifically welcomed as these had been two of the fastest growing demographics in the Borough.

Further discussions were had on how the outcomes from the projects, which benefited from grants from the Community Chest, could be aligned with priorities within the STP. It was felt that these projects could potentially contribute to the development of the local policy landscape, particularly relating to programmes which improved community care and encouraged self-care.

Members felt that it would be valuable for Healthwatch Brent to continue to keep the Board updated on how these projects progressed and whether there were any potential opportunities for closer partnership working between different organisations.

RESOLVED that the progress of the Healthwatch Brent Community Chest programme be noted.

11. **Any Other Urgent Business**

There was no other urgent business to be transacted.

The meeting was declared closed at 8.22 pm

COUNCILLOR KRUPESH HIRANI
Chair