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Brent Clinical Commissioning Group

Health and Wellbeing Board - Supplementary

Wednesday 3 July 2013 at 7.00 pm
Boardroom - Civic Centre, Engineers Way, Wembley, HA9 0FJ

Membership:

Voting Members	Non Voting Members
Councillor R Moher (chair)	Ann O' Neill Health Watch representative
Councillor Crane	Phil Porter Director Adult Social Care
Councillor Hirani	Sara Williams Interim Director Children and Families
Councillor Pavey	TBC Director of Public Health
Councillor HB Patel	Sue Harper Director Environment and Neighbourhood Services
(tbc) CCG Representative	Christine Gilbert Interim Chief Executive
(tbc) CCG Representative	
(tbc) CCG Representative	

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www.brent.gov.uk/committees

The press and public are welcome to attend this meeting

recycle for Brent

Agenda – Supplementary

Introductions, if appropriate.

Apologies for absence and clarification of alternate members.

Item		Page
6	**Future plans for health and social care integration - the Pioneer Bid**	1 - 14
	This expression of interest document should be read in conjunction with the previously circulated report on the Health and Wellbeing Board agenda.	
11	**Health and Wellbeing Strategy**	15 - 32
	Brent's Health and Wellbeing Board brings together senior representatives from Brent Council, Brent Clinical Commissioning Group (CCG) and Public Health to work in partnership to improve the health of the population of Brent. The item was not available when the agenda was published and added to the agenda at the request of the Chief Executive for consideration by the Board. As this is the first meeting of the Brent Health and Wellbeing Board it is important that the members are familiar with the Borough's Health and Wellbeing Strategy.	

Date of the next meeting: Wednesday 11 September 2013

Please remember to ***SWITCH OFF*** your mobile phone during the meeting.
- The meeting room is accessible by lift and seats will be provided for members of the public.

LIVING LONGER AND LIVING WELL

North West London Expression of Interest for Health and Social Care Integration 'Pioneer' Status

June 2013

NHS
Brent
Clinical Commissioning Group

NHS
Central London
Clinical Commissioning Group

NHS
Ealing
Clinical Commissioning Group

NHS
Hammersmith and Fulham
Clinical Commissioning Group

NHS
Harrow
Clinical Commissioning Group

NHS
Hounslow
Clinical Commissioning Group

NHS
West London
Clinical Commissioning Group

NHS
Hillingdon
Clinical Commissioning Group

Brent

City of Westminster

London Borough of Hounslow

THE ROYAL BOROUGH OF
KENSINGTON AND CHELSEA

Central London Community Healthcare **NHS**
NHS Trust

Central and North West London **NHS**
NHS Foundation Trust

Chelsea and Westminster Hospital **NHS**
NHS Foundation Trust

Ealing Hospital **NHS**
NHS Trust

Hounslow and Richmond Community Healthcare **NHS**
NHS Trust

Imperial College Healthcare **NHS**
NHS Trust

The Hillingdon Hospitals **NHS**
NHS Foundation Trust

The North West London Hospitals **NHS**
NHS Trust

West London Mental Health **NHS**
NHS Trust

West Middlesex University Hospital **NHS**
NHS Trust

NIHR CLAHRC
for Northwest London

Health Education
North West London

INTRODUCTION

Clinical Commissioning Groups and Local Authorities from across North West London, health and care providers and other partners welcome this opportunity to apply to be a pioneer for integrated care. Across North West London, there is clear consensus that our vision for care closer to home is right and we believe that becoming a pioneer will help further our objective to bring about better outcomes and experience for people using services, and their carers, at a more sustainable cost. With pioneer support, we can accelerate implementation, form stronger relationships across all partners and address the major questions in creating a truly integrated health and care system for our population.

We recognise the scale and complexity of a bid representing many localities and a diverse population of two million people. However, we are confident that our application, including case studies from North West London, demonstrates how we can best meet these challenges by working together. We believe it is at this scale where a real difference to service users, families and carers can be made.

Across eight areas, we have developed a genuine partnership between health, social care, third sector and patient and user-led organisations. We are proud of our significant track record as early leaders of the move to integrate care at scale and pace, as evidenced by the many ambitious and innovative initiatives across localities and at various levels of the system. Every day, the Integrated Care Pilot now established across all of our boroughs shapes the care of many of our highest risk, most vulnerable patients. The Tri-borough's participation as one of the first wave Community Budget Pilot sites provides an excellent opportunity to deliver on our vision and to build on our commitment to sharing the learning from this work.

However, we know that we need to look beyond individual efforts if we are to achieve whole system integrated care. The Out of Hospital Strategies that underpin 'Shaping a Healthier Future'[1] propose a long-term sustainable model for care in a challenging context of growing demand, changing patterns of need and limited future resources.

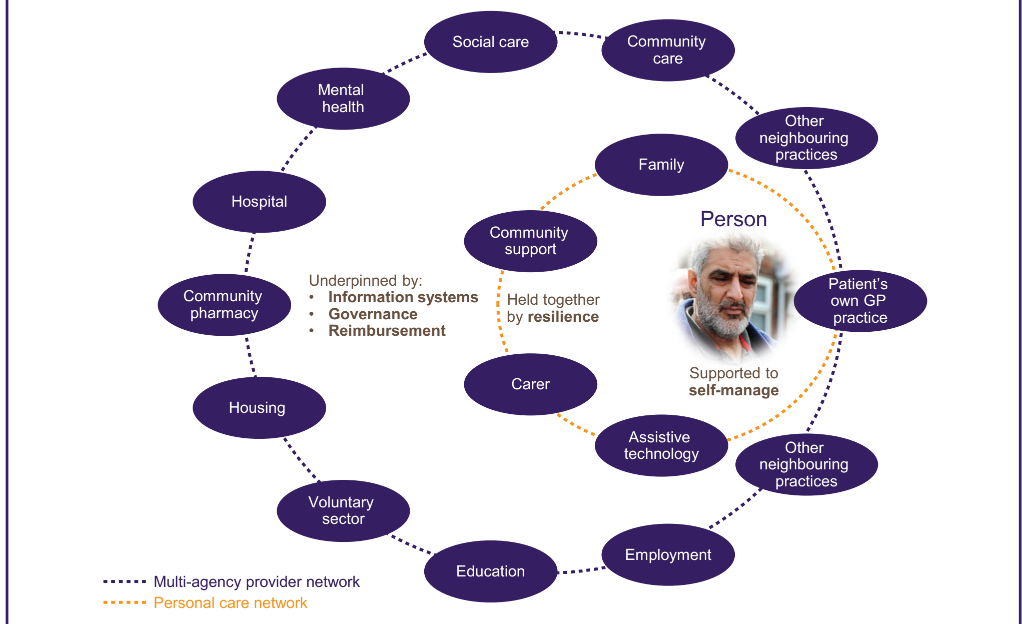
Whilst the changes to the acute provider landscape are currently subject to formal reviews, there is a consistent shared commitment across all partners to avoiding unnecessary hospital admissions and delivering care closer to home. We can only achieve this by increasing personalisation, choice and control, improving our out of hospital care, joining up services, aligning incentives and preventing vulnerable people from 'falling through the gaps'.

It is our hope that becoming a pioneer will enable us to work with central Government agencies and other localities to find pragmatic solutions to the questions we have identified as key to realising this vision:

- How to stratify population risk to identify those who would most benefit from integrated care
- How to develop an organisational form for health and social care to pool multimillion budgets and jointly commission outcomes-focused care
- How to align care delivery at a network level and incentivise a multi-agency group of providers to act through a capitated payment system where benefits to the patient can be identified
- How best to legally share patient information between organisations
- How to evaluate which elements of the integrated approach work best and spread learning at scale and pace.

By applying for pioneer status, we want to provide leaders and organisations, at all levels, the space and resources to think and act differently so that they can address the systemic barriers to achieving truly patient-centred care. Each of our eight localities will retain their own unique approach but we are aligned in our objective of delivering better outcomes for our local populations. All of our Health and Wellbeing Boards have integration as a key theme of their strategies and have voiced their support for our application. Most importantly, the people of North West London have told us very clearly of their experiences and it is with them that we have developed our shared vision: 'Living Longer and Living Well'.

Exhibit 1: Integrated Networks of Care



[1] Agreed by eight CCGs and all NHS trusts, 'Shaping a Healthier Future' is the largest transformation programme being undertaken across NWL to change the configuration of acute and out of hospital services.

1. OUR VISION FOR WHOLE SYSTEM INTEGRATED CARE

Our vision for whole system integrated care is based on what people have told us is most important to them. Through patient and service user workshops, interviews and surveys across North West London (NWL) we know that what people want is choice and control and for their care to be planned with people working together to help them reach their goals of living longer and living well. They want their care to be delivered by people and organisations who show dignity, compassion and respect at all times.

However, people's current experience of health and care services is often disjointed and fragmented. Each individual providing care may be doing a good job, but taken as a whole the individual and their family experience care that is poorly coordinated and confusing. Our objective must be to deliver better organised care at home which therefore avoids preventable emergency stays in hospital, or long term dependency on institutional care.

Integrated Care Delivery across Brent and Harrow

STARRS is a multi-disciplinary provider partnership delivering rapid assessment and response to patients experiencing short-term health crises. It is jointly commissioned, on outcomes, by the CCGs and Local Authorities and provided by the local acute and community trust in partnership with social care.

Mrs Lynch is 79, lives alone and has cellulitis which is not responding to oral antibiotics. Rather than send her to A&E, her GP refers her to STARRS who conduct an assessment two hours later. Having identified raised infection markers, STARRS liaise with the infectious diseases consultant and on his recommendation carry out IV antibiotic treatment at home with a review in the consultant's outpatient clinic.

STARRS also send an occupational therapist to make home adjustments. Mrs Lynch improves significantly and following discharge from STARRS, the district nurse continues to monitor her, encouraging her to join a support group.

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Building upon the success of STARRS, North West London Hospitals Trust, working with Buckinghamshire New University, has been selected by Skills for Health for a national pilot, funded by UK Commission for Employment and Skills, to develop community-facing, higher level clinical support roles.

Our vision for integrated care is based around three key commitments to people using our services:

1. **People and their carers and families will be empowered to exercise choice and control, to manage their own health and wellbeing and to receive the care they need in their own homes or in their local community.** We will work together to promote the long term, sustainable wellbeing of the whole person.
2. **GPs will be at the centre of organising and coordinating people's care.** GPs will work with others in integrated networks (multidisciplinary groups) building on the relationships established through the Integrated Care Pilots described below and drawing together all the services and resources needed to support people to meet their care goals. The organising principle for coordinated care will be the GP's registered list.
3. **Our systems will enable and not hinder the provision of integrated care.** We will pay for people's health and care needs on a basis that rewards outcomes not contacts. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system. Information about people's care will be shared with them and, with their permission, across the providers of their care.

As well as adopting the National Voices narrative, we have also consulted upon and agreed a set of Out of Hospital Standards, developed with the involvement of all of the partners to this application, together with users and carers. These standards and local Adult Social Care mandates describe some of the outcomes which our Whole System Integrated Care Programme should deliver. Most importantly, people should be supported to remain independent for as long as possible and lead full lives as active participants in their community. They should be cared for and supported in their own homes or community, making care out of hospital the first point of call.

We will only be successful if we deliver against these expectations for care – and when people tell us that their outcomes and experience of care have improved. Historically we have measured the success of our integration initiatives using measures from the National Outcomes Frameworks, such as whether individuals with long-term conditions feel independent and in control of their lives. Locally we have augmented these with a number of clinical processes and outcome measures, a number of which are drawn from the primary care Quality and Outcomes Framework, staff surveys and user surveys.

Developing measures of success for integrated care is challenging and as a pioneer,we would welcome the opportunity of further support in this area, and to share our learning with others.

Finally, our proposals for Whole System Integrated Care must deliver financial efficiencies for reinvestment into care of our ageing population. Through the 'Shaping a Healthier Future' Programme and the Community Budget financial modelling, we have identified the type and quantum of financial efficiencies that we expect to see across our system. We will continue to refine these estimates based on previous experience and emerging national evidence.

2. OUR TRACK RECORD OF DELIVERING TRANSFORMATION AT SCALE AND PACE

NWL has a very strong track record of delivering public sector transformation at scale and pace. The scale and diversity of integration efforts across our eight Boroughs is too broad to capture in full in this application but here we highlight those initiatives which have particularly influenced and informed key elements of our thinking on whole system integration:

Providers working together and with patients to change care delivery:

North West London Integrated Care Pilot

> "The ICP is the foundation on which we will build integration."
>
> GP

Established in July 2011, the Integrated Care Pilot (ICP) is a provider-led initiative serving NWL's entire population of two million people. It involves professionals from community health, mental health, primary care, secondary care, social care, community pharmacy and specialist nursing coming together with patients and carers to realise a shared vision of high quality services. All provider partners to this application, including the local authorities, are members of the ICP.

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Enabled by a unique data warehouse which links and shares provider information, the ICP identifies people with the most complex health and social care needs and stratifies risk. Providers can then come together to co-create integrated and proactive care plans tailored to individual need. A bespoke IT tool enables patients, as well as professionals, to access their own health data and take ownership of their care plan.

> "Prior to using the tool, we were unaware of how 'vulnerable' some of our patients are to recurrent admissions … we have been able to provide care plans where before we would not have identified these patients."
>
> GP

Multi-disciplinary groups (MDGs) meet monthly with the aim of improving the care of individuals with complex needs. As well as providing significant benefits for patients, the MDGs have encouraged more collaborative working, shared learning and closer relationships between care providers. Significant investment in senior leadership and dedicated programme support has played a major role in driving the ICP's success, along with the active involvement of patients including large-scale simulation events run by patients for professionals. We have also identified additional benefits beyond the original objectives, for example notably improved awareness of available local services.

To date, the ICP has produced over 36,731 care plans and is currently holding 42 MDGs each month. Emergency activity for targeted patient groups has seen a decrease of 14% in Inner NWL alone.

Imperial College and the Nuffield Trust have undertaken a formal evaluation of the initial stage of the ICP which shows[2]:

- **68.9% of patients** felt they had increased involvement in decision making;
- **76.7% GPs** felt MDGs had improved their knowledge of patient care;
- **71.7% of attendees at MDG meetings** felt the MDGs had facilitated professional collaboration.

[2] http://www.nuffieldtrust.org.uk/our-work/projects/north-west-london-integrated-care-pilot-evaluation

Commissioners working together with providers to change the commissioning framework and delivery model:

Community Budgets Pilot, Tri-borough of Hammersmith and Fulham, Kensington and Chelsea and Westminster City Councils

From 2012/13 to 2014/15 the health sector in the Tri-borough needs to deliver efficiency savings of £115 million, and adult social care budgets face reductions of around £38 million. Demand for services is expected to rise at around 3% to 4% per annum over the next decade.

Tri-borough partners realised that the siloed approach to the provision of complex services and the differential entitlement to receiving them – free at the point of delivery for health and means tested social care – had created perverse and costly incentives for providers. They therefore began to look for integrated solutions that would address this and combat the rising pressure on spending and service provision.

Building on their local experience, the Tri-borough were selected by Government as one of four Community Budgets Pilot sites across the country. This involved working in partnership with the Department of Communities & Local Government, HM Treasury, and the Department of Health to achieve improved experience for the service user and potential cost savings, through much closer integration of health and social care.

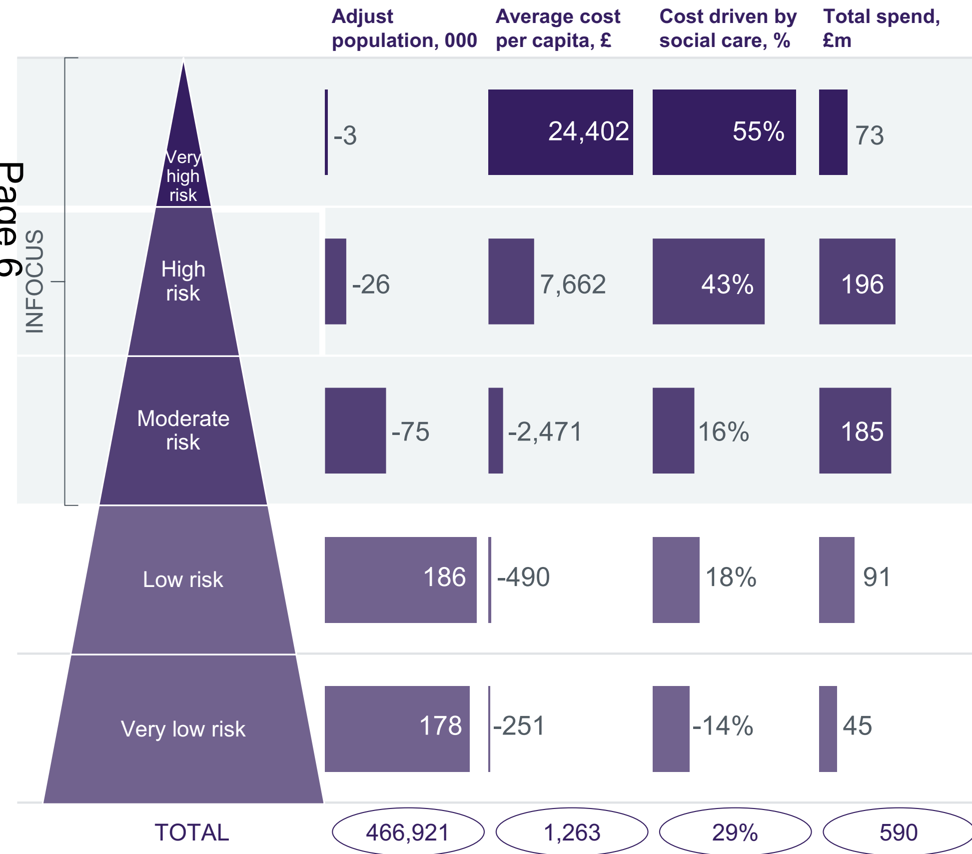
After creating a unique integrated patient-level data set of health, social and community care, the Community Budgets Pilot developed a business case for taking a whole system approach to integration across the three boroughs. This identified how care would be delivered and coordinated in an integrated system and the changes that would be needed to enable this system, such as aligned financial incentives, integrated provider networks, shared information and joint accountability and decision making.

The business case also identified some key areas where central Government support is required to address the barriers to integrated care:

- **Developing a new reimbursement model** that supports a move away from a national tariff system to a capitated payment based on outcomes and in line with contracting and competition regulations
- **Freeing our staff from complex workarounds** to empower them to operate across organisations and in hybrid roles
- **Engendering a culture whereby sharing information** about patients between the providers caring for them is the norm
- **Enabling the upfront funding of investment in integrated care;** where this investment is needed before savings are achieved.

Exhibit 2: Population usage of health and social resource by risk category (output from Tri-Borough Community Budgets Pilot)

It is estimated that by Year 5, targeted preventative interventions enabled by funding costs of £28 million could save around £66 million per year across the Tri-borough



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Commissioners and providers working together and with users to design improved pathways of care:

Mental health integration, North West London

One of the biggest enablers to transforming mental health delivery is a high quality and consistent urgent care pathway. This will allow GPs to effectively manage patients at greater clinical risk in the community and for patients to move seamlessly through the system.

Fifty senior representatives, clinical leaders, service users and carers from all eight CCGs, local authorities and the two mental health trusts in NWL have come together to co-design a common pathway for urgent assessment for mental health. The pathway includes common standards around elements such as response time and reporting, a cultural shift towards shared responsibility and improved communication routes between primary and secondary care. It also considers the training requirement to create teams with an optimal skill mix to deliver the assessments.

A formal programme board has been set up to drive further mental health transformation at scale and pace and to work with other key partners including housing, criminal justice and employment.

Health and social care providers working together to transform the care delivery model: Forming a Health and Social Care Integrated Care Organisation, Hounslow and Richmond

Hounslow and Richmond Community Healthcare NHS Trust, Hounslow and Richmond Councils and Hounslow and Richmond CCGs are developing a business case to form an Integrated Care Organisation. The business case sets out a compelling service model for a new organisation staffed by social care and community health staff with care fully integrated and organised into three areas focused entirely around the needs of the service users rather than the organisations – first contact; community enablement, recovery and independence support; and long term care and support.

Changes to the way care is organised will significantly enhance service users' experience, reduce fragmentation and increase independence, choice and control. For staff, new ways of working outside of existing organisational service models will provide opportunities to create new integrated roles. The business case identifies significant outcome benefits for service users and financial modelling demonstrates significant savings as a result of the integration. The target is to enable recurrent savings of 2% to 3% on acute commissioning budgets and 2% to 5% on long-term adult social care budgets relating to the ICO functions, resulting in a long-term savings goal of £8 million to £13 million and providing the platform for all the partners to deliver the rest of their integrated care strategies.

3. OUR APPROACH TO WHOLE SYSTEM INTEGRATED CARE

To achieve the vision outlined in Chapter 1 and building on our track record described in Chapter 2, we now have an ambitious proposal for Whole Systems Integrated Care in NWL. Using our combined resources and understanding of local need, we are committed to working together to tackle the rising demand and the changing disease profile within a constrained economic environment.

We welcome that each locality, and each network within each locality, may take a different approach to achieving our vision, in the same way that each individual and their family may have a different idea of what 'living well' looks like for them. However, together we can learn much through sharing knowledge and experience, we can bring about greater traction on the whole system changes required, we can accelerate pace and reduce fragmentation, and we can underpin our programme with a shared and robust evaluation framework.

Our first commitment: People and their carers and families will be empowered to exercise choice and control and to receive the care they need in their own homes or in their local community

Promoting the long-term, sustainable wellbeing of the whole person will require a preventative and personalised approach, taking into account the social determinants of health and wellbeing. Through evaluation of themes arising from the ICP multidisciplinary discussions, we are improving our understanding of how a whole system response can address the barriers to living longer and living well. We are currently undertaking a series of Discovery Interviews to explore this further and help inform new ways of working to support the vision.

We know we can point to pockets of excellent practice. For example, the Wellwatch Service in Central London CCG proactively generates an individual's risk score and works with them to tailor a package of care based upon their needs. Our local authorities have made significant moves towards personal budgets for users of care and support. However, we know there is much more to do. We want to empower individuals and their families to plan their own support through the promotion of personal budgets for health as well as social care. This will draw upon the work being undertaken in Tri-borough as one of the national pilot sites and the expertise of the NWL Commissioning Support Unit (CSU), one of the partners to our application, who have been selected to be the host for the DH Personal Health Budgets team for London.

We believe that the move towards capitated budgets will accelerate this work and want to **work with national partners** to drive this development. We believe the user should be the most significant commissioner of their own care.

Success will mean working with a range of partners to utilise and strengthen the social capital available within our communities.

Social inclusion
Ealing

Ealing Council and West London Mental Health Trust have set up a social enterprise called Accession to offer employment based training opportunities for people with mental health problems and people with long term health conditions. The aim is to offer real work based experience for those most marginalised in the employment market and therefore combat social isolation, improve health and wellbeing and also reduce reliance on state funding. The businesses have been set up in partnership with local voluntary organisations.

So far the Cabinet Office has funded the development of a viable business case and the service already has a number of businesses across the borough including two shops, a print & design business, picture framing, warehousing, a café and visitors centre and a digital inclusion Project. There are ambitious plans for more.

Our second commitment: GPs will be at the centre of coordinating care, working with others in integrated networks to support people to meet their individual goals.

Integrated care means coordination across care settings, including acute, community, primary and social care, and between mental and physical health services. It also requires strong relationships with local third sector and independent organisations providing care and support.

Our work to date clearly demonstrates the engagement and commitment of health and care providers across NWL. Through our ICP multidisciplinary groups which meet each month, we have cemented an alliance between GPs, secondary care, mental health, social care, community health and third sector organisations.

We want to build upon this alliance and further develop our **networks of care** (each of which has a total population of around 50,000 people), placing GPs at the centre of organising and coordinating people's care. Not all care or co-ordination has to be delivered by individual GPs, but the organising principle for coordinated care will be the GP's patient register.

We recognise that delivering care differently will require all providers to work in new ways as well as changes to the way care is commissioned. The cultural and workforce changes required, together with the need to have an integrated information system, are significant. We envisage that the first wave of Networks of Care will be ready to commence in shadow form in early 2014. We would value working **with national partners** to support this organisational development and delivery programme at pace.

Understanding peoples' priorities from General Practice

We surveyed over 1000 service users, representative of the NWL population about their priorities for General Practice.

The top three priorities were:

1. I can quickly get an emergency appointment when I need one
2. I have enough time in my appointment to cover everything I want to discuss
3. I can rely on getting consistently good service at my GP surgery.

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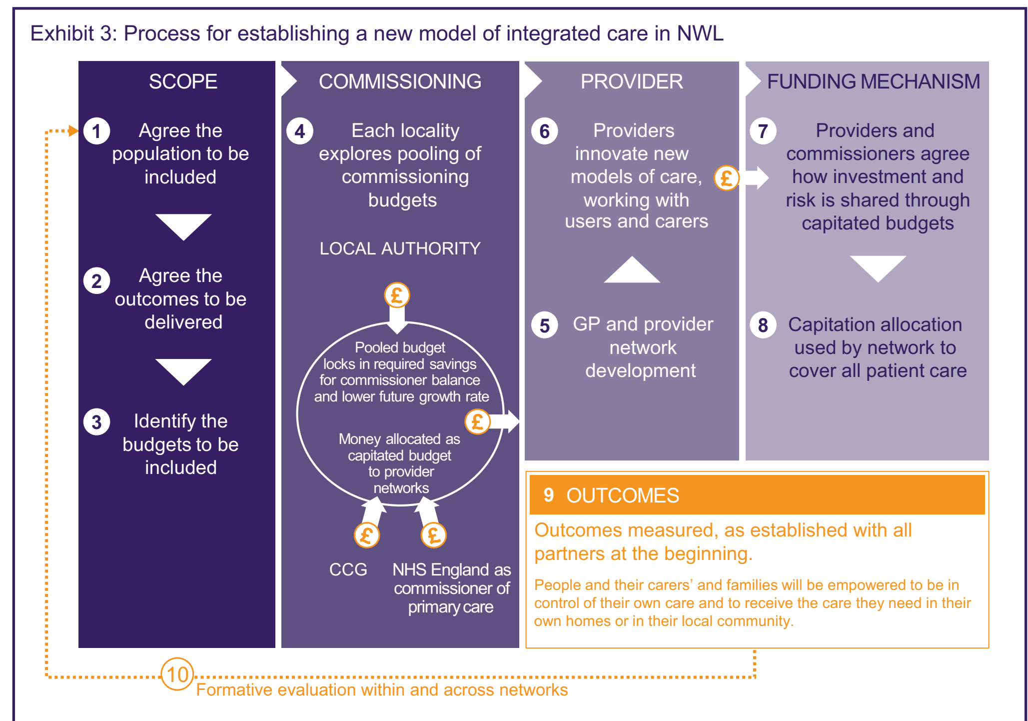
We learned that access is a complex issue because what patients want depends on overall health needs and the immediacy of their presenting condition, rather than demographic or other determinants. We are clear that delivering these three priorities will require new ways of delivering primary care, it cannot be a case of more of the same. We want to use this application to work with NHS England and GPs to explore new models of care.

Our third commitment: Our systems will enable not hinder the provision of integrated care

Exhibit 3 demonstrates the ten steps we have identified as necessary to achieving whole system change. We have already started working on these steps and we believe that being selected as a pioneer site will accelerate achievement of these changes.

1. Agree the population to be included: We will take a predictive risk-based approach to understanding our population, including who will benefit most from integrated care, what drives their health and social care needs and how they use health and social care services. Initial work in NWL suggests that people in the top 20% of risk are most likely to have multiple long-term conditions and intersecting health and social care needs. We are keen to work with **national partners** to explore this approach further.
2. Agree the outcomes to be delivered: Working with users,carers, health professionals, our external evaluator and national partners, we want to establish from the outset the outcomes to be achieved, based on the evidence of what works, as well as how these will be measured. **The overall outcome we seek is to ensure that our local populations are living longer and living well.**
3. Identify budgets: We will identify spend at user level for 'target' populations most likely to benefit from integrated care, and aggregate the user data to establish indicative total spend for this population group.

Exhibit 3: Process for establishing a new model of integrated care in NWL



4. Commissioning governance: Each locality, together where appropriate with NHS London, now the NHS England London Region, will explore pooling of commissioning budgets where there are defined population benefits. We will establish a new commissioning framework for integrated care, including outcomes to be achieved, how services should be delivered and the framework for evaluation. We will draw on the expertise of NWL CSU as we look to develop new contractual frameworks. We would also welcome working with **national partners** to explore the options in relation to funding flows, in particular personal contributions to care.
5. GP and provider network development: Creating new provider ventures that can operate as networks of care is a critical component of changing the way that care is delivered. Providers will be supported to explore the options for working together through GP-led networks under integrated contracting arrangements.
6. Providers innovate new care models: Providers in networks and across networks will work with users and carers to design and implement new innovative care models to deliver defined outcomes. These could incorporate personal health and social care budgets, involvement of other agencies and micro-commissioning of new providers.
7. Capitated budgets: We will explore the use of capitated budgets to fund a person's total health and care needs where there are defined benefits of doing so. Commissioners and providers will agree how they plan to share the investment needed in integrated, community-based services, the associated risk as well as potential savings and efficiencies. We recognise that we will need to work with **national partners** leading the development of new pricing mechanisms and contractual arrangements to achieve this at pace.
8. Capitation allocation: Provider networks will then apply to receive a capitation allocation to provide integrated health and social care services to patients and users. This will include consideration of new payment mechanisms for 'network' components and overhead costs required.
9. Outcomes: As described above in Step 2, our overall aim is to improve outcomes for service users and to explore whether this can be done at more sustainable cost. We will be realistic about the timescales for a whole system change and will have journey as well as outcome measures.
10. Evaluation: We will work alongside an evaluation partner, as well as **national partners**, to establish robust measures of success, and continually evaluate the programme. We will have formative evaluation within and across networks and across localities. This will support localities through their Health and Wellbeing Boards to identify progress and guide implementation to achieve goals and outcomes. We are keen to work with other pioneer sites to share learning.

To enable transformational change, we will explore **how data will be shared** between relevant providers, commissioners and the patient when the patient agrees this is appropriate and it is in their interests to do so. NWL CSU with CCG support has recently invested in a new NWL Business Intelligence system which will link data across care settings and support evaluation of interventions and outcomes for integrated care.

We are also working together to develop a **future workforce** with the commitment and capabilities required to deliver integrated care. The key education, training and research bodies of NWL – Health Education NWL, Buckinghamshire New University, Imperial College Health Partners[3] and CLAHRC[4] – are all partners to our application.

We are currently implementing significant work across our localities to integrate health and social care roles, while partner organisations have begun working together to identify and develop new competencies and roles required, as well as what is needed to break down existing organisational and professional boundaries. Our future workforce should be equipped with the requisite skills to deliver the right care in the right setting and it should be supported by the appropriate technology, leadership and culture to work flexibly across boundaries and in partnership with individuals and their carers.

Finally we will ensure a sustained, proactive approach to **risk management**, based on best practice requirements, to maximise the likelihood of achieving our vision. Effective management of risk has been an integral part of the management of the 'Shaping a Healthier Future' programme, underpinned by clear accountability arrangements for both clinical and non-clinical risk and we will seek to build upon this robust approach.

[3] Imperial College Health Partners is the Academic Health Sciences Network for NWL

[4] CLAHRC is the North West London Collaboration for Leadership in Applied Health Research and Care

4. PLANS FOR STAKEHOLDER ENGAGEMENT AND GOVERNANCE

We know that successful integration will depend on active and ongoing partnerships between people who use services, their family and carers, commissioners and providers of services across the public, independent and third sectors.

Engaging with service users, families and carers

Our plans are built upon, and will be constantly refined by, an understanding of what matters to the people using our services and their views about how they can be improved. Our NWL-wide Patient and Public Representative Group, including CCG Patient and Public Involvement lay members, representatives from Healthwatch and from our key patient and carer groups, ensures that consideration of key areas of patient interest such as travel, access and equalities are embedded in all aspects of our work. We will continue the practice established through our ICPs to have patient representatives at every level of our governance structures.

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> There is a really welcome attitude to the patients and carers user group and to involving us in the design of the pilot so it really works. You can always tell when people are really listening.
>
> ICP Patient Representative

As part of developing this application we held a workshop with over 50 people who use services, carers and their representatives from across NWL as well as local Healthwatch representatives. Participants expressed a strong desire to be included in the co-design of integrated care and at every stage from ideas to implementation.

Our engagement with service users and carers uses the work of National Voices and the Think Local Act Personal partnership as the firm foundation for patient-centred care. Each of our Health and Wellbeing Boards has adopted the National Voices Narrative and we have started working with service users to translate elements of the Narrative into 'measures of success'.

To ensure that the views and input of people using our services remain at the heart of delivery, we have committed to co-producing with service users a person-centred framework for evaluating the quality of integrated care.

Engaging with our workforce

During 2012, NWL CCGs engaged staff extensively through workshops, focus groups and interviews with approximately 60 to 80 clinicians, including case management teams, GPs, nurses and representatives of community service providers, to understand what workforce skills and capacity would be required to change existing models of provision. We will continue to engage key staff groups as we move to whole system co-design and local implementation.

Engaging with wider partners

Recognising that people's health and wellbeing is dependent on a number of wider factors, our partners are committed to working with others on issues such as housing, leisure, transport, education, employment and probation. Having public health partners sitting within our local authorities and as key members of our Health and Wellbeing Boards presents a vital opportunity to collectively address the economic, cultural and environmental influences on people's health.

Boroughs are also actively working on schemes to ensure a range of suitable housing provision to meet the needs of an ageing population, including investment in different models of supported housing and extra care accommodation.

In June, the NW London ICP teams hosted a roundtable discussion with David Prior, Chair of the Care Quality Commission, to discuss how regulatory bodies could begin to broaden their focus from individual service and organisational performance to whole system level. We have committed to work collaboratively with the CQC, assisting the formative development of the regulatory process in a way that will support the monitoring and assurance of integrated systems across England.

Governance

We recognise that working across eight areas could lead to complexities in governance. However, all partner organisations come with a strong track record of working together through formal governance arrangements to oversee service change aimed at improving outcomes and delivering efficiencies.

Crucially, we are aligned through the commitment of our Health and Wellbeing Boards to truly integrated care.

Going forward, we have put in place robust governance arrangements to support and assure our whole system partnership working whilst clearly respecting the sovereignty of each of the organisations taking part.

Each of the **Health and Wellbeing Boards** will assume responsibility for leadership of the integration programme in their area and the relevant local authority and CCG will report to it. Each of our Health and Wellbeing Boards includes representation from local Healthwatch.

Across the eight boroughs, we will set up **a commissioners' forum** so that CCGs, NHS England London Region and local authorities can share learning and address problems together in order to develop a model for an integrated commissioning framework.

We will also set up **a joint commissioner and provider forum** to co-design a sustainable commissioning and provider framework. Its membership will include commissioners, providers and representatives ofpeople using services, as well as the Academic Health Science Network and Health Education England NWL.

Much of this is already funded for 2013/14. As we move to rapid implementation we will need to consider what additional resource might be required.

5. OUR COMMITMENT TO SHARING LESSONS, DRAWING ON EVIDENCE AND UNDERTAKING ROBUST EVALUATION

We have an excellent track record of sharing lessons on integration, we are developing plans which have a robust evidence base and will continue to develop a systematic evaluation process.

Sharing and promoting lessons learned

NWL has a strong commitment to sharing lessons on integration. We have found that speaking to others nationally and internationally has helped us to assess and refine our ideas on what works and what challenges we should anticipate. Recognising the value of working with others beyond NWL, we have invested a substantial amount of time both in communicating our lessons learned and in taking time to learn from others. Examples of our continued commitment to share learning include:

- Hosting round table discussion and action learning events
- Presenting at national and local conferences, including LGA, ADASS and ADCS National Children and Adults Conference 2012 and DCLG's Community Budget Conference 2012
- Participating in London-wide events through NHS London, LGA, ADASS, London Councils, Joint Improvement Partnership and other forums
- Participating in the King's Fund Integrated Care learning set
- Hosting visits from or liaising with other localities in England including Greater Manchester, Cheshire West and Cheshire, Essex, Bournemouth, Poole, Dorset, Devon and Norfolk
- Hosting visits from international delegations
- Working jointly with the recently established Public Service Transformation Network through Tri-borough's involvement as a Community Budget Pilot site and by hosting a colleague from the Department of Health to be seconded jointly to our programme and to the Network
- Exploring the possibility of establishing formal learning partnerships with international areas (e.g. New Zealand's health and social care economy), building upon the relationships we have developed to date and similarities between systems
- Sharing our tools, models, best practice guidance, research and learning via our websites.

We believe the opportunity to share our lessons and learn from others over the coming years would be one of the greatest benefits of becoming a pioneer site.

Drawing on evidence

In developing our plans we have drawn on the following different bodies of evidence.

1. Case studies of successful integration initiatives nationally and internationally, particularly those described by the King's Fund and the Department of Health Integrated Care Pilot site evaluation.
2. Literature on reducing emergency admissions (Purdy, Roland). As we believe that integrated care has the potential to reduce emergency admissions, it is important that we draw on the knowledge of what service models have been shown to be effective in this regard.
3. Literature on clinical best practice, most importantly NICE guidelines.
4. An extensive review of international practice in relation to payment systems and new models of commissioning, contracting and provider incentives.

Supporting robust evaluation

We have a clear commitment to undertaking systematic evaluation, as shown by our work with Imperial College and the Nuffield Trust in evaluating the first year of the Integrated Care Pilot in Inner North West London.

We plan to ensure that robust evaluation continues to be a key part of this programme from the beginning, including:

- Long term formative evaluation: Working with Imperial College Health Partners (the Academic Health Sciences Network for NWL), we will tender for a partner or consortium of partners to perform a formative evaluation during the first three years of the NWL Whole System Integrated Care programme. This evaluation will include qualitative elements, such as evaluation of users' views, staff experience and organisational processes, and quantitative evaluation of impact on activity and potentially cost.
- External challenge sessions: To start the process of external review, we are working with the Nuffield Trust to deliver a series of challenge events where colleagues from outside our area and representing different parts of the system will scrutinise elements of our programme.

Should we be successful in our application for pioneer status, we would welcome the opportunity to collaborate in a formal evaluation process co-ordinated across pioneer sites. We look forward to working with national bodies to design measures of success regarding integration and believe our emerging integrated health and social care data sets and previous experience of developing measures of patient and staff satisfaction in external and internal evaluations would help to inform this process.

In addition, the scale of the programme across NWL offers a unique opportunity to improve the evidence base for integrated care, which to date has focused on relatively small-scale projects, often based on coordinated care pathways rather than a whole system approach.

6. NORTH WEST LONDON: A WHOLE SYSTEM APPROACH BASED ON PARTNERSHIP

Next steps

Our partners have already begun a period of co-design to inform local implementation across the eight localities. Over the next six months we will be working together, and with others, to explore some of the fundamental issues we need to address to deliver whole system integration and to make progress at scale and pace.

We anticipate that the first wave of sites will be live by January 2014 working together under 'whole system' commissioning and provision arrangements to improve outcomes for the local population.

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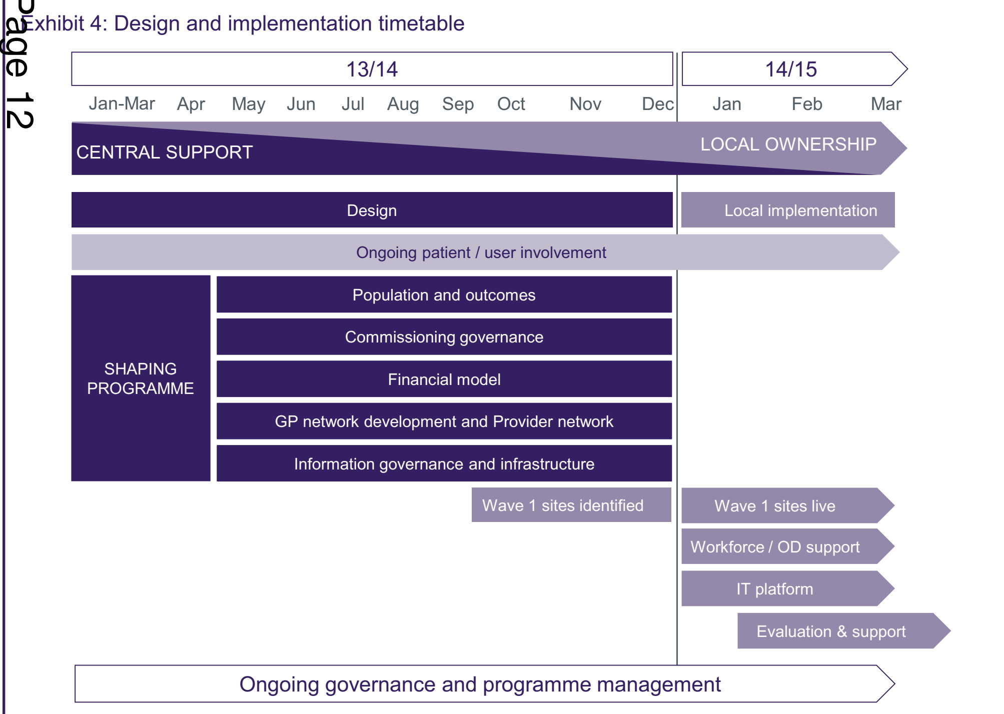
Exhibit 4: Design and implementation timetable



Conclusion

We believe that the examples highlighted in the above application demonstrate our clear commitment to delivering care that is high quality, proactive and preventive, and responsive to the needs and views of service users, families and carers. The range of partners supporting this application in itself demonstrates the strength of local leadership. The breadth of the experience we have gained and the quality of the relationships we have developed provide firm foundations for the next step: co-designing and implementing a whole system approach across NWL.

Achieving pioneer status will bring significant benefits to the people of NWL as we look to move forward at scale and pace, with the support of central Government to:

- Find joint solutions to common barriers
- Access and galvanise support for implementation
- Give confidence to local leaders in taking forward innovative proposals
- Share and learn with other parts of the country.

We offer a unique proposal in terms of our scale across NWL and the complexity of the health and social care landscape within it. Our geography offers an opportunity to show how wide scale reform of acute service enables local reform of integrated community provision to meet local need and to achieve person-centric care: bringing together the three commitments we make as part of our vision.

We want to work with national partners and other localities across the country embarking on the same journey – to share learning and expertise and to identify solutions to common challenges and potential barriers to joined up care. We welcome Government's offer to work in this new form of partnership and believe there are clear mutual benefits to working differently in this way if we are to provide a radical and ambitious response to the challenges of the future and to achieve our vision for the people of NWL of 'Living Longer and Living Well'.

> "We welcome Government's offer to work in this new form of partnership to help achieve our vision for the people of NWL of 'Living Longer and Living Well'.

APPENDIX1: NORTH WEST LONDON EXPRESSION OF INTEREST FOR PIONEER STATUS GUIDE TO APPLICATION

Primary Criterion	Supporting Considerations	Relevant chapter of NWL application
Articulate a clear vision of its own innovative approaches to integrated care and support	This should include how it will:	
	» Adopt the Narrative developed by National Voices, aligned with *Making it Real*;	Chapter 4: Plans for stakeholder engagement & governance, “Engaging with service users, families and carers”
	» Integrate around, and deliver better outcomes, including experiences for, individuals, families, carers and communities;	Chapter 1: Our vision for whole system integrated care Chapter 2: Our track record of delivering transformation at scale and pace Chapter 3: Our approach to whole system integrated care, “Our first commitment” Chapter 4: Plans for stakeholder engagement & governance, “Engaging with service users, families and carers”
	» Align with outcome frameworks;	Chapter 1: Our vision for whole system integrated care
	» Identify potential financial efficiencies for reinvestment; and identify potential measures of success.	Chapter 1: Our vision for whole system integrated care Chapter 2: Our track record of delivering transformation at scale and pace
Plan for whole system integration	This should encompass mental and physical health, social care and public health, as well as other public services, such as education, involving the community and voluntary sectors, as appropriate, across their local areas.	Chapter 2: Our track record of delivering transformation at scale and pace Chapter 3: Our approach to whole system integrated care Chapter 4: Plans for stakeholder engagement & governance, “Engaging with wider partners”
	The plan should include how the locality will deliver greater prevention of ill health and deterioration of health and personalisation through better integrated care and support.	Chapter 3: Our approach to whole system integrated care, “Our first commitment” Chapter 4: Plans for stakeholder engagement & governance, “Engaging with wider partners”
	The plan should include those who would benefit most from person-centred, coordinated care and support, such as intensive users of services who repeatedly cross organisational boundaries or who are disproportionately vulnerable.	Chapter 2: Our track record of delivering transformation at scale and pace Chapter 3: Our approach to whole system integrated care, “Our third commitment”
	It should also take into account how public services should be integrated with the unpaid contributions of families and communities.	Chapter 3: Our approach to whole system integrated care, “Our first commitment” Chapter 4: Plans for stakeholder engagement & governance
Demonstrate commitment to integrate care and support across the breadth of relevant stakeholders and interested parties within the local area	This should include local executive and political leadership, staff groups including clinicians, patient groups, people who use the services, carers and families.	Chapter 4: Plans for stakeholder engagement & governance
	Areas will also need to demonstrate robust governance structures, including for information sharing, to sustain the approach, as well as a robust plan for engaging local Healthwatch, people who use the services, all staff groups and the public in local service reform. **The involvement and support of Health and Wellbeing Boards** (as a minimum, by the end of the selection process) will be an **essential prerequisite** for any area to become a pioneer.	Chapter 3: Our approach to whole system integrated care, “Our third commitment” Chapter 4: Plans for stakeholder engagement & governance
Demonstrate the capability and expertise to deliver successfully a public sector transformation project at scale and pace	This might be evidenced by:	
	» A proven track record in this area, strong local leadership and accountability;	Chapter 2: Our track record of delivering transformation at scale and pace
	» Demonstrable and robust plans to address key local barriers to integrated care and support;	Chapter 2: Our track record of delivering transformation at scale and pace Chapter 3: Our approach to whole system integrated care Chapter 6: North West London: A whole system approach based on partnership
	» Risk management mitigation strategies, to maximise the likelihood of the area delivering its vision for integrated care and support across its locality.	Chapter 3: Our approach to whole system integrated care, “Our third commitment”
Commit to sharing lessons on integrated care and support across the system	This would be expected to include involvement in peer to-peer (including clinicians) promotion, dissemination and learning networks.	Chapter 5: Our commitment to sharing lessons, drawing on evidence and undertaking robust evaluation
Demonstrate that its vision and approach are, and will continue to be, based on a robust understanding of the evidence	This will include: » Plans that have taken account of the latest available evidence; » Understanding of the potential impact on the relevant local providers and intended outcomes; » A commitment to work with national partners in co-producing, testing and refining new measurements of people’s experience of integrated care and support across sectors; » A commitment to participate actively in a systematic evaluation of progress and impact over time.	Chapter 2: Our track record of delivering transformation at scale and pace Chapter 3: Our approach to whole system integrated care Chapter 4: Plans for stakeholder engagement & governance Chapter 5: Our commitment to sharing lessons, drawing on evidence and undertaking robust evaluation

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Health and Wellbeing Board
3 July 2013

For Action

Health and Wellbeing Strategy

Reasons for urgency

In accordance with the Access to Information Rules, the following item was considered urgent in the opinion of the Chair in order to appraise members of the latest developments before the next meeting. The item was not available when the agenda was published and added to the agenda at the request of the Chief Executive for consideration by the Board. As this is the first meeting of the Brent Health and Wellbeing Board it is important that the members are familiar with the Borough's Health and Wellbeing Strategy.

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Brent

NHS Brent

The Brent Health and Wellbeing Strategy

2012 – 2015

Introduction

The role of the Health and Wellbeing Board

Brent's Health and Wellbeing Board brings together senior representatives from Brent Council, Brent Clinical Commissioning Group (CCG) and Public Health to work in partnership to improve the health of the population of Brent. The key functions of the Board include:

- To coordinate the development of the Joint Strategic Needs Assessment (JSNA) which articulates the health and wellbeing needs of the residents of Brent.
- To determine the priorities for, and prepare a Joint Health and Wellbeing Strategy for Brent.
- To promote joint commissioning and integrated provision between the NHS, public health and social care.
- To consider Brent Clinical Commissioning Plans and Social Care Commissioning Plans and ensure that they are in line with the new Health and Wellbeing Strategy.

What we hope to achieve

Through the development of the Health and Wellbeing Strategy, the Board aims to improve health and wellbeing across Brent and to reduce the health inequalities that exist within our borough.

This strategy is not a comprehensive collection of all future commissioning intentions across health, public health and social care; that can be found in other key documents such as the commissioning intentions of the CCG. It is also worth noting that just because something isn't explicitly mentioned in the strategy it is not important or that work on it won't continue. Rather this strategy focuses on four key priorities for the Board, where partnership working can bring real added value to health and wellbeing across Brent over the next three years.

How we developed our strategy

The bedrock of this new strategy is our refreshed local JSNA which articulates the challenges which need to be addressed to improve the health of our population.

We have developed our thinking bearing in mind the wider changes that are occurring in the NHS and social care. This strategy reflects existing commissioning plans and strategies such as the CCG Commissioning intentions and the Children's Partnership Plan. It also takes particular note of the proposed Out of Hospital Care Strategy which outlines the ambition to provide better integrated services closer to patients' homes within community and primary care settings.

Introduction

How we developed our strategy (continued)

The other crucial element to develop this strategy has been stakeholder engagement throughout both the development of our JSNA and subsequently through consultation with both Brent LINk and Brent CVS on the key priorities for this strategy.

The Health and Wellbeing Board has considered all of these three elements in drawing up its list of key priorities. This document lays out the vision and principles of the Health and Wellbeing Board including the four key priorities for our strategy:

- **Giving every child the best start in life**
- **Helping vulnerable families**
- **Empowering communities to take better care of themselves**
- **Improving mental wellbeing throughout life**

For each of these priority areas, key strategic objectives have been defined with impact indicators to enable us to monitor overall progress over the next three years.

Next steps

This draft strategy was agreed by the Health and Wellbeing Board in July 2012 and will be put out for a formal two-month consultation in August 2012. It will be formally approved in October 2012

In parallel with the consultation we will also be conducting an Equality Impact Assessment (EIA), reports for both the consultation and the EIA will be published in October 2012.

Background

People and place

Brent is a place of contrasts. Home of the iconic Wembley Stadium, Wembley Arena and the spectacular Swaminarayan Hindu Temple, our borough is the destination for thousands of British and international visitors every year.

Brent is served by some of the best road and rail transport links in London and the area is accustomed to the successful staging of major events such as the Champions League Final in 2011 and Olympic Games events in 2012.

Our population is young, dynamic and growing (311,200 according to the 2011 census). Our long history of ethnic and cultural diversity has created a place that is truly unique and valued by those who live and work here.

Despite these strengths Brent is ranked amongst the top 15% most-deprived areas of the country. This deprivation is characterised by high levels of long-term unemployment, low average incomes and supported through benefits and social housing. Children and young people are particularly affected with a third of children in Brent living in a low income household and a fifth in a single-adult household. The proportion of our young people living in acute deprivation is rising.

Key challenges

Living in poverty generally contributes to poorer health, wellbeing and social isolation. The statistics show that people on low incomes are more likely to have a life limiting health condition, take less exercise and have a shorter life.

While overall life expectancy is in line with the rest of London there are significant health inequalities within the borough. For example the gap in life expectancy for men between the most affluent and the most deprived parts of the borough is 8.8 years.

Our diversity is a great strength and our various communities are valuable assets to bring about real change for families and individuals. But at the same time, many new communities are still not accessing the information and services available to help them improve their health and wellbeing.

Community engagement is a cross-cutting theme which runs throughout this strategy. Only by working together with our communities and the voluntary sector will we be able to improve health and wellbeing for all of our population.

There are enormous organisational changes occurring and proposed within the wider NHS including: the reconfiguration of commissioning organisations and hospital providers;

Background

Key challenges (continued)

and the replacement of many non-acute services in hospitals with better integrated services based closer to patients in the community and within primary care.

These organisational and service changes could bring about real improvements in the quality of care received by many patients. But at the same time there is a risk that organisational change will distract partners from much of the prevention work required to promote health and wellbeing more widely in our communities.

Our JSNA highlights a number of key health and wellbeing challenges which this strategy will aim to address including:

•Low rates of readiness for school amongst under-fives

•Poor oral health amongst children

•Rising levels of obesity – 12% of under 5s and 22% of 12 year olds are obese. Almost 25% of adults in Brent are estimated to be obese

•Low levels of participation in physical exercise – over 50% of adults do no physical exercise

•Increasing rates of alcohol-related hospital admissions

- Mental health remains the single largest cause of morbidity within Brent affecting one quarter of all adults at some time in their lives.
- Cardiovascular disease, chronic respiratory disease and cancers are the biggest killers in Brent and account for much of the inequalities in life expectancy within the borough.
- High levels of many long-term chronic conditions which are often related to our poor lifestyles, relative deprivation and in some cases our ethnic make-up. Diabetes is a good example of such a condition and we currently have 18,000 registered diabetic patients in Brent with numbers likely to grow in the future. We need to improve outcomes for these patients by helping more patients take a more active approach to their own care as well as improving the quality of our services in the community.
- The need to increase access to, and to expand, key prevention and screening programmes
- Rising levels of dementia amongst older adults
- Rates of tuberculosis (TB) in Brent are amongst the highest in the country.

Brent

NHS Brent

Our vision and priorities

The Health and Wellbeing Board wants to create an environment in Brent that enables individuals and families to lead healthy lives, and where health and wellbeing is at the heart of service delivery. This will require a commitment from both individuals and a range of local organisations to take more responsibility for our health and wellbeing. By focussing on our four key priority areas, we believe that we can add value to existing commissioning plans and make real inroads into reducing health inequalities across the borough.

Giving every child the best start in life

Giving each child in Brent the best start in life and preparing them for school is one of the strategy's priority areas. The first years of life are crucial for the physical, intellectual and emotional development of individuals and have lifelong effects on many aspects of health and wellbeing. We intend to divert much of our energy to improving the quality of life for our youngest residents, focussing on key areas such as parenting programmes, improving access to services for hard-to-reach groups; and encouraging healthy behaviours through a range of settings including children's centres and nurseries.

Helping vulnerable families

Helping vulnerable families to thrive is crucial to tackling the health inequalities that currently exist

Overview of our strategy

Aims:

Improve health and wellbeing

Reduce health inequalities

Vision/principles:

Improving life chances

Thriving families

Resilient communities

Influencing wider partners to sign up to the health and wellbeing agenda

Delivering better care, closer to home: the best possible care at the right time in the right place

Priorities:

Giving every child the best start in life

Helping vulnerable families

Empowering communities to take better care of themselves

Improving mental wellbeing throughout life

within Brent. We will do more to help specific groups including families with complex social needs.

More widely, we recognise our responsibility to address the socio-economic factors which have the greatest impact on many of our families: low income, unemployment and housing. There are no quick solutions to these problems, but they will be a major focus of the Health and Wellbeing Board's work over the coming years, helping to ensure that partner organisations in Brent are working to help address the key social determinants of health.

Empowering communities to take better care of themselves

Given the rise in local demand for health and social care, the NHS in Brent will only thrive if local people develop greater capacity to manage their own health and health care. The NHS in Brent will play a full role in working with local people to improve self management and will achieve this by commissioning much better self management of care for people with long term conditions. We will also commission health improvement services that will work with communities to help them take better care of themselves. We will work with our diverse resourceful communities to improve their capacity to take better care of themselves. This is vital across all aspects of health care, but is especially so for improving mental health.

Improving mental wellbeing

Mental health is a key priority for this strategy and we recognise the need to promote mental wellbeing in our communities and to address the stigma and lack of awareness around mental illness. This will involve us actively working with our communities, voluntary and faith groups to actively promote mental wellbeing and increase levels of awareness.

We are keen to ensure that Brent commissions a comprehensive, recovery focused, mental health service which will provide care in an integrated and coordinated manner. This will build on our commitment to expand the provision of early interventions for people with mental health problems and to improve the quality of care for individuals with serious mental illness; which includes the need to provide people recovering from illness with meaningful employment and secure housing.

Giving every child the best possible start

What are our key issues?

Brent has seen an improvement across a number of child health outcomes in recent years including immunisation and breastfeeding rates. However oral health and childhood obesity remain two areas of real concern. More than 11% of local children are already obese in their reception year, this is a significantly higher rate than the rest of London. Similarly we have the highest rates of dental decay in young children (44% of our under-5s).

The first few years of life have a crucial impact on the future development of children. Positive and supportive parenting is key to this and there is good evidence of the beneficial impact of parenting programmes. In Brent we have a range of parenting programmes, however the drop-out rate from local programmes is high and we need to examine how we can better tailor our services to meet the needs of our communities.

We are committed to supporting the early development of healthy behaviours and fostering a supportive community and accessible services for parents and families. There are a whole range of teams who contribute to this including midwives, health visitors, children's centres, primary care teams and specialist services. However we need to do more to ensure that all communities have access to the same information and services. And we need to increase engagement with black and minority ethnic groups who have not traditionally accessed our local services.

Readiness for school is a key marker of future life chances. In Brent only 57% of 5-year olds reach a good level of development at age 5 (compared to 59% across London). In addition to the support that is given to families by Children's and health services, we are keen to expand on work with schools and nurseries to improve the wellbeing of children in their early years.

Brent

NHS Brent

Giving every child the best possible start

Key objectives:

Our six key objectives to deliver progress on this priority will include:

1. Strengthening and expanding our current **parenting programmes** with a focus on learning from evaluation.

2. Ensuring the sustainability and delivery of the **Child Oral Health Strategy**

3. To expand **partnership working** with schools, nurseries, playgroups and other Early Years settings to improve the wellbeing of children.

4. Improve the offer of our current **interventions to prevent and manage childhood obesity**

5. Engage with **hard-to-reach individuals and communities** through the use of community champions

Impact indicators:

We will monitor progress around three key impact indicators:

Oral health in children under-5s

Obesity at reception year

Readiness for school

Additional output/outcome measures are described against each objective in the action plan which follows.

Helping vulnerable families

What are our key issues:

The importance of working with vulnerable families to tackle health and social problems cannot be overstated. A whole family approach is being developed to help break the cycle of poverty, unemployment, crime, substance abuse and poor educational attainment that affect some families in Brent. We are developing an initiative to work intensively with 300 such families initially and this number will eventually rise to 800.

There are a number of drivers behind the Health and Wellbeing Board's decision to prioritise helping vulnerable families, not least the Ofsted Inspection of Safeguarding and Looked After Children in 2011. This inspection identified key areas for improvement that are being taken forward. The importance of this work is understood and recognised by the Board and is a central component to this part of the strategy.

The reported use of drugs, alcohol and smoking amongst young people remains a high priority and given our dynamic demographic make-up we need to remain focused and build on existing work to further reduce risk-taking behaviour amongst adolescents.

Brent's unemployment rate is higher than the London and national average. Similarly, average incomes in Brent are below London and national averages, which makes much of the borough unaffordable to live in for people on low incomes. There are currently 18,000 people on the Housing Register in Brent (11,000 who have an identified housing need), but only 871 lettings to social housing were made in 2011/12. New changes to the benefit system may result in even more overcrowding within the private and social housing sectors and the accompanying detrimental impacts on physical and mental health.

Reducing the impacts of poor quality housing and low income on health and wellbeing is one of our key objectives. And the Health and Wellbeing Board is determined that it does all that it can to enable all families in Brent to thrive. Our current regeneration strategy focuses on getting people back into work and the council is drafting a new tenancy and housing strategy which will also examine how we can further reduce the impacts of poor housing.

Helping vulnerable families

Key objectives:

Our six key objectives to deliver progress on this priority will include:

1. Improve the **identification and assessment of all vulnerable children** underpinned by **robust safeguarding procedures**
2. Better **multidisciplinary working for children with additional or complex needs**
3. Improve outcomes for **Looked after children**
4. Helping **families with complex needs**
5. Improve the health of young people through **addressing risk-taking behaviour.**
6. Reduce the impact of **poor quality housing** on health and wellbeing
7. Reduce the impact of **unemployment** on health and wellbeing

Impact indicators:

We will monitor progress around the following key impact indicators:

Educational and health outcomes of Looked after Children*

Childhood poverty

Overcrowding

Long-term unemployment

Additional output/outcome measures are described against each objective in the following action plan.

* To be developed further

What are our key issues?

Far too many of us in Brent are not living well and are storing up health problems for the future. We have a relatively young population and yet we have the third lowest levels of physical activity in England. Sedentary lifestyles, poor diets and stress are leading to a large proportion of our population developing long-term chronic diseases such as diabetes, heart disease, high blood pressure and chronic bronchitis.

Worryingly, local people who do develop these long-term conditions often have poor outcomes in terms of complications and deaths. There are a multitude of reasons for this, which include the need to improve the quality of some community and primary care services.

However at the same time we need to ensure that communities are able to promote more independence and responsibility for their health and healthcare needs. This includes encouraging individuals to seek appropriate help earlier, as good treatment started early can prevent many future complications.

In addition, patients need to become more engaged with and more knowledgeable about their care, so that they feel happy to engage with and agree with the long-term treatment plans which are needed to control their disease(s) over the years. Too often we find that many patients simply do not understand their treatment and unilaterally stop taking their medicines, which often has serious adverse consequences.

If we want primary and community services to be more pro-active and prevent more future disease, than we need to ensure that we use our resources more wisely. In these difficult economic times we need to maximise the impact of our doctors and nurses by reducing the number of inappropriate visits which could have been dealt with at home or by the pharmacist; for example common coughs and colds.

Similarly, changes in adult social care, mean that more families need to become aware of the new personalisation agenda and how this can maximise opportunities to access better social care for themselves or their loved ones.

We need to reach out to all people in Brent and promote healthier lifestyles, better preventative services and a more responsible use of our healthcare resources. And once people do develop a chronic condition, we need to work with communities to help ensure that patients are engaged with, and better understand their health and social care package.

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Empowering communities to take better care of themselves

Key objectives:

Our six key objectives to deliver progress on this priority will include:

1. Promoting **independence and responsibility for our health and healthcare**
2. Encouraging everyone to be **physically active**
3. Promoting **healthy eating**
4. Strengthening our **tobacco control** partnership
5. Strengthening **partnership work around alcohol**
6. Increasing **early diagnosis and testing for HIV and TB**

Impact indicators:

We will monitor progress around the following key impact indicators:

Cardiovascular admissions

Cardiovascular mortality

Proportion of adults who are physically inactive

Smoking prevalence

Additional output/outcome measures are described against each objective in the following action plan.

Mental wellbeing throughout life

Mental ill health is the single most common cause of morbidity in Brent. It will affect around one in four of all adults and one in ten children.

Promoting mental wellbeing and intervening early to help children and adults before they develop serious mental health conditions is the most effective approach to tackle these conditions. This approach needs to be taken throughout the life course whether it is helping; new mothers with post-natal depression, children who are finding it hard to adjust to school, or adults who are struggling with mild anxiety or depression.

We have made some progress to-date but need to continue to expand our service offer. For example we have some very good programmes which work with children with low-level conduct disorders in schools. Family group-therapy is an excellent intervention which can benefit children, families and schools and overall this is one of the most cost-effective mental health interventions. However at the moment this service is only provided to a limited number of Brent schools.

In 2010/11 there were over 16,000 Brent adults who were on a GP practice register for depression. We have recently made large increases in the provision of psychological therapies which can help many individuals with anxiety disorders or depression. However we still need to do more to match the growing needs of our population.

During the JSNA consultation many individuals and organisations raised concerns over the quality of services for people with a serious mental illness. Our rates of in-patient admission for individuals with a serious mental illness are high. And we are aware that we need to improve the general health and wellbeing of these patients, rather than simply focusing on medical treatments alone. This includes the need to help individuals find meaningful employment and secure housing following recovery.

Finally as our population ages, older people’s mental health will becoming an increasing priority with the need for better early intervention to reduce the impact of dementia on patients and families.

Mental wellbeing throughout life

Key objectives:

Our six key objectives to deliver progress on this priority will include:

1. **Mental health promotion** before people become unwell
2. Early identification of mothers with **post-natal depression**
3. Helping **children with low-level mental health problems** in school
4. Increase the provision of **talking therapies**
5. Improving **wellbeing for people with a serious mental illness**
6. Early identification and intervention for **dementia**

Impact indicators:

We will monitor progress around the following four key impact indicators:

Dementia prevalence

Depression prevalence

Emergency hospital admissions for mental illness

Additional output/outcome measures are described against each objective in the following action plan.

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