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Brent

Health Partnerships Overview and Scrutiny Committee

Tuesday 28 January 2014 at 7.00 pm
Boardroom - Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

Membership:

Members Councillors:	**first alternates** Councillors:	**second alternates** Councillors:
Daly (Chair)	Mitchell Murray	Moloney
Hunter (Vice-Chair)	Sneddon	Brown
Colwill	Baker	Kansagra
Harrison	Singh	Naheerathan
Hector	Aden	Al-Ebadi
Hossain	Ogunro	RS Patel
Leaman	Green	Clues
Ketan Sheth	Gladbaum	Van Kalwala

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democracy.brent.gov.uk

The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members

Item Page

1 Declarations of personal and prejudicial interests

Members are invited to declare at this stage of the meeting, any relevant financial or other interest in the items on this agenda.

2 Deputations (if any)

3 Minutes of the previous meeting held on 4 December 2013 1 - 10

The minutes are attached.

4 Matters arising (if any)

5 Diabetes Services in Brent 11 - 22

The report covers services currently provided, including; healthy eating and physical programmes, awareness and health checks, primary care measures through the Quality and Outcomes Framework; GP insulin scheme, community and secondary care provisions and diabetic eye screening services.

6 Brent Clinical Commissioning Group finances 23 - 32

The report outlines Brent's current position, with a surplus of £26m in 2013/14, and an overview of the key areas and their current spends. Also outlined are 2013/14 QIPPs and investment plans and an overview of the approach to 2014/15 QIPPs and investment plans.

7 Brent Clinical Commissioning Group commissioning intentions 2014/15 33 - 76

Brent Clinical Commissioning Group (CCG) is presenting the Health Partnerships Overview and Scrutiny Committee with its commissioning intentions for 2014/15 for the committee's comments. The report provides an overview of the CCG's commissioning aims along with a more detailed appendix of their plans for 2014/15.

8 18 Weeks Referral To Treatment Incident and Urology Serious Incident 77 - 88

The report restates the plans to expand some areas of capacity including theatres and to commission external providers in order to cope with the additional capacity required to deal with the large volume of affected patients with some additional details. Also highlighted is a different, more recently identified, incident that has occurred in urology, where patients booked on a planned waiting list for diagnostic/cystoscopy procedures had not been offered an appointment.

9 Plans for Central Middlesex Hospital 89 - 124

The report is attached.

10 Health Partnerships Overview and Scrutiny Committee work programme 2013/2014 125 - 126

The work programme is attached.

11 Any other urgent business

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

12 Date of next meeting

The next meeting of the Health Partnerships Overview and Scrutiny Committee is scheduled to take place on Tuesday, 18 March 2014 at 7.00 pm.

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.

Brent

MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Wednesday 4 December 2013 at 7.00 pm

PRESENT: Councillor Daly (Chair), Councillor Hunter (Vice-Chair) and Councillors Colwill, Harrison, Hector, Hossain and Ketan Sheth

Also present: Councillor Hirani (Lead Member for Adults and Health)

Apologies for absence were received from: Councillors Leaman

NHS representatives present: Tina Benson (Director of Operations, North West London NHS Hospitals Trust), David Cheesman (Director of Strategy, North West London NHS Hospitals Trust), Daniel Elkeles (North West London Clinical Commissioning Groups), Tracey Jepson (London Ambulance Service), Rob Larkman (Chief Officer, Brent, Ealing, Harrow and Hillingdon Clinical Commissioning Group), Ethie Kong (Chair, Brent Clinical Commissioning Group), Sarah Mansuralli (Assistant Chief Operating Officer, Brent Clinical Commissioning Group) Jo Ohlson (Chief Operating Officer, Brent Clinical Commissioning Group) and Dr Mark Spencer (Shaping a Healthier Future).

Brent Council officers present: Mark Burgin (Policy and Performance Officer, Strategy, Partnerships and Improvement), Bryony Gibbs (Democratic Services Officer, Legal and Procurement), Phil Porter (Interim Director, Adult Social Services) and Melanie Smith (Director of Public Health, Adult Social Services)

1. **Declarations of personal and prejudicial interests**

None.

2. **Minutes of the previous meeting**

RESOLVED:-

that the minutes of the previous meeting held on 8 October 2013 be approved as an accurate record of the meeting.

3. **Matters arising (if any)**

Rob Larkman (Chief Officer Brent, Ealing Harrow and Hillingdon Clinical Commissioning Groups (CCGs)) provided a brief update on the procurement of cardiology services. He advised that the procurement process which had identified the preferred bidder had been referred to the system regulator for review and formal enquiries were in process. A decision would be issued by February or March 2014 an the contract would not now be able to be awarded in line with the expected timetable.

4. **Health Services: Winter Provisions**

The committee considered reports from the Brent Clinical Commissioning Group (CCG) and the North West London Hospitals Trust (NWLHT) on their plans to cope with the anticipated pressure on services over the winter period. The reports were presented by Jo Ohlson (Chief Operating Officer, Brent CCG) and Tina Benson (Director of Operations, NWLHT) respectively.

In summarising her report, Jo Ohlson clarified that Brent CCG was responsible for ensuring that there were sufficient services to meet demand over the winter but did not commission General Practitioner (GP) services; this latter task lay with the National Health Service England (NHSE). A briefing had been provided by NHSE on the relevant activity undertaken by the organisation and this would be circulated to the committee.

Outlining the work of Brent CCG, Jo Ohlson explained that £6.4m funding had been secured via winter bid plans to support a range of schemes across the local Brent-Harrow health economy, with a further £6.6m provided by Brent CCG. Schemes included the Short Term Assessment, Reablement and Rehabilitation Services (STARRS), an Integrated Care Pilot aimed at those most at risk of hospital admission, and increasing access to GPs via extended opening hours, including Saturday appointments. With reference to this latter project, it was noted that there was a need to promote these expanded opening times and work was being undertaken to explore possibilities of direct appointment bookings via the 111 service. Members' attention was drawn to the table setting out the creation of additional bed capacity across several sites and an update was provided. In addition to those reported, a further 6 mental health beds would be provided on the Northwick Park Hospital (NPH) site. Members were advised that NWLHT was using capacity at both NPH and Central Middlesex Hospital (CMH) to ensure all available beds were used for suitable patients. It was anticipated that from December onwards there would be sufficient beds in the system. However, risks of a surge in demand on services remained.

Jo Ohlson set out the planned work to reduce Delayed Transfers of Care (DTOCs) from hospital to community settings. Principal causes of DTOC included patients awaiting either health or social care assessments or appropriate residential or nursing home placements, and a lack of appropriate / accurate information on potential discharges. A series of actions had been agreed to address these issues including increasing capacity within the NWLHT discharge team and creating a further 6 reablement beds. An escalation process had also been established to ensure appropriate overview of the process.

Tina Benson outlined the actions being taken by the NWLHT to address anticipated difficulties, such as excessive patient waiting times in Accident and Emergency (A&E) departments, during the winter period. These actions sought to increase bed capacity, improve flow through the emergency pathways and embed seven-day working. The report also set out performance against the four-hour emergency target, which required that those attending A&E must be seen, treated, admitted or discharged in under four hours. It was emphasised that the pressures on Northwick Park Hospital (NPH) were largely related to admissions rather than attendances, which in fact were fairly stable, lending greater importance to the Brent CCG work focussing on admission avoidance. Tina Benson explained that a capacity gap of up to 89 beds had been identified but there was insufficient space to accommodate the required number of beds at NPH. 40 additional beds had been installed at NPH

and Brent CCG had funded in excess of 50 beds within the community. There was also potential for further external capacity of 22 beds. It was emphasised that patients were being informed that their care could be provided across a network of sites. Members were advised that the additional beds were not reflected in the table setting out performance trajectory in relation to the four-hour emergency target. This trajectory gave a year end performance of 94.4 per cent against the national target of 95 per cent. Performance against this target would continue to be reviewed, with a focus on understanding the impact of the additional beds provided. Breaches of the target also related to access to specialist teams, termed 'speciality breaches'. Staffing had been expanded across these teams to address this problem. Tina Benson concluded her presentation by noting that a self-management target had been set to keep breaches of the four hour target to under 5 per day.

During members' subsequent discussion several queries and issues were raised by the committee. A member noted the impressive achievements of STARRS and further information was sought about its operation. The Committee queried the contribution of GPs to meeting the pressure on services over the winter period and asked how this was monitored. Details were requested of the number of home visits undertaken and whether, per practice, there was a correlation between levels of home visits and A&E attendances. Members queried the number of calls received by 111 via the out of hours GP services by provider, how these were dealt with and the resulting number of home visits undertaken.

The Committee also sought clarification regarding the action implemented by NWLHT to provide additional consultant emergency surgeons for critical care outreach. An update was requested on whether seven-day working had been successfully implemented. Members asked the Health representatives to outline services provided to nursing homes. Confirmation was sought that there were no 'mothballed' or unused wards at NPH and queries were raised on the co-ordination of bed capacity between NPH and CMH. A member asked how many bed days had been lost due to patients awaiting assessment. The committee queried the plans in place to work co-operatively with neighbouring hospital trusts in the event of excessive service demand.

Responding to the queries raised, Jo Ohlson explained that the STARRS scheme in Northwick Park Hospital (NPH) was funded by Brent CCG and Harrow CCG. STARRS provided a range of services with teams comprising different health professionals including specialist nurses, consultants and occupational therapists. It aimed to support patients in hospital and after discharge by providing concentrated rehabilitation support and continuing their care at home or at 'step down' facilities such as those provided at Willesden Hospital. David Cheeseman advised that a presentation on STARRS could be provided at a future meeting of the committee.

Addressing members' queries regarding GP services, Jo Ohlson explained that all GPs were required to offer home visits subject to clinical need but that this would not be monitored by NHSE. Similarly, data on use and outcomes of out-of-hours services could only be gathered by Brent CCG for the 14 out of 67 GP practices in Brent for which it retained this responsibility. The majority of GP practices had contracted their out of hours services with Harmoni and the remainder with London Central and West Unscheduled Care Collaborative (LCW UCC). To access these services, people could call either their GP's telephone number or 111. Calls would

be triaged and based on an assessment of clinical need could result in a home visit or the option to see a GP. Brent Residents accessing out of hours services provided by Harmoni would be able to attend either NPH or Hillingdon Hospital; those with LCW UCC would attend St Charles Hospital. It was emphasised that many patients would not be aware that there were three different services offered in Brent. At present, residents in nursing homes would simply be registered with a GP. There was some exploration of how this service might be commissioned with a provider to ensure greater visibility and more effective support and community care.

Tina Benson explained that the critical care outreach referred to in relation to the provision of additional consultant surgeons, encompassed specialist support to teams within the hospital site. Members were further advised that 7 day working had been successfully embedded and an increasing number of the London equality standards, many of which applied measures over 7 days, were being met as a result. This allowed greater opportunity for benchmarking performance.

Tina Benson confirmed that there were no mothballed wards at NPH and advised that patients attending NPH would be transferred to CMH where appropriate as all medical beds were treated the same across both sites. It was anticipated that there were sufficient beds to meet demand over winter but it was considered that further work was required to minimise length of stay. Improvements were expected in this area however, as a number of community strategies were implemented. Jo Ohlson advised that there had been 172 bed days lost over a period of 3 weeks as a result of patients awaiting assessment. Rob Larkman (Chief Officer, Brent, Ealing Harrow and Hillingdon CCGs) informed members that discussions were underway with colleagues across North West London to ensure that appropriate contingency plans were in place to ensure that neighbouring services supported each other in responding to surges in demand.

The Chair invited Tracey Jepson (London Ambulance Service) to comment on the winter pressures. Tracey Jepson advised that the action plan was due to 'go live' on Monday 5 January and would work alongside other relevant plans. It would be a live document and would be subject to regular review. A breakdown for the last three months of the number of ambulance conveyances to NPH and CMH for A&E, Urgent Care Centres and transfers was requested by the committee. Tracey Jepson advised that she did not have the information to hand but would provide the data for circulation to the committee.

Members thanked the representatives for their reports and advised that written summaries of the information presented to the meeting would be of assistance to the committee. The Committee also requested that any figures provided be broken down to show both the overall figure and a Brent only figure. Further to this, members' emphasised the importance of respect for patients and asked that this be reflected in any reports.

RESOLVED:

That the reports presented to the committee from the Brent Clinical Commissioning Group (CCG) and the North West London Hospitals Trust (NWLHT) on their plans to cope with the anticipated pressure on services over the winter period be noted.

5. **Brent CCG "Wave 2" Commissioning: Impact Assessment and Consultation Plans**

Sarah Mansuralli (Assistant Chief Operating Officer, Brent Clinical Commissioning Group) introduced a report to the committee regarding Wave 2 of the procurement plans of Brent Clinical Commissioning Group (CCG). Wave 2 procurement covered the re-procurement of musculoskeletal services, trauma and orthopaedics, rheumatology and gynaecology. Members were advised that Brent CCG had awarded a contract in December to consultants Mott MacDonald to undertake an impact assessment and a formal consultation in relation to the procurement. Action plans for these two components had been drawn up by Mott MacDonald and were attached for the committee's information. The impact assessment would cover four key areas: a health impact assessment, an quality impact assessment, a travel and access impact assessment and an organisational impact assessment. The consultation would primarily comprise several consultation events, an online survey and focus groups with key patient and hard to reach groups. A consultation booklet would also be produced. It was emphasised that a further consultation on the proposed service specifications would be held subsequently. Sarah Mansuralli introduced representatives of Mott Macdonald and advised that they were in attendance to address any queries the committee might have.

Members' sought clarity on the purpose of the formal consultation and discussed the importance of there being a good understanding by those conducting the consultation of Brent's diverse communities and how to best engage those communities. Rob Larkman (Chief Officer for Brent, Ealing, Harrow and Hillingdon CCGs) explained that the formal consultation was aimed at involving local people in the re-design of the services and was not a statutory consultation. The representatives from Mott MacDonald advised that they had been involved in a number of London service reconfigurations. They were currently undertaking activities to better understand the providers and had been engaging with the Council for Voluntary Services (CVS) Brent. They would be talking to those who would be affected by the service plan and would make use of the equality and engagement database of Brent CCG. For those for whom English was a second language, community groups and translators would be made use of. David Cheeseman (Director of Strategy, North West London NHS Hospitals Trust commented that he had welcomed the opportunity to talk to someone independent of Brent CCG regarding the impact on the services concerned.

RESOLVED:

That the report on Wave 2 of the procurement plans of Brent Clinical Commissioning Group (CCG) be noted.

6. **NW London Hospitals: 18 Week Referral to Treatment Targets Incident**

Tina Benson (Director of Operations NWLHT) presented the report to the committee on an incident resulting in lack of compliance with the 18 week referral to treatment target (RTT). This target related to patients' right to receive consultant led treatment within 18 weeks of referral. Members were advised that in February 2013 it was identified that 60 per cent of patients on the waiting lists did not have an open care pathway which meant that waiting times had been wrongly recorded. As a result, approximately 2700 patients had been waiting longer than 18 weeks of which

approximately 560 were Brent residents. In response to this, action had been taken which ensured that all those waiting over 18 weeks received offers of treatment, with agreed dates.

Tina Benson explained that following an internal review, NHS Interim Management and Support (IMAS) had been invited to review processes and pathways underlying the RTT. The review found that systems and processes had not been sufficiently robust, there had been a gap between increased service demand and capacity, and staff-culture had resulted in some staff members feeling under pressure to undertake actions which resulted in incorrect records of patients waiting times. Since the findings of the review were made available, considerable progress had been made and a comprehensive action plan had been produced, with input from CCGs. The action plan included updating policies, staff training, enhanced monitoring and auditing of data recording and reporting and establishing additional outpatient clinics. Additional capacity would also be outsourced to alternative NHS providers and private providers of patients' choice.

During member discussion, the committee sought assurance that patients would be appropriately tracked. Further details were sought on plans to monitor and audit patients' care pathway 'clocks'. An update was requested on post-op care and clarity was sought on the demand and capacity issue identified by the IMAS review. A member raised a query regarding communication with patients.

Tina Benson replied to the queries raised and explained that outsourced projects were frequently managed; patients were kept on a separate spreadsheet which was updated twice-weekly following information exchange between NWLHT and the provider in question. Efforts were made to ensure that a shared record was maintained which meant for instance that on the day of surgery records from both organisations were available for reference. There was also a good set of performance indicators which had been established by Brent CCG. Members were advised that additional capacity was being resourced at NWLHT in order to support routine auditing of data. It was now possible to monitor on a weekly basis the numbers of patients who had had their care pathway 'clocks' stopped and/or who had been added to the elective waiting list.

Addressing questions of capacity, Tina Benson explained that additional therapists had been employed for post-op care and additional STARRS support had also been agreed. It was acknowledged that the commissioning plan did not reflect the current level of activity and discussions were now being held to ensue a robust plan was in place for the contract for the forthcoming year. In order to address immediate issues, 87 additional theatre sessions were required, which the CCG had agreed to deliver. Use would have to be made of other centres as it was not possible to recruit sufficient numbers of staff within the required timeframe. Rob Larkman (Chief Officer – Brent, Ealing, Harrow and Hillingdon CCGs) briefly outlined the commissioning process, explaining that assumptions of service demand relating to elective activity would be agreed with the provider. If the activity exceeded the assumed level, an existing mechanism was in place through which additional activity could be funded. A capacity assessment exercise would be conducted in advance of agreeing the commissioning process for the forthcoming year to ensure that base assumptions were as accurate as possible.

Responding to a query, Jo Ohlson advised that all relevant patient information regarding the incident leading to non compliance with the 18-week target had been shared with patients' GPs and all letters sent to patients had been copied to GPs. GPs were encouraged to refer appropriately but there was no disincentive to refer. Tina Benson emphasised that it was made clear that there was patient choice but that as not all sites were able to offer all types of procedures, patients were offered a primary site initially which took account of locality.

The Chair thanked the presenting officers for their contributions and asked that the committee be provided with further details of the capacity assessment exercise at its next meeting.

RESOLVED:

That the report be noted.

7. **Update on Plans for Central Middlesex Hospital**

Rob Larkman (Chief Officer – Brent, Ealing, Harrow and Hillingdon Clinical Commissioning Groups (CCGs)) provided an update to the committee on the plans for Central Middlesex Hospital (CMH) under the Shaping a Healthier Future (SaHF) programme. He advised that colleagues from SaHF, Daniel Elkeles (North West London CCGs) and Dr Mark Spencer, were also present to address any queries from the committee.

Rob Larkman reminded the committee that Ealing Council had referred the SaHF plans to the Secretary of State for Health and had made an application for Judicial Review (JR). The JR had been declined and in October 2013, the Secretary of State for Health had given his broad approval to the SaHF proposals including that CMH become a Local Hospital and Elective Centre. The Secretary of State for Health had also recommended that the changes to A&E at CMH take place as soon as practicable after winter. It was emphasised that the current restricted opening hours of the A&E service at CMH were not a result of the SaHF proposals but instead were related to clinical safety issues.

Members were advised by Rob Larkman that the plans for CMH created potential for significant investment in the site. Work was currently being undertaken to build a long term sustainable model for the site. Working groups had been established which would complete evaluations of clinical and financial factors as well as exploring the impact on patients of moving existing services to CMH. An Equalities Impact Assessment would also be completed to explore how protected patient groups would be affected by any proposals. Weekly meetings were being held to oversea the progress of the work streams. Members attention was drawn to the list of options under consideration, set out in the report. In response to a query it was clarified that this list represented the core elements of the portfolio of services being considered for CMH. It was emphasised that there would be full and meaningful engagement with local residents and other stakeholders. In line with this, an engagement plan was being developed. Rob Larkman concluded by noting that a final report setting out proposals for CMH would be presented to the Partnership Board and Implementation Programme Board on 6 February 2014. Approval would then be required to be sought through several decision making bodies including the

Clinical Commissioning Groups, National Health Service England (NHSE), Trusts and the NHS Trust Development Body (NTDA).

In the subsequent discussion, the committee raised a number of issues. A member queried the percentage of the CMH site currently in use and sought an explanation for the figure provided. In response, David Cheesman (Director of Strategy NWLHT) advised that approximately 65 per cent of CMH was currently being used and at present the A&E service was closed overnight for reasons of clinical safety. Additional elective work had been transferred to CMH from Northwick Park Hospital (NPH) but without a 24 hour A&E service this would only be temporary. Daniel Elkeles explained that the aim for CMH was to make it into a large hub for elective services; this was considered best use of the site based on its size and location. It would not be possible to install additional surgical beds for instance to meet a capacity gap as whilst there was the physical space at CMH there were not the teams that were required to support those beds.

The committee expressed concern regarding the potential transfer of mental health services from the adjacent Park Royal Hospital (PRH) site and queried the reasoning for this. Dr Mark Spencer informed the meeting that there were currently four wards at the PRH, encompassing an admissions assessment unit, two acute mental health units and a mother and baby unit for those with post natal depression. The current facilities at the PRH were not sufficient and it would be possible at CMH to provide a higher quality accommodation at ground level with access to courtyards. Daniel Elkeles advised that the mental health units were low security, unlocked wards and would have a separate entrance to the rest of CMH.

In thanking the representatives for their contributions, the committee requested that an update on the plans for CMH be provided at the next meeting in January 2014, alongside a report on the proposals for Willesden Hosptial.

RESOLVED:

i. That the report be noted

ii. That an update on the plans for Central Middlesex Hospital be provided to the committee at its next meeting in January 2014.

iii. That a report on the proposals for Willesden Hospital be provided to the committee at its next meeting in January 2014.

8. **Health Partnerships Overview and Scrutiny work programme 2013-14**

The committee reviewed the work programme, noting the items that were scheduled for the forthcoming meeting in January 2014.

RESOLVED:

That the work programme be noted.

9. **Date of Next Meeting**

The committee noted that the next meeting was scheduled for 28 January 2014.

10. **Any Other Urgent Business**

None.

The meeting closed at 9.15 pm

M Daly
Chair

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Brent	**Health Partnerships Overview and Scrutiny Committee** 28th January 2014 **Report from the Assistant Chief Executive**
For Action	Wards Affected: ALL

Diabetes Services in Brent

1.0 Summary

1.1 Members will be aware that diabetes is an ongoing concern in Brent where incidents of diabetes are among the highest in the country. This joint report from Brent Council's public health team, Brent CCG and NHS England outlines the diabetes services currently provided in Brent and proposals for changes and redesign of the service.

1.2 The report covers services currently provided, including; healthy eating and physical programmes, awareness and health checks, primary care measures through the Quality and Outcomes Framework; GP insulin scheme, community and secondary care provisions and diabetic eye screening services.

1.3 Diabetes services in Brent are to be reconfigured from April 2014. The new model of delivery will be primarily based around a community based integrated pathway for patients.

2.0 Recommendations

2.1 The committee is recommended to consider the services currently provided and question officers on the current provision, particularly any gaps in service, poor performance or other concerns. The committee is further recommended to question officers on the proposed integrated pathway to establish whether it is satisfied that this new model will deliver the improvements suggested.

Contact Officers

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Diabetes in Brent

1. Purpose of the report:

1.1 This report provides an update to Brent HOSC on diabetes. It covers the current and expected future numbers of people with diabetes in Brent and the level of complications in the diabetic population with comparison to the national picture.

1.2 The report has been produced jointly by Brent Council public health team, Brent CCG and NHS England and covers the range of services commissioned by these partners. These range from health promotion and diabetes prevention activity; awareness raising and risk assessment; intensive lifestyle support to those with pre-diabetes; diagnosis and management of diabetes in primary care (including an expansion of the traditional primary care role to include insulin initiation); and secondary care services, including diabetic eye screening.

1.3 The report concludes with an account of the CCG's identification of the case for change in current services for people with diabetes in Brent and the plans for service redesign.

2. The Epidemiology of diabetes in Brent

Numbers of people with diabetes in Brent

2.1 There are currently 22,097[1] people on GP diabetes registers in Brent. Diabetes prevalence varies across the five CCG localities in Brent, being highest in Kingsbury at 9.6% and lowest in Kilburn at 6.1%. NHS Brent has seen a 38% increase in the prevalence of diabetes between 2008/09 and 2012/13 (see table 1). This is likely to be due to a combination of population growth, improved detection and recording on GP systems, as well as an increase in the actual prevalence, as described below.

2.2 In October 2013 Diabetes UK reported the prevalence of diabetes in Brent to be 10.5%, the highest in the UK and compared to a national rate of 7.4%. The Diabetes UK figure is an estimate and higher than the numbers recorded by GPs, which reflect the actual number of *diagnosed* diabetic patients. It is estimated that one in four people with diabetes in London are undiagnosed. These individuals are unaware they have diabetes and are at a high risk of developing long term complications.

Table 1 - Prevalence per year (QOF register)

Year	Diabetes register (on 01 April)
2008/09	15,990
2009/10	16,699
2010/11	18,011
2011/12	20,987
2012/13	22,097[2]

[1] QMAS data as at 01 Apr 11
[2] See 1

Expected increase in the number of patients living with diabetes

2.3 The prevalence of diabetes in Brent is projected to rise, fuelled by the ageing of the population, increasing numbers of people who are obese and overweight, and the high proportion of black and Asian ethnic groups in the borough who are more susceptible to diabetes.

2.4 The Association of Public Health Observatories predicts the number of people with diabetes on GP registers in Brent will increase to just over 25,000 by 2020. This would represent a prevalence of 11.2% and compares to a predicted prevalence of 8.7% for London over the same time period.

Rates of complications associated with diabetes

2.5 People with diabetes are at risk of a range of complications, including heart disease, stroke, foot disease which may necessitate amputation, kidney disease and loss of sight. Early diagnosis, good diabetic care and self management can reduce the risk of complications.

2.6 The main findings of the 2011/12 National Diabetes Audit, which gathers data to identify the additional risk of diabetic complications and mortality in people with diabetes when comparisons are drawn with the general population, were as follows:

- In Brent, people diagnosed with diabetes were 35.6% more likely than the general population to have a MI (Myocardial Infarction) and 29.9% more likely to have a stroke[3].

- People with diabetes in Brent were 56.5% more likely than the general population to have a hospital admission where heart failure was recorded.

- In Brent people with diabetes have a 19.4% greater probability of dying in a one year period than the general population.

2.7 Figure 1 compares the prevalence of complications in the diabetic population in Brent to that in the diabetic population in England. People with diabetes in Brent are less likely to have complications than people with diabetes in England.

[3] National Diabetes Audit 2011/12

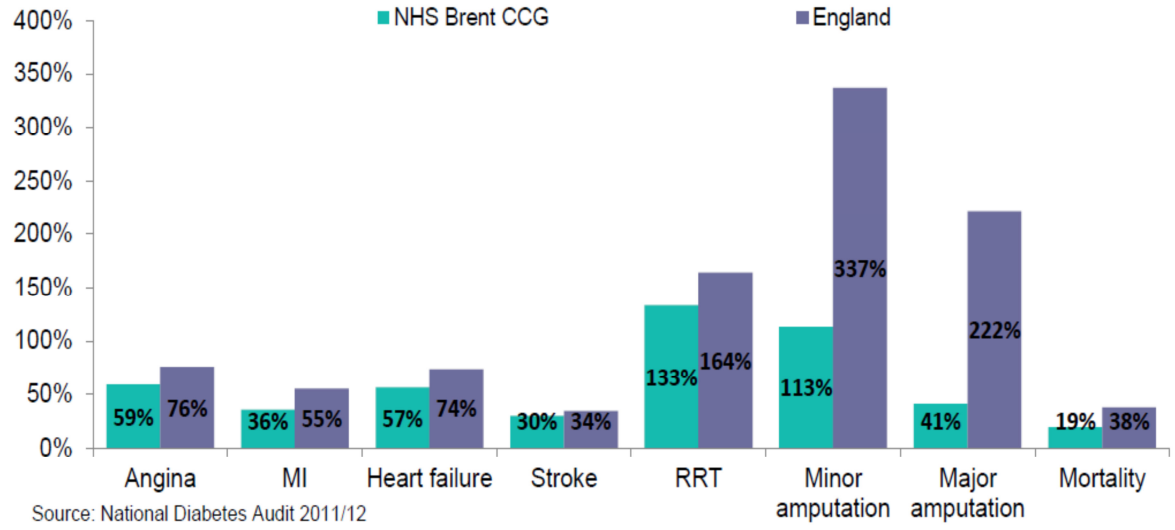


Figure 1 Prevalence of diabetes associated complications.

RRT: Renal replacement treatment – a marker for kidney disease
Source: National diabetes audit 2011/12

2.8 The Yorkshire and Humber Public Health Observatory published data in 2012 on the number of people who were admitted to hospital for diabetic foot disease. In Brent during 2008 – 11, there were 565 episodes of care for diabetic foot disease, equivalent to 10 episodes of care per 1000 people with diabetes each year. This is lower than the national rate of 18.1 per 1000[4].

Overview of Services in Brent:

3. Summary of NHS Brent CCG annual diabetes costs for 2013/14:

3.1 Total allocated budget is £9,493,000. This includes primary care prescribing, CCG prevention & health promotion, secondary care, urgent emergency care, community and the local enhanced service for GPs

4. Health promotion and prevention of diabetes

4.1 Brent Council in conjunction with Brent CCG has been working closely with its communities to reduce the impact of diabetes throughout the borough. The following is a summary of the main events and programmes which are already in place or will commence in January 2014.

Physical activity programmes

4.2 Brent Council Sports development unit have provided a programme of events targeted at those residents who are less active and at risk of diabetes. Programme highlights include:

- Healthy led walks programmes
- Over 50s exercise classes

[4] Diabetic Foot Disease Profile for NHS Brent Teaching, diabetes health intelligence programme, YHPHO, January 2012.

- Free swimming for over 60s throughout Brent
- Installation of outdoor gyms in 6 parks
- An exercise referral scheme which is run through 3 leisure centres

Healthy eating

4.3 Brent planning team are looking to consult on changes to planning laws to reduce the saturation of fast food outlets in the borough and restrict the presence of fast food outlets to within 400 metres of schools.

4.4 To support these planning decisions, the Brent Council healthy lifestyles team are conducting a unique research project in which 8 local schools have agreed to participate. All year 7 and 10 year olds have completed a questionnaire to establish how frequently they use local takeaways in their lunch hour and after school.

Diabetes awareness raising, risk assessment and health checks

4.5 There is a cohort of people in Brent who are at high risk of developing diabetes by virtue of their family history, ethnicity, weight and waist measurement, but who may be unaware of this risk.

4.6 Since 2013, Brent council have collaborated with Diabetes UK to launch a community engagement programme, using community champions to promote awareness about diabetes in the high risk population in the borough. Community champions may include individuals from key faith groups, community organisations or those already suffering diabetes.

4.7 Diabetes UK offer individual risk assessments and advice on reducing the risk of diabetes. These were trialled in Brent at a recent Council staff health and wellbeing event at which around 50 staff took up the offer.

4.8 NHS health checks are offered by GPs in Brent, and since April 2013 have been commissioned by the Council as part of its new public health responsibilities. The NHS Health Check programme aims to help prevent diabetes – and also heart disease, stroke, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or who has certain risk factors, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk.

4.9 So far in 2013/14, 2750 individuals have received an NHS Health Check in Brent and from these 35 individuals were newly diagnosed with diabetes. A further 344 individuals were identified as having pre-diabetes and have been referred to our local Moving Away from Pre Diabetes Programme.

Moving Away from Diabetes Programme

4.10 Brent has developed its own intensive lifestyle intervention for individuals who are identified as being at high-risk of developing diabetes in the future. The Moving Away from Pre-diabetes (MAP) programme uses an intensive behaviour change approach to help residents make sustainable changes to the way they eat and exercise. The overall aim of MAP is to reduce the incidence of diabetes and cardiovascular disease in the Brent community.

4.11 The MAP programme is an example of collaborative working between leisure services, Brent Council and the Nutrition and Dietetic Service of Ealing Integrated Care Organisation. Brent leisure services provide the venues for the group exercise and nutrition education sessions. Brent Council Sports and Parks Service provide the fitness instructors and facilitate the provision of leisure centre membership for all participants of the MAP programme (funded by the programme). The programme content, development and implementation is overseen and delivered by dieticians from the Ealing Integrated Care Organisation.

4.12 Since commencing in November 2011, over 700 pre-diabetic patients in Brent, have received some level of intervention from the MAP programme. During 2012/13, 173 participants completed the program. We estimate that 71% of participants demonstrated real improvements in their blood glucose levels after the six-month programme, with one third of patients no longer being pre-diabetic.

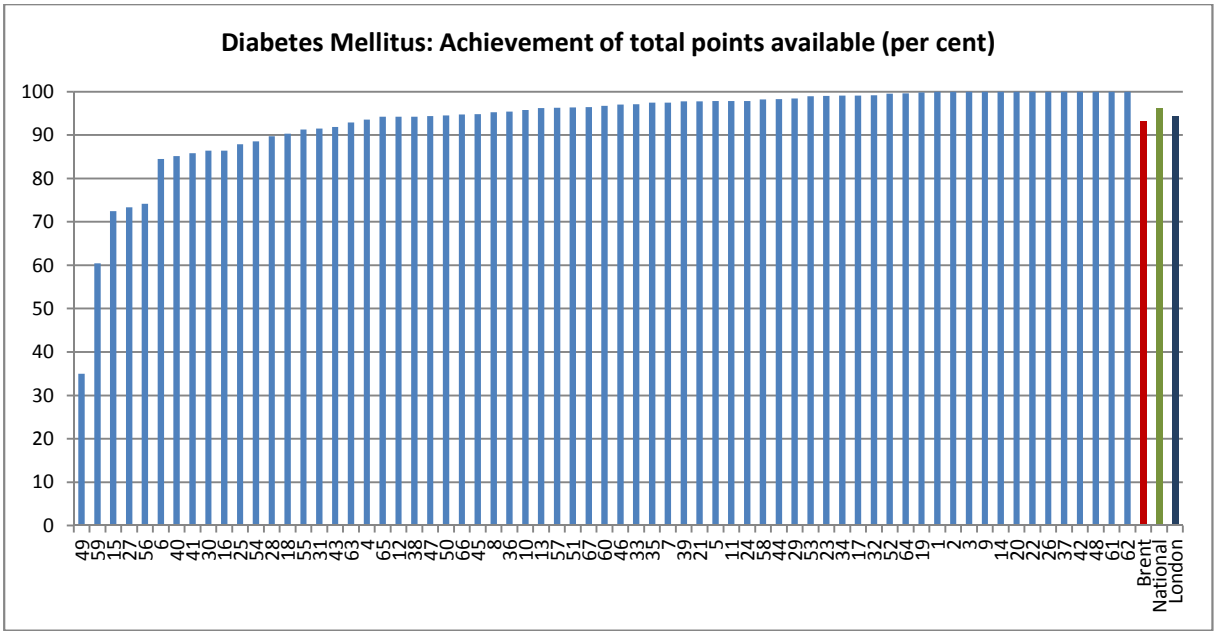
4.13 The latest results (November 2012 to December 2013) for 112 patients that completed the intensive 6 month intervention, showed that 66% of those retested (70 patients) are no longer pre diabetic

5. Primary Care

5.1 Although there are no requirements in the standard General Medical Services (GMS) contract relating specifically to the management of diabetes, all contractors who have a list of registered patients are contractually required to provide services for the management (including consultation, examination, investigation and referral) of their patients who are suffering from any chronic disease.

5.2 Diabetic patients are currently managed in primary care under the standard GMS/PMS contract, including additional health checks under the Quality and Outcomes Framework (QOF). All Brent practices also participate in QOF, which financially rewards practices for meeting a range clinical and organisational quality indicators. There are currently 16 diabetes specific indicators these include: regular blood sugar levels, annual blood pressure monitoring, retinal screening, dietary review and access to diabetes education programmes.

5.3 The graph below demonstrates that the vast majority of Brent practices are achieving a high number of points for the diabetes domain of QOF (using 2012/13 QOF achievement data).



6. Brent GP Insulin Initiation Scheme

6.1 The Diabetic Insulin Local Enhanced scheme (LES) was rolled out across Brent in April 2012 and supports integrated diabetic care delivered in primary care. With 22,000 + diabetic patients in Brent it is crucial that practices are skilled in initiating insulin therapy. This is in line with the CCG vision to provide care as close to patients as possible and increase the role of primary care in both the management and self-management of people with chronic diseases.

6.2 Traditionally insulin conversion has been undertaken within secondary care. However, with both diabetes and other chronic conditions there is a move to provide care as close to patients as possible and therefore increasing the role for primary care in the management of diabetes.

6.3 Training workshops across the 5 localities where delivered to ensure practices received adequate training to meet specific standards. Uptake of the scheme has been slow. Brent CCG is exploring options to improve this in order to strengthen primary care capacity given the increasing number of patients requiring insulin.

7. Community Care – Ealing Integrated Care

7.1 This service provides an integrated pathway for patients with Type II Diabetes from prevention and health promotion through to intensive care and support (case management and self-management programmes). All Diabetes community care has to be delivered within the framework and competencies dictated by National Institute of Clinical Excellence (NICE). The care pathway ensures there is a seamless service from adolescent to adults for patients diagnosed with Type II Diabetes.

7.2 The Diabetes community pathway is a consultant led multi-disciplinary service incorporating a range of specialisms: diabetes nurse consultant, diabetes specialist nurses, nutrition and dietetics, podiatry and GPs with specialist interests in

Diabetes.

7.3 The service provides Primary and Secondary care services managing poorly controlled patients with Type II Diabetes. This includes offering patients the opportunity to attend rapid access outpatient clinics as well supporting the self-management of their long term condition through education programmes, domiciliary visits and case management when an exacerbation occurs. This is underpinned through the education and up-skilling of primary care community teams and the production of management and drug guidelines to standardise care.

8. Secondary Care Services

8.1 In conjunction with primary and community services, secondary care aims to provide a holistic treatment and management services. This includes the following:

- Outpatient services
- Admission avoidance and expedited discharged strategies
- Inpatient Provision/services

9. Brent diabetic eye screening (DES) services

9.1 NHS England is now responsible for commissioning of screening services which include diabetic eye screening. One of the complications of diabetes is disease of the retina which can result in visual impairment. Screening aims to detect changes in the retina early at a stage when treatment, often by laser, can preserve sight.

9.2 The Brent diabetic eye screening programme is provided by the Ealing Integrated Care Organisation. The screening service is community based operating across three sites:

- Wembley
- Jeffery Kelson Centre (Central Middlesex Hospital – CMH)
- Willesden Community Hospital

9.3 Following a positive screening test, patients are referred to ophthalmology services at Central Middlesex Hospital.

9.4 The programme is monitored through a programme board that meets quarterly. The Board is responsible for overseeing delivery of services in Brent to national standards as set by the NHS Diabetic Eye Screening Programme (DESP). The DESP sets national KPIs. The table below provides national KPI data for Q1 2013/14 and annual data for 2012/13. This indicates that performance in the Brent programme is generally to an acceptable standard.

Table 2.

KPI	KPI title	KPI description	Target	Annual performance 2012/13	Q1 2013/14 performance (latest published data)
DE1	Diabetic retinopathy - uptake of digital screening encounter	The proportion of individuals who attend eye screening following an invitation in the reporting period	Underachieving: < 70% Acceptable: 70% - 79.9% Achievable: 80% AND GREATER	77%	77% London range 70-89%
DE2	Diabetic retinopathy - results issued within 3 weeks of screening	The number of subjects attending for screening to whom a screening result letter was issued within 3 weeks (21 days) of the screening encounter.	Underachieving: < 70% Acceptable: 70% - 94.9% Achievable: 95% AND GREATER	95%	94% London range 80-100%
DE3	Diabetic retinopathy - timely consultation for R3 screen positive	Subjects referred with proliferative retinopathy receiving consultation within 4 weeks (28 days) of notification of positive test	Underachieving <80% Achieving – 80% and greater	87%	60% London average 76.4% **

** It should be noted that data for DE3 can be based on (fortunately) very small numbers of patients found to have disease which requires urgent ophthalmology assessment. Therefore when a few patients rebook their appointment this can have a disproportionate effect.

9.5 The national model for diabetic eye screening programme is changing. The recall periods, currently annual, will change so that patients with certain levels of disease will be monitored more closely within a community screening setting before being

referred to ophthalmology. This will ease pressure on ophthalmology units seeing patients that are being referred currently but do not require treatment. These changes are likely to come into affect during 2014/15.

9.6 A new piece of software is being developed to automatically extract data from GP systems to inform programmes of the diabetic population. Brent DES has opted to become an early implementer of the software which will remove the need for GPs to make manual referrals to the programme when a patient is diagnosed as diabetic.

9.7 The Wembley site is unable to cope with current demand, despite attempts to redirect patients to other sites. The service and NHSE are working to review capacity and if necessary will make amendments to the current capacity across the three sites.

10. Diabetes Service Redesign from April 2014

Case for change – National and Local Guidance

10.1 The residents of Brent have changing health needs, as people live longer and live with more chronic and lifestyle diseases, this places greater demand on primary and community care. Local acute providers continue to see an increase in demand for outpatient care which is putting pressure on services and increasing waiting times.

10.2 Brent CCG has recognised the need to invest in diabetes services. This means optimising the role of general practice in delivering planned care and ensuring that specialist advice and input is used to good effect to support local clinicians in delivering the best outcomes for patients. By supporting and enabling primary, secondary and community providers to work together more effectively there is an opportunity to avoid patients developing complications.

10.3 The advantages of the redesigned integrated pathway community based service are:

- To provide a consultant led service where patients are seen by a multi-disciplinary team and treated in one appointment as clinically appropriate
- Achieving value for money, ensuring that patients are treated in an environment most appropriate to their needs at the right cost.
- Opportunities to up skill GPs and practice nurses in diabetes care
- Facilitate early discharge back to GP care
- Develop a clinical network of care to provide Tiers 1 and 2 care within localities

10.4 The proposed model of service will ensure that:

- Primary care clinicians have a framework for providing Tier 1 and 2 services
- Brent CCG have robust outcomes data to monitor the performance of providers to rapidly improve health outcomes for patients with diabetes and reduce the variation in care across primary care localities
- The level of expertise across primary care is increased. This will enable a reduction in services duplicated across primary care, community and secondary care
- Increase the provision and access of the DESMOND education programme including the development of an ethnic specific programme.

Proposed Investment in Diabetes

10.5 Brent CCG has approved an additional investment of £693K to enhance and further develop the community based integrated diabetes pathway. The proposed model is to increase clinical capacity as a sustainable way of delivering high quality integrated diabetic care, for all patients with type 2 diabetes except for those with very complex needs.

10.6 The new model invests in building additional clinical capacity within the service including the following:

- Diabetes Specialist Nurse (DSN)
- DESMOND Nurse Trainer
- DESMOND Dietician
- Clinical Psychologist
- Administrator
- Dietician
- Podiatrist
- Operational manager

10.7 The redesigned integrated service will work collaboratively to deliver the following:

- A single point of access to a consultant led integrated service including GPSI and specialist nurses where patients are seen by a multi-disciplinary team and treated in one appointment as clinically appropriate
- Triage to the right clinician first time
- Prompt discharge back to GPs supported by clear treatment plans.

10.8 The advantages of the redesigned integrated service is to improve health outcomes by:

- Providing early detection and identification
- Involving patients in the decisions around personalised care planning
- Developing patient knowledge, skills and confidence for better self-management
- Demonstrating robust clinical and operational outcomes
- Targeting high risk populations

Dr Melanie Smith
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Brent Clinical Commissioning Group

Dr David Finch
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NHS England

Brent	**Health Partnerships Overview and Scrutiny Committee** 28th January 2014 **Report from the Assistant Chief Executive**
For Action	Wards Affected: ALL

CCG Finances

1.0 Summary

1.1 Bent Clinical Commissioning Group has recently received its financial allocation for 2014/15 from NHS England. To tie in with this, this report provides a general overview of NHS, and more specifically CCG, finances. In particular it provides information on Brent CCG and its financial plans for 2014/15.

1.2 The report outlines Brent's current position, with a surplus of £26m in 2013/14, and an overview of the key areas and their current spends. Also outlined are 2013/14 QIPPs and investment plans and an overview of the approach to 2014/15 QIPPs and investment plans.

1.3 Details of the 2014/15 and 2015/16 financial allocations are provided, which are not expected to keep pace with the expected cost increases during this period. The report also explains the pooled Better Care Fund which will support closer, more integrated, working between health and social care and outlines the figures for 2014/15 and 2015/16. Finally, the report outlines changes that the CCG is obliged to make in the way it commissions Local Enhances Services from GPs from 2014/15 onwards and the options being considered for the ongoing commissioning of these services.

2.0 Recommendations

2.1 The committee is recommended to question officers on the figures and other information provided and on the CCG's financial plans for 2014/15 and beyond.

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NHS Brent Clinical Commissioning Group

Report to: Brent Health Partnerships Overview and Scrutiny Committee (OSC)

Report from: NHS Brent CCG

Date of meeting: 16 January 2014

Re: **CCG Financial Briefing Paper**

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1. Purpose of the Paper

1.1 The purpose of this briefing paper is to set out:

- The national financial framework for CCGs and the NHS Financial regime.
- Brent CCG's financial allocations and planning framework for 2014/15 and 2015/16 and the financial context that the CCG is operating within.
- The CCG's QIPP & Investment plans in this context.

2. National Financial Framework

2.1 Under the Health and Social Care Act 2012 funds flow through the NHS in the following way:

- Treasury allocates Department Expenditure Limit to Department of Health, who allocate NHS commissioning funding to NHS England
- NHS England are responsible for allocating funding to Clinical Commissioning Groups
- NHS England commission directly services such as specialist services and primary medical services

2.2 The CCG must utilise its allocation to fulfil its statutory functions which are comprised of:

a) Commissioning community and secondary healthcare services (including mental health services) for:

- All patients registered with its Members; and
- All individuals who are resident within the London Borough of Brent who are not registered with a member GP practice of any Clinical Commissioning Group (e.g. unregistered);

b) Commissioning emergency care for anyone present in the London Borough of Brent

2.3 The CCG is required to frame its commissioning plans and priorities in line with the national Operating Framework published by the NHSE, and to contract with its providers using national business rules including PbR (Payment By Results) whereby CCGs pay NHS acute providers according to a National Tariff for outpatient and inpatient activity.

2.4 Hospital providers receive income from CCGs, NHS England and Local Authorities. The vast majority of clinical income is received through application of the National Tariff and the business rules for Payment by Results. Providers may receive other income from private patients and other sources such as for catering, car parking etc. Education and Training funding comes from NHS Health Education England and Research and

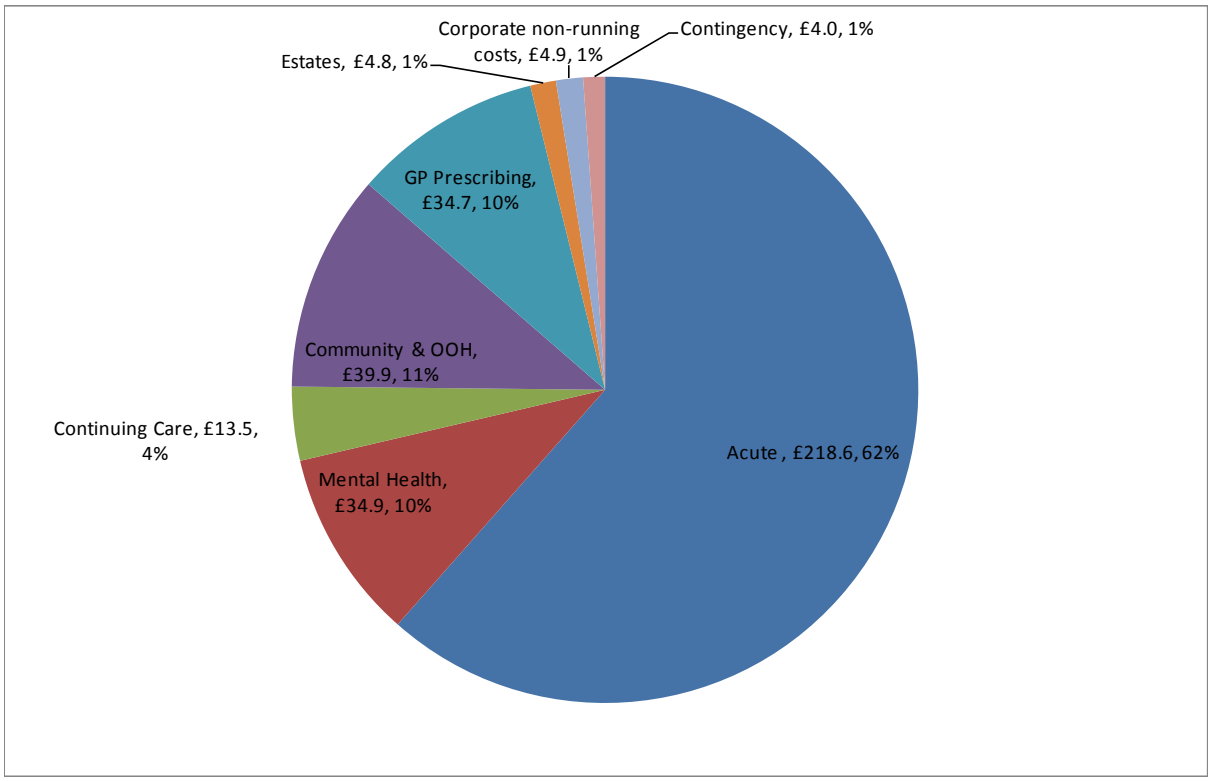
Development funding comes from the NHS National Institute for Health Research and others. Capital funding is subject to a separate Business Case process managed by the NHS Trust Development Authority.

3. 13/14 Brent CCG Financial Position

3.1 Each year CCGs are required to deliver agreed financial plans with the NHSE. Brent CCG inherited a healthy financial position from the PCT and agreed a surplus budget of £26m in 13/14.

3.2 Surpluses are normally carried forward and for 13/14 NHSE have confirmed that surpluses forecast at month 6 will be able to be carried forward into future years. At Month 6 Brent forecast a surplus of £29.2m and therefore this funding will be carried forward and be available for the CCG.

3.3 Total CCG spend at Month 8 c£350m is shown in the table below.



3.4 Community services includes the community contract with Ealing ICO, HIV, Children and Families, community investment schemes, carers, intermediate care and palliative/hospice services. Out of Hospital services are the local enhanced schemes payable to GP Practices. Further detail is included in Section 10.

3.5 Mental Health services include contracts with NHS providers such as CNWL, investment in Dementia services and SLAs with the voluntary sector. Corporate non-running costs include staff costs on clinical services such as prescribing advice and expenditure on GP IT. Estates costs relate to the cost of void space not recharged to providers.

4. Pan-CCG Financial Arrangements

4.1. In 2013/14 Brent CCG has agreed to take part in two Pan-CCG financial arrangements. The first is to use 2% non-recurrent headroom (a national financial planning requirement)

to support Shaping a Healthier Future implementation across NW London, covering the following:

- The programme management costs for Shaping a Healthier Future during implementation
- Pump priming CCGs' Out-of-Hospital investments and delivery teams on the ground in each CCG
- Providing resources to providers to support the transition of services and the provision of transitional funding

4.2 Secondly, it has agreed to take part in a pan-Brent, Harrow and Hillingdon CCG in-year risk share arrangement. The objective is to establish a mechanism for CCGs to share in-year risk on external issues (as opposed to those that are within the CCG's internal ability to control). Recommendations on the application of the risk share are due to be made to all CCG Finance Committees and Governing Bodies in January / February.

5. 13/14 QIPP and Investment plans

5.1 The CCG's forecast net QIPP savings is £8.1m including £3.9m in the acute sector, £1.8m on mental health continuing care closer to Brent (repatriation) and £1m on GP Prescribing.

2013/14 QIPP SCHEMES		FOT Actuals
	Local Scheme Name	£'000
Acute	Referral Standardisation/ Referral management	-536
Acute	Outpatients at lower cost - Ophthalmology	-54
Acute	End of Life	-575
Acute	Outer North West London -Cluster Integrated Care	-567
Acute	Acute contract metrics	-1,302
Acute	STARRS Stretch	-500
Acute	Primary Care Divert / Clinical SPA	-408
Community	Productive Community Health Services	-567
Continuing Care	Continuing Care	-100
Continuing Care	Mental Health savings on budget FYE 12/13 repatriation	-829
Continuing Care	Mental Health savings on budget 13/14 repatriation	-1,000
Mental Health	Mental Health savings on budget CNWL	-235
Mental Health	Mental Health savings on budget small contracts	-96
Mental Health	Mental Health savings on budget BEH	-300
Prescribing	Reduction in Prescribing costs	-1,023
BRENT Total		**-8,092**

5.2 The CCG's investment plan forecast for 2013/14 is £16.3m. The forecast spend on non-acute investments is £8.9m, the vast majority on community and out of hospital schemes. There is also forecast spend of £5.2m on Winter planning schemes and £2.2m on improving the 18 Weeks performance at NWLHT.

BRENT CCG - 13/14 INVESTMENTS

Budget heading	Budget area	FOT Spend £'000
Gynae Pathway - Harness/Willesden	Community	100
Outer ICP	Community	1,066
Additional 2 beds Pembridge Unit	Community	57
Re-ablement Funding	Community	1,795
Self care projects	Community	50
STARRS Stretch	Community	516
Community Investment Reserve	Community	164
Breastfeeding Team	Community	210
MSK enhanced Pathway	Community	82
Paediatric OT	Community	113
IAPT	MH	148
Dementia	MH	220
LD Self - assessment action plan	MH	78
LAC Audit	MH	8
GP IT Pressure	Out Of hospital	171
EMIS Web extension	Out Of hospital	706
LAC Nursing Team	Out Of hospital	30
Primary Care Network Development	Out Of hospital	1,134
Diabetes (Insulin) LES	Out Of hospital	70
Cardiology Diagnostics LES	Out Of hospital	75
Better GP Performance Outcome	Out Of hospital	576
Phlebotomy LES - extend to all practices	Out Of hospital	200
Phlebotomy LES - top up existing	Out Of hospital	40
Primary Care Single point access	Out Of hospital	254
Primary Care Hub/Access	Out Of hospital	813
Organisational Development	Out Of hospital	100
Scriptswitch	Prescribing	154
Non-acute investment		8,930
Winter / Emergency planning	Winter	5,160
18 Weeks investment	18 Weeks	2,197
Acute investment		7,357
Total		16,287

6. 14/15 & 15/16 CCG Allocations

6.1 NHS England has responsibility for determining funding allocations to commissioners within the NHS system. At their Board meeting on 17 December 2013 they considered a paper that sets out the proposed funding allocations for 2014/15 and 2015/16. The paper outlined:

- The proposed formula to be used to determine the target allocation for CCGs
- The proposed distribution of funding between different elements of commissioning (CCGs, primary care, specialist commissioning, public health, and other commissioned services). This includes funding arrangements for Integrated Transformation Fund (now called the Better Care Fund (BCF)) and the running cost allowance
- The proposed distribution of funding within the CCG element of commissioning, including the pace of change of movement away from historical allocations to the target allocations (which are based on a national formula for how funding should be distributed between CCGs).

6.2 NHS Brent CCG's financial allocations for 2014/15 and 15/16 are set out in the table below.

14/15	14/15	14/15	15/16	15/16	15/16
Uplift	Uplift	Distance from target	Uplift	Uplift	Distance from target
£'000	%	%	£'000	%	%
7,841	2.14%	7.67% over	6,362	1.70%	6.28% over

6.3 Brent received the minimum level of growth awarded to CCGs in 14/15 (2.14%) and 15/16 (1.7%) due to being over the capitated target allocation level (i.e. assessed as 7.67% (£28m) over funded in 14/15).

6.4 The uplift of 2.14% in the 14/15 allocation and 1.7% in the 15/16 allocation will not keep pace with the estimated 3-4% per annum cost pressures that Brent CCG is expected to face due to local demand and cost growth. The impact of a reducing allocation (relative to demand) over the next few years needs to be mitigated through delivery of Out of Hospital strategies and the CCG's savings and investment strategies.

6.5 As in previous years, the allocations guidance from NHS England confirms that commissioning organisations are required to set aside some of their funding for non-recurrent expenditure. NHS England has increased this requirement in 2014/15 to 2.5%, and it is envisaged that the Pan NWL-wide financial strategy will continue to support SaHF. In addition BHH collaborative financial arrangements are expected to continue.

7. Better Care Fund

7.1 The Better Care Fund plan requires local areas to formulate a joint plan for integrated health and social care and to set out how their single pooled Better Care Fund budget will be implemented to facilitate closer working between health and social care services. Joint plans should be approved through the relevant local Health and Wellbeing Board and be agreed between all local CCGs and the Upper Tier Local Authority. Health and social care providers should also be closely involved in plan development.

7.2 In 2014/15, a total of £1,100 million (increased from £859 million) will transfer to Local Authorities for social care to benefit health, using the same formula as 2013/14. This will become transacted through a central Section 256 transfer. In 2015/16, this funding will be part of the pooled Better Care Fund; while it will continue to be allocated to areas on the same basis as in previous years, the funding will be added to CCG allocations. CCGs will be required to pass this funding to the Better Care Fund pooled budget along with the funding from core CCG allocations.

7.3 From 2015/16, the Better Care Fund will also include a £1.9 billion contribution from core CCG funding, over and above the existing £300 million re-ablement funding and £130 million carers' breaks which will also be pooled in the Better Care Fund. Core CCG funding going to the pooled Better Care Fund will be allocated based upon the CCG allocation formula. Additional contributions to the Better Care Fund from Local Authorities, in the form of social care capital grants and disabled facilities grants, will continue to be allocated to them by central government on the same basis as for 2014/15.

7.4 Locally £13.7m will transfer from CCG baseline into the Better Care Fund (BCF) in 2015/16 in addition to the £6.2m received in 14/15. Plans for this fund will be taken to the Health and Wellbeing Board.

8. 2014/15 QIPP and Investment Plans

8.1 QIPP and Investment planning for 2014/15 has been subject to a rigorous process to ensure early stakeholder engagement in proposed schemes.

8.2 Following clinical and stakeholder engagement, each scheme has been subject to scoping and refinement with a view to determining the feasibility and deliverability of schemes. This was done through developing Project Initiation Documents (PID) which scoped the:

- QIPP/Investment potential
- Assessment of deliverability/feasibility
- Procurement approach and delivery model
- Risk rating

PIDs which have demonstrated low value and/or impact have been rejected on eh basis of poor value for money in terms of return on investment/effort.

8.3 The QIPP Programme Management function has identified a Senior Responsible Officer (SRO) and Clinical Responsible Officer (CRO) for each QIPP and investment scheme which will ensure clinical and managerial ownership, delivery and PMO management of schemes as they progress through to approval and delivery phases.

8.4 Both QIPP and Investment plan schemes are contained within the CCG's commissioning intentions for 2014/15, as these schemes will be subject to provider and commissioner contract negotiations and/or service development plans.

9. Evaluation of QIPP & Investment Projects/Schemes

9.1 All CCG commissioned services are subject to regular contract and performance reviews. The delivery of QIPP and investment schemes is monitored through a Programme Management approach. Issues are escalated for intervention to the QIPP Sub Committee, a subcommittee of the CCG Executive Committee and/or through the QIPP, Finance and Performance Committee, which is a formal Committee of the Governing Body.

9.2 For new investment schemes in addition to the routine monthly contract and performance reviews, there are more comprehensive evaluation plans in place.

10. Out of Hospital services commissioned from GPs

10.1 The following local enhanced services are being delivered by Brent GP Member Practices:

- Childhood surveillance for children under 5 years where their registered practices does not undertake
- Prescribing and administration of hormone blockers for treatment of prostate cancer
- Phlebotomy for 12 years and over
- Insulin initiation
- Register and plan for patients requiring palliative care
- Register and plan for carers
- Undertake ECG monitoring and 24 hour ambulatory blood pressure monitoring.

The forecast outturn on spend for these services in 13/14 is £3.7 m. In addition £1.0 m is earmarked to spend with practices to reimburse them for time spent and outcomes achieved for commissioning such as cost effective prescribing.

10.2 Brent CCG is considering for 14/15 commissioning of all services currently commissioned through a local enhanced service agreement, in line with national requirements.

The options for the CCG are:

a) To cease commissioning the service

b) To consider whether:

- Only one provider is capable of providing the service
- Only one provider or provider type is most capable of providing services
- Benefits of competitive tendering outweigh the cost of running a competitive tender process

10.3 A procurement panel, including Lay Member and External GP representative, was held in December 2013 to consider the above. The panel is due to make a recommendation to the Governing Body on the 29th January 2014.

10.4 In 2014/15 Brent CCG intends to commission services from the four GP networks in Brent for the following services:

a) Subject to successful pilot for extended GP services, locality primary care access centres for 7 day GP services outside core contract hours.

b) A number of services currently commissioned through Local Enhanced Services.

c) Integrated care services from GP networks and other providers for:

- Adults vulnerable to hospital admission or residential care
- 24/7 urgent care

10.5 The intention is to commission services from the four GP networks through out of hospital contracts. Procurement would be subject to the same Procurement Panel process described in 10.3 above.

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Brent	**Health Partnerships Overview and Scrutiny Committee** 28th January 2014 **Report from the Assistant Chief Executive**
For Action	Wards Affected: ALL

CCG Commissioning Intentions 2014/15

1.0 Summary

1.1 Brent Clinical Commissioning Group (CCG) is presenting the Health Partnerships Overview and Scrutiny Committee with its commissioning intentions for 2014/15 for the committee's comments. The report provides an overview of the CCG's commissioning aims along with a more detailed appendix of their plans for 2014/15.

2.0 Recommendations

2.1 The committee is recommended to review the CCG's intentions and priorities and to comment on these prior to the finalisation of the final commissioning approach.

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NHS
Brent
Clinical Commissioning Group

Report to: Brent Health Partnerships Overview and Scrutiny Committee (OSC)

Report from: NHS Brent CCG

Date of meeting: 13 January 2014

Re: **CCG Commissioning Intentions**

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1. Purpose of the Paper

1.1 The purpose of this briefing paper is to set out the CCG's commissioning intentions for 2014/15 within the context of the national and local planning environment that the CCG is operating within.

1.2 The report provides a summary of the commissioning intentions and the processes and engagement that has supported their development. The PowerPoint presentation slide deck (v8.1 14 January 2014) is attached to this report for further detail. Paragraph 3.5 summarises the commissioning intention's aim and identifies the slide number specific to this service area in the attached presentation.

2. Background

2.1 The CCG's statutory commissioning functions broadly include:

a) Commissioning community and secondary healthcare services (including mental health services) for:

- All patients registered with its Members; and
- All individuals who are resident within the London Borough of Brent who are not registered with a member GP practice of any Clinical Commissioning Group (e.g. unregistered);

b) Commissioning emergency care for anyone present in the London Borough of Brent

2.2 The commissioning intentions set out the CCG's intentions with regard the range of services it has responsibility for commissioning across community and secondary care services. The commissioning intentions further set out how it will work collaboratively with NHS England to support improvements in primary care and ensure the continuous improvement of services it has responsibility for commissioning. Fundamentally, the CCG's commissioning intentions describe how it will achieve the shift of care to more community and out of hospital settings in line with its strategic aims.

2.3 Commissioning intentions serve as a notice to all providers of community and secondary about which services and the models of care that will be commissioned by NHS Brent CCG. The Commissioning Intentions provide a basis for robust engagement between NHS Brent CCG and its providers, and are intended to drive improved outcomes for patients, and transform the design and delivery of care, within the resources available.

3. CCG Commissioning Intentions 2014/15

3.1 NHS Brent CCG's commissioning intentions have been developed to bring out about improvements that have been identified through:

- Regular dialogue with providers as part of contract and performance monitoring arrangements
- Engagement with patients and the public about service requirements/experience to date
- Engagement with member practices and clinicians about service requirements and experience to date
- National planning guidance issued by NHS England and the Secretary of State (A Mandate from the Government to the NHS, November 2013).
- The CCG's QIPP and Investment plan for 2014/15
- Changes in the local health system and patient demography indicators

3.2 The CCG's commissioning intentions further seek to improve patient outcomes against benchmarked performance in nationally defined domains which include a subset of performance indicators. The CCG's performance against the five domains is variable, as set out below. The CCG's commissioning intentions seek to address this variability.

- **Domain 1 – Preventing people dying prematurely**

Performance indicates that there has been deterioration in the potential years of life lost resulting from cardiovascular, liver and alcohol related liver diseases. However, fewer deaths have resulted from cancer and respiratory diseases

- **Domain 2 – Enhancing quality of life for people with Long Term conditions**

Data suggests that Brent is achieving a national average of people feeling supported to manage their condition. There is an increase in non elective admissions for ambulatory care conditions but a decrease in admissions relating to asthma and epilepsy.

- **Domain 3 – Helping people recover from episodes of ill health or following injury**

There has been a small decrease in emergency admissions for acute conditions that do not usually require admissions. Above average performance for Patient Recorded Outcomes for elective procedures including hip and knee replacements

- **Domain 4 – Ensuring that people have a positive experience of care**

Patient experience of GP out of hours service is just below the England average

- **Domain 5 – Treating and Caring for People in a Safe Environment and Protecting Them From Avoidable Harm**

No benchmarking data available from 2013/14

3.3 The process for developing the CCG's commissioning intentions commenced in September 2013 and included the following internal and external engagement sessions:

Initial discussion at QIPP Subcommittee	11th September 2013
Development of plan process and timescales discussion at QIPP, Finance & Performance Committee	25th September 2013
QIPP and Commissioning Intentions (CI) planning workshop with CCG Executive members	9th October 2013

Further discussion on progress and developments to date at CCG Executive	23rd October 2013
Engagement with Health and Well Being Board on draft commissioning intentions 2014/15	30th October 2013
Engagement with member practices at Member Practice Forum re draft QIPP and CI	30th October 2013
Discussion on draft plans and CI with CCG GB	6th November 2013
Early engagement with patients and the public (Health Partners Forum)	20th November 2013
Discussion on draft plans and CI with EDEN Subcommittee	27th November 2013
Draft CI and QIPP to QIPP, Finance and Performance Committee	27th November 2013
Draft Medium term financial plan – 2014/15 CIs and QIPP	30th November 2013
Development of PIDs to support schemes	October and November 2013
Review and Refinement of PIDs	November and December 2013
Activity calculations and phasing of schemes	December 2013
On-going engagement with patients and the public regarding commissioning intentions – workshops planned	December 2013 to January 2014
Submission of commissioning intentions, QIPP and Investment activity and finance projections to CSU to support contract negotiations	Week commencing 6th January 2014
Finalise CI's, QIPP and Investment Plans	Week commencing 13th January 2014
Engagement with Health Overview and Scrutiny Committee regarding Commissioning Intentions 2014/15	28th January 2014
Approval of commissioning intentions, QIPP and investment plans for 2014/15 by Governing Body and QIPP, Finance and Performance Committee	29th January 2014

3.4 The process for developing commissioning intentions which incorporates the CCG's QIPP and Investment planning for 2014/15 has followed a more rigorous process than 2013/14 given the deteriorating financial forecast that the CCG has been anticipating (reduced allocations and impact of BCF) and the performance against QIPP and Investment Plan delivery in 2013/14 which has been less than expected due to a variety of factors.

3.5 NHS Brent's CCG's commissioning intentions set out the requirements of providers and the CCG deliverables in the following areas with a view to achieving improved outcomes and transformational change in line with national guidance and local priorities:

- The CCG's QIPP requirements for 2014/15 and beyond
- An overview to the commissioning intentions for 2014/15
- The commissioning intentions to improve:
    - Health and Well Being in accordance with the Health and Well Being Strategy's key priorities (slide 9).

- Patient & Public Involvement to align with most recent NHS England guidance on transforming participation (slides 14-15).
- Improving Quality, Patient Safety and Patient Experience to ensure the CCG fulfils its duties with respect to the recent high profile enquires into healthcare (slides 16-20).
- Whole Systems Integrated Care to align with the Whole Systems Integrated Care Programme across North West London which has been awarded pioneer status nationally (slide 21).
- Acute Care to reduce urgent care demand, readmissions and planned care in out of hospital settings (slides 22-24).
- Community Health Services to increase the scope of community services in improving outcomes for people with long term conditions being supported in the community (slides 25-26).
- Mental Health Services to create better shared care across primary and secondary care, reduce reliance on inpatient care and provide improved access to psychological therapies (slides 27-30).
- Learning Disabilities to ensure better physical health outcomes through more preventative care for people with learning disabilities (slide 31).
- Children's Services to improve the quality and consistency of services for children across a range of providers (slide 33).
- Supporting NHS England to develop primary care in accordance with the NHS England guidance (slides 33-35).
- Continuing Healthcare to improve systems and processes to improve performance and response times as well as joint working (slide 36).
- Informatics to highlight to providers the need for interoperability of clinical systems in the patient's best interests (slide 37).

3.6 A key aim of our commissioning intentions is to reduce reliance on urgent care, moving to a more anticipatory and integrated model of care across services in order to improve patient outcomes and achieve the best use of NHS resources. We see the next year as being critical for implementing Out of Hospital services to effectively respond to our changing provider landscape.

3.7 Through our commissioning intentions, the CCG recognises the need to work effectively with our partners to achieve the vision of fully integrated care and our aspiration of becoming a whole systems integrated care pilot site. We see integrated care and effective partnerships as a key enabler to improving health outcomes amongst Brent's diverse communities and ensure better use of NHS resources, collaborating with others as appropriate.

4. Conclusion

4.1 NHS Brent CCG's commissioning intentions for 2014/15 are a comprehensive set of improvement goals for community and secondary services, designed to align with our strategic aims and objectives.

4.2 The CCG would welcome comments and the identification of areas for improvement within the draft commissioning intentions attached (v8.1 14 January 2014) from the Brent Health Overview and Scrutiny Committee.

NHS BRENT CLINICAL COMMISSIONING GROUP

DRAFT COMMISSIONING INTENTIONS 2014/15

V8.1 14 January 2014

Contents

NHS Brent Clinical Commissioning Group

Introduction and Overview

NHS Brent Clinical Commissioning Group

Brent CCG is currently in a strong position to radically improve health care outcomes and build on our effective health and social care partnerships. Our strength is in our member practices who have demonstrated their ability to effectively respond to the wide system changes that clinical commissioning has brought about in 2013-14. We have built strong foundations both corporately and through our member practices to be confident about our ability to consolidate these achievements going forward.

We see the next year as being critical for implementing Out of Hospital services to effectively respond to our changing provider landscape. We recognise the need to work effectively with our partners to achieve the vision of fully integrated care and our aspiration of becoming a whole systems integrated care pilot site. We see integrated care and effective partnerships as a key enabler to improving health outcomes amongst Brent's diverse communities and ensure better use of NHS resources, collaborating with others as appropriate.

Brent is ranked amongst the top 15% most deprived areas of the country. Our draft commissioning intentions that we are developing with our key stakeholders, will ensure that we continue to work towards improving health outcomes for our population. Recognising this, our commissioning intentions are designed to improve health outcomes. We will do this by:

- Improving health and wellbeing in partnership with the Health & Wellbeing Board, patients, the wider community and commissioning services to address the key health issues within Brent, such as reducing health inequalities.
- Improving uptake of preventative services while reducing mortality and morbidity resulting from poor long-term condition management.
- Ensuring appropriate use of commissioned services so that Brent CCG manages activity within the available budget.
- Ensuring patients receive the right care, in the right setting by the most appropriately skilled clinician, which will improve the quality of care patients receive and reduce dependency on acute care.
- Working with local authority and other partners towards our aspiration of Whole Systems Integrated Care in Brent.
- Providing a proportion of outpatient appointments in community settings, rather than in acute settings, at lower cost and higher quality, where it is clinically safe and cost effective to do so.
- Providing services designed to minimise inappropriate A&E attendance and non-elective admission, e.g. urgent care centres, community beds and clinics for proactive long-term condition case management.

System Challenges

NHS Brent Clinical Commissioning Group

There are number of challenges in the local system:

DEMAND
Non elective care attendances increased and lengths of stay for such admissions are rising
Demand for inpatient and urgent care is rising and impacting provider's ability to provide timely planned care

PROVIDERS
Impending merger of main acute and community providers into a single provider trust
2 main acute providers are financially challenged

PERFORMANCE
Individual Access to Psychological Therapies
Patient experience/Friends and Family Test
18 weeks RTT
Cancer Care
Long term conditions (dementia, COPD, CHD and asthma)

SYSTEM WORKING
Information sharing across providers and intra-operability of information systems to enable integrated care
Better Care Fund Whole Systems Integrated Care and Pioneer application
NHS Transitional issues

Demographics

NHS Brent Clinical Commissioning Group

- 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
- 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 long history of ethnic and cultural diversity has created a place that is truly unique and valued by those who live and work here.
- Overall life expectancy is in line with the rest of London, but there are significant health inequalities within the borough
- Over 130 different languages are now spoken in our schools
- Brent is the most ethnically heterogeneous borough in the country
- The chances of 2 people in Brent being from different ethnic groups are higher than anywhere else in the country

Our population is young, dynamic and growing (311,200 according to the 2011 census)

Brent is ranked amongst the top 15% most-deprived areas of the country.

Deprivation is characterised by high levels of long-term unemployment, low average incomes and a reliance on 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

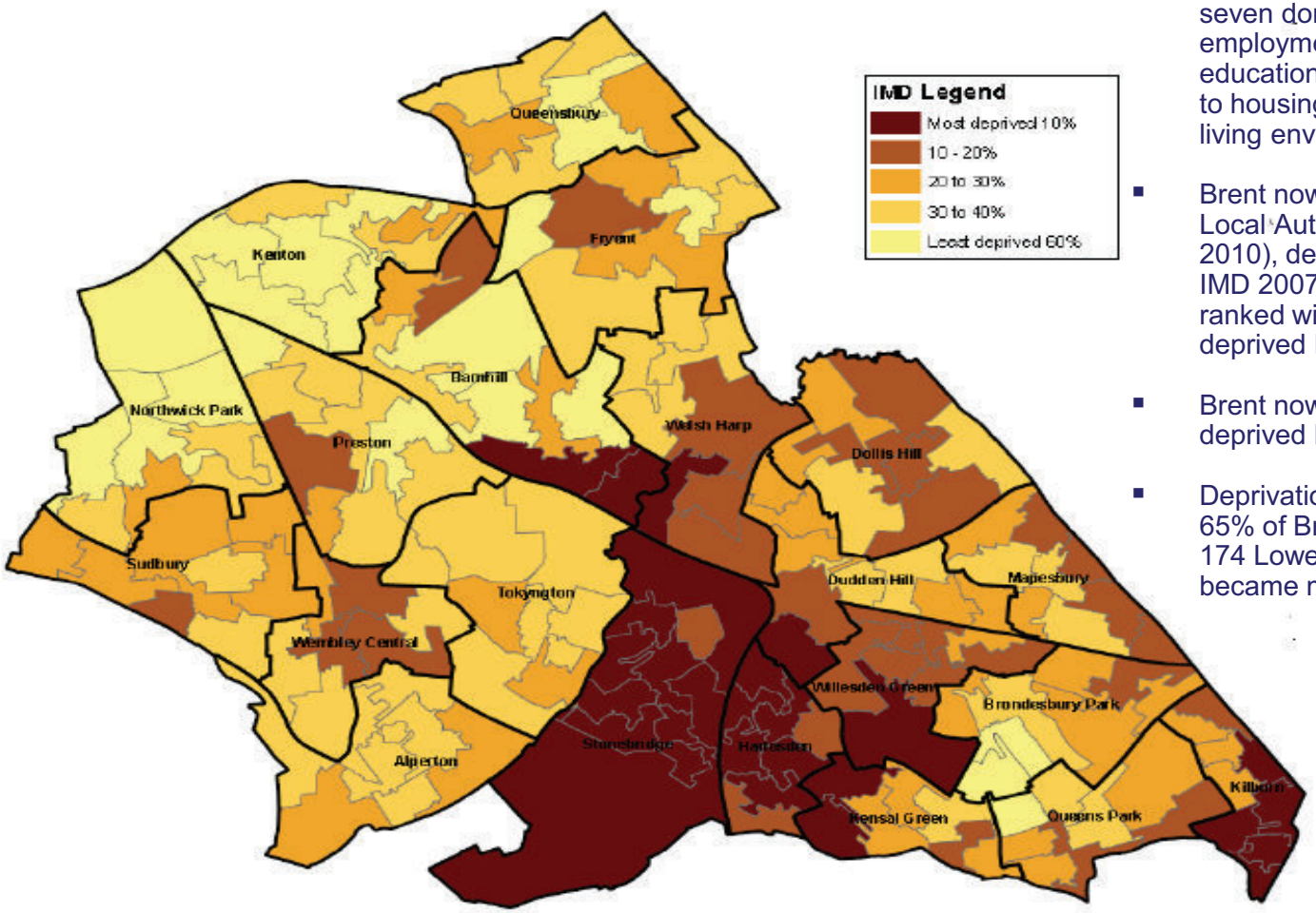
The gap in life expectancy for men varies for the most affluent and the most deprived parts of the borough by 8.8 years

The population is relatively young with 43% of residents under 30 yrs and more than 30,000 people over 65 yrs

Demographics (cont'd)

NHS Brent Clinical Commissioning Group

Map of deprivation across Brent CCG



Source: IMD 2010, Department of Communities and Local Government, March 2011
Note: LSOA categorised as deciles. Six least deprived deciles grouped as one for the above banding.

- The Index of Multiple Deprivation (IMD) is constructed by combining the seven domain scores – income, employment, health and disability, education, skills and training, barriers to housing and services, crime, and living environment.
- Brent now ranked 35th most deprived Local Authority in England (IMD 2010), declining 18 places since the IMD 2007 were published. Brent ranked within 15% of the most deprived Local Authorities in England.
- Brent now ranked as the 11th most deprived borough in London.
- Deprivation levels increased across 65% of Brent areas. 114 of Brent's 174 Lower Super Output Areas became more deprived.

Health Challenges

NHS Brent Clinical Commissioning Group

- Low rates of readiness for school amongst under-fives
- Poor oral health amongst children under five
- Rising levels of obesity – 11% of pupils in reception year, almost 24% of year 6 pupils are obese and 21% of adults in Brent are estimated to be obese.
- Low levels of participation in physical exercise – only 52% of adults achieve at least 150 minutes of physical activity per week
- 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 this, and we currently have around 21,750 people (7.7% of people on GP registers in 2011/12) in Brent diagnosed with the condition with numbers likely to grow in the future.
- We need to improve outcomes for patient with long term and chronic conditions by helping more patients take a pro-active approach to their own care as well as improving the quality of our services in the community. We need to do this by increasing access to, and expanding key prevention and screening programmes.
- There are rising levels of dementia amongst older adults in line with the national trend.
- Rates of tuberculosis (TB) in Brent are amongst the highest in the country.

Benchmarking Performance

NHS Brent Clinical Commissioning Group

- Benchmarking performance made available to CCGs provides a useful baseline to measure performance and impact of the CCG's commissioning.
- The CCG's performance against the five domains is variable in each domain.
  - **Domain 1 – Preventing people dying prematurely**
    - Performance indicates that there has been a deterioration in the potential years of life lost resulting from cardiovascular, liver and alcohol related liver diseases.
    - However, less deaths have resulted from cancer and respiratory diseases
  - **Domain 2 – Enhancing quality of life for people with Long Term conditions**
    - Data suggests that Brent is achieving a national average of people feeling supported to manage their condition.
    - There is an increase in non elective admissions for ambulatory care conditions but a decrease in admissions relating to asthma and epilepsy.
  - **Domain 3 – Helping people recover from episodes of ill health or following injury**
    - There has been a small decrease in emergency admissions for acute conditions that do not usually require admissions
    - Above average performance for Patient Recorded Outcomes for elective procedures including hip and knee replacements
  - **Domain 4 – Ensuring that people have a positive experience of care**
    - Patient experience of GP out of hours service is just below the England average
  - **Domain 5 – Treating and Caring for People in a Safe Environment and Protecting Them From Avoidable Harm** (no benchmarking data available)

Health & Wellbeing Strategy

NHS Brent Clinical Commissioning Group

Brent's Health & Wellbeing Board was established on 24 June 2013. On 30 October 2013, the Board is being asked to

- Confirm principles of the Health & Wellbeing Strategy ahead of the finalisation of the Health & Wellbeing Strategy
- Confirm the objectives for each priority in the Strategy
- Note the progress to be made for each objective and use this as a basis for future meeting planning
- Task officers with a final version of the Health & Wellbeing Strategy with an action plan for Board approval in December 2013

The draft principles are:

- We will work together to deliver:
  - Services and cultures which promote self care and personal responsibility
  - A focus on disease prevention and health promotion
  - Opportunities for individual and community empowerment
  - A single point of contact for services users and a "joined up" approach between services which means every contact counts
  - Safe, high quality services which respond to individuals
  - An on-going dialogue with our communities, residents and patients
  - Achieving more for less and making the very best use of resources

The draft priorities are:

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

Brent CCG's draft Commissioning Intentions are guided by these draft principles and priorities

Brent CCG and its members

NHS Brent Clinical Commissioning Group

67 member GP practices who are organised into five localities

Wembley Locality

1 **Population: 53,896**
# of Practices : 11

Kingsbury Locality

2 **Population: 73,953**
# of Practices : 16

Willesden Locality

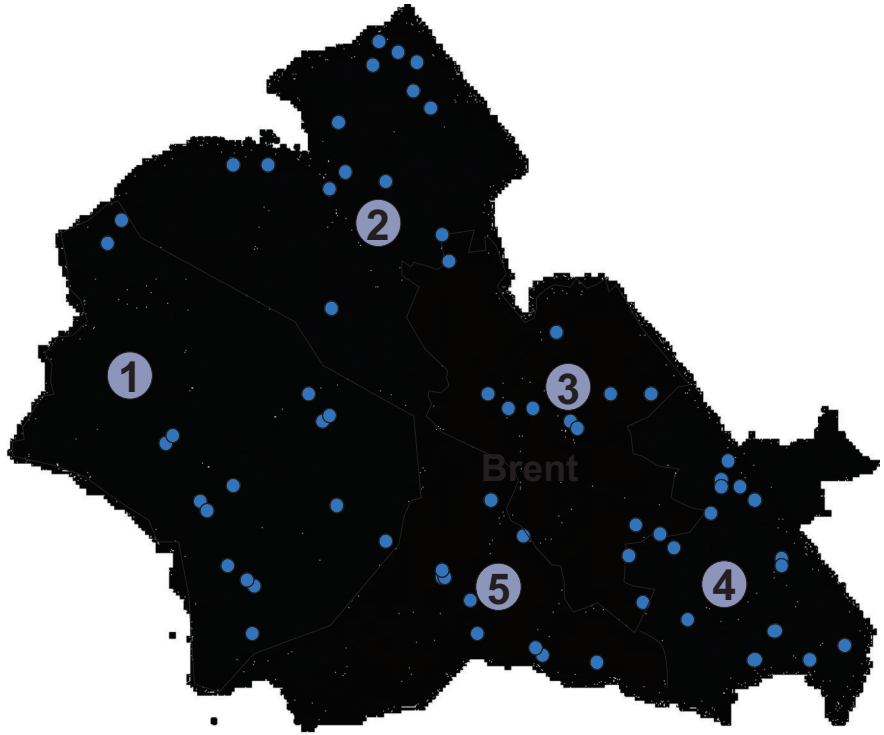
3 **Population: 50,084**
# of Practices : 10

Kilburn Locality

4 **Population: 77,372**
# of Practices : 14

Harness Locality

5 **Population: 80,559**
# of Practices : 16



Brent CCG – Provider Landscape

NHS Brent Clinical Commissioning Group

Provider	Sector	% contract £
North West London Hospitals	Acute	39%
Imperial	Acute	20%
CNWL Mental Health FT	Mental Health	13%
Ealing ICO	Community Service	9%
The Royal Free	Acute	5%
Other Acute	Acute	9%
London Ambulance NHST	LAS	4%
Other	Other	1%
TOTAL		100%

As can be seen from the table above Acute contracts account for 73% of Brent CCG total contract expenditure with Mental Health accounting for 9% of total expenditure and Community for 9%.

QIPP Requirements 2014/15 and beyond

NHS Brent Clinical Commissioning Group

- The CCG's QIPP requirement for 2014-15 and beyond is determined by the assumptions underpinning our Medium Term Financial Strategy (MTFS) which is based on a five year financial model.

- The assumptions underpinning the MTFS include:
  - Brent will receive 2.14% growth in funding in 2014/15 and 1.7% in 2015/16 to bring the CCG allocation in line with capitation based allocation target
  - QIPP delivery will be a net 2% (£8m) per annum
  - The H&SC Integration Fund in 14/15 – 15/16 is assumed to transfer £19,832m funding away from the CCG by 2015/16 without a corresponding reduction in spend
  - There is no new recurrent investment from 14/15 onwards over and above pressures from demographic and non-demographic growth
- The output of this range of assumptions would generate a surplus that exceeds the planned 13/14 surplus in 14/15 and then reduces dramatically after 15/16 and moves into deficit from 17/18 as the recurrent financial position deteriorates and the non-recurrent benefit from carry forward surpluses no longer support the position.

- This scenario is not an acceptable one and therefore options are required to both reduce the non-recurrent surplus in 14/15 and also to address the deterioration of the recurrent position.

- This will require the CCG to increase its QIPP requirement from 2% (£8m) to 3% (£11m), which is in line with national requirements

- We will therefore seek to achieve QIPP through working with member practices and providers to achieve local efficiencies, based on the opportunities indicated by national and local benchmarking data.

Commissioning Intentions 2014/15 – Overview

NHS Brent Clinical Commissioning Group

- We will take a standardised approach to commissioning and contracting with all providers to:
  - Transform services where new designs are required to improve quality and value for money
  - Contract and performance manage using the levers of, the national standard NHS contract in its entirety
  - Review service specifications to ensure that they meet local needs and make the best use of up to date evidence and innovations in health care
  - Apply rigorous and measurable quality and safety requirements and performance reporting regimes requiring adherence to national standards
  - Make transparent the elements making up contract values so as to facilitate value for money review and financial disaggregation
  - Promote productivity improvement through benchmarking and promote innovation by entering into CQUINS which are truly innovation focussed
  - Promote integration across services and agencies to truly improve outcomes for Brent residents
  - Commission services in a manner that interface effectively with GP networks

- We are requiring all providers to work collaboratively towards shared electronic records to enable seamless patient care and enable better outcomes through continuity and consistency of care. This will require all providers across primary, community and secondary care to ensure interoperability of clinical systems to enable the aspirations of whole systems integrated working across organisational boundaries to the benefit of patients and carers.

Commissioning Intentions – Patient and Public Involvement

NHS Brent Clinical Commissioning Group

- The CCG has established a number of networks to support dissemination of information and engagement with service users and the public during 2013/14.
- The effectiveness of these structures and networks is currently under review and options with a view to strengthening, broadening and ensure diverse representation are being consulted upon
- In 2014/15, the CCG intends to implement recommendations for improving our patient and public engagement mechanisms in line with the outcome of the review and consultation.
- It is the CCG's intention to engage with a broad range of networks and groups to involve our stakeholders in developing our commissioning intentions and implementing these throughout 2014/15.
- With an increasing number of individual residents, communities and voluntary sector organisation added to our stakeholder data base, we will be taking every opportunity to engage with a wider range of stakeholders
- We intend to have greater visibility by ensuring any interaction and for a is timely and relevant, therefore we will cross referencing our communications with our key strategic partners ensuring a variety of feedback mechanisms are in place to ensure we capture patient experience and public feedback direct to the CCG and via Healthwatch and Council for the Voluntary Sector

Commissioning Intentions – Patient and Public Involvement

NHS Brent Clinical Commissioning Group

The CCG is operating to the following timescale for developing its commissioning plans. The process will be shared with key stakeholders to enable their understanding:

- **25th September** – Agreement of process and timescales for developing Commissioning Intentions at QIPP, Finance & Performance Committee
- **9th October** - Commissioning Intentions planning workshop with CCG Executive and key members of staff
- **23rd October** – Approval of draft commissioning intentions to share with providers, partners, patients and the public by CCG Executive
- **30th October** - Discussion on commissioning intentions at GP member practice forum
- **6th November** – Discussion on commissioning intentions with Governing Body
- **6th – 12th November** – Discussion at the 5 PPG meetings
- **20th November** - Early engagement with patients and public at Health Partners Forum
- **27th November** – Engagement with EDEN Committee
- **27th November** – Commissioning intentions shared and discussed at the Carers Forum
- **27th November** – Discussion at QIPP, Finance and Performance Committee
- **30th November** – Final draft of medium term financial strategy, commissioning intentions for 2014-15

Where relevant the key issues identified through this engagement work will be captured and directly inform our Commissioning Intentions 2014-15. Feedback received to-date suggests that our stakeholders would like to be involved at the earliest possible stage and in a format that they can understand. Our communications mechanisms underpin our strategic delivery and enables compliance with the equality objectives. This will be fully taken into account whilst the production and design of each engagement forum including any formal or informal presentations used to brief our community stakeholders, partner organisations and the Health and Wellbeing Board on our plans.

Commissioning Intentions: Improving Quality, Patient Safety and Patient Experience

NHS Brent Clinical Commissioning Group

The CCG has considered each of the major reports that have brought the issues of quality and patient experience into sharp focus during 2013 (second Francis Report into the events at Mid Staffs NHS Foundation Trust, the Berwick report into Patient Safety and the Keogh review into Acute Hospital Care) and fully endorses the degree of ambition and challenge that they hold for commissioners as well as providers of care.

The CCG is committed to driving up the quality of care including the experience of patients and carers and is seeking via these commissioning intentions to delivering just that. It has worked in partnership with clinicians, patients, carers and their representatives to develop key priorities and ideas for improvement.

It should be noted that these intentions do not simply apply to NHS Trusts, but they apply to every service, every care home and every GP surgery from whom we commence services. The values and ambitions outlined here are the entitlement of our residents whether they are children, of working age, older or living with a long term condition.

Key Actions

When read together all the reports have a number of common themes. The CCGs has developed its response under 5 key headings:

1. Placing the quality of patient care, especially patient safety, above all other aims.
2. Engaging, empowering, and hearing patients and carers throughout the entire system and at all times.
3. Organisational Culture and Leadership
4. Making better use of data and intelligence
5. Transparency and Accountability

Improving Quality, Patient Safety and Patient Experience

NHS Brent Clinical Commissioning Group

1. Patient Safety

- The CCG will continue to ensure that all its commissioning activities promote and enhance the safety patients and service users in the care system. It will draw upon the growing evidence of base of what works, however it will also expect to commission services from organisations that share this overarching value.
- All trusts, including Mental Health Trusts and other providers will be expected to have implemented the use of an appropriate early warning system and have clinically appropriate escalation procedures for deteriorating, high-risk patients - in particular at weekends and out of hours.
- The CCGs will continue to work across the health system to achieve a year on year reduction in HCAIs moving beyond simply MRSA and C. Difficile. We will continue to expect the 'zero tolerance' goals to be supported.
- We will require enhanced performance with respect to
  - The management and investigation of incidents including evidence of learning
  - Assurance that service alerts and early warning systems are effectively addressed
  - The delivery of a provider specific action plans aimed at the reduction of its known harms to patients.
- We will expect to have formal oversight of provider QIPP plans and will expect to see some form of quality impact assessment. This will be especially the case when clinical staffing levels are under review.
- The CQC has recently produced its first 'bandings' of local hospitals as a result of its Intelligent Monitoring System. The CCG will work with Trusts to understand the issues especially where the banding gives cause for concern and will work with regulators and other to either ensure that standards improve or, if necessary, consider decommissioning the service.

2. Engaging, empowering, and hearing patients and carers throughout the entire system and at all times

The CCG is committed to acting as the system leader that delivers effective patient and carer leadership and empowerment, not only at the strategic level but also via its individual providers.

- We will expect all our providers to be collecting 'real time' patient experience feedback and to demonstrate how they are using this to improve the way they deliver services.
- We will be working with providers and patient representative groups to agree key measure of patient/carer experience that can be used across the whole pathway.
- We will be working with our providers to ensure the full implementation of the Clwyd/Hart Review of the NHS Complaints process. In particular we will expect:
  - Improved performance on respond times etc
  - Evidence of service changes and improvements in response to feedback
  - Assurance that patients and carers are satisfied with the process of handling
  - Evidence that responsibility for complaints and patient feedback is 'owned' at all levels of the organisation and especially the Board.
- We will expect providers to provide evidence and to how they have quality assured their own performance and will, if necessary, require an independent review of performance.
- We will use of the contractual levers available to us to ensure improved performance.
- We will expect providers to share these results findings, not only within their organisations, but the CCG and patient groups as evidence of transparency and openness

3. Organisational Culture and Leadership

The Francis Report (2013) placed the need for NHS to address the issues of culture and leadership at the heart of his report, almost considering it as the necessary pre-requisite of quality. The CCG also recognises the importance of culture not only with respect to its own organisation but also across the wider NHS.

- It will therefore require evidence and assurance from its providers that they have used an appropriate methodology to assess their own organisational culture and they are addressing any issues emerging from this work. It will also seek further assurance that the values, principles and behaviours outlined in the NHS constitution is at the heart of the organisations' decision making.
- It will also look for evidence that staff are also engaged and report being able to participate in strategy and delivery.
- When the CCG consulted patients, carers and its staff the two most often quoted values were putting patients first and openness. The CCG will particularly seek evidence in these areas.

4. Making better use of data and intelligence

- The Keogh Report highlights that '***Too often, boards were honing in on data that reassured them they were doing a good job, rather pursuing data that revealed inconvenient truths, thereby missing opportunities for improvement'***
- During 2014/15 the CQC and CCGs will be working to ensure that they are making better use of data to understand quality and drive improvement. We will be looking fro evidence that the Boards of our providers are also taking personal responsibility for quality across each and every service line that they deliver.
- As commissioners we will be expecting to use service level data, both qualitative and quantitative to drive our commissioning and focus our priorities.
- We will take a more rigorous approach to our scrutiny of Trusts Quality Accounts and the commentary we provide as a reflection of our commitment to transparency.
- Brent CCG will use benchmarking data to ensure that improvements are made to quality and availability of services as well as ensuring that QIPP and investment schemes reflect these priorities.

5. Transparency and Accountability

- The CCG will seek assurance that providers are working to put accessible, accurate and relevant information into the public domain as well as seeking assurance as to how the provider Board has reviewed its system of governance to ensure clarity of accountability within the organisation.

Commissioning Intentions 2014/15
Whole Systems Integrated Care

NHS Brent Clinical Commissioning Group

- During 2014/15 Brent CCG will continue to integrate care across pathways based on patients and their needs. We are working collaboratively with our CCG partners in North West London to design a new model of care for the parts of our populations we think would most benefit from an integrated approach from commissioners and providers.
- The co-design period is bringing together partners from across NWL including service users (lay partners), commissioners and providers from across health and social care to address some of the key questions for integration.
- The recommendations that are developed through co-design will be taken forward, adapted and tailored for local implementation at borough level, with commissioning decisions made jointly by local authorities and CCG boards.
- It is anticipated that a number of 'early implementation' sites will launch in shadow form from April 2014 and these sites will receive investment support to implement their plans.
- Brent CCG is keen to be an early implementer site and we will work with our partners in the Local Authority through a recently established Integration Board, accountable to the Health and Well Being Board to progress locally agreed integration priorities.
- As implementation proceeds we will work with providers to ensure that we can demonstrate that these new models of care will deliver enhanced patient safety as well as outcomes and patient experience

Commissioning Intentions – Acute Care

NHS Brent Clinical Commissioning Group

Brent CCG's strategy for commissioning acute provision is to ensure that acute care is still provided by acute providers, in an acute setting, but that non-acute elements of each care pathway are provided in more appropriate settings, at a lower cost. This will increase efficiency by aligning the care setting to effectively meet patient needs.

The CCG's strategy will not only impact on acute provision, but also require improved primary and community care to enable the shift in care provision, so that patient can be appropriately managed in non-acute settings. Outpatient care will need to be delivered in an integrated way across the health economy, supported by co-ordinated and communicated care plans.

Unscheduled Care

Brent's unscheduled care programme aims to reduce non-elective activity by providing more capacity in primary care and other alternative care settings for patients in the community or in lower intensity settings of care where clinically appropriate.

- In line with our A&E Recovery and Improvement Plan and Winter Surge Plan, Brent member practices together with community and acute commissioned care will provide anticipatory planned care, reducing the burden of unplanned unscheduled care on the local health system.
- Brent CCG will work with primary and secondary care partners to achieve this through a series of initiatives, including:

❑ **Ambulatory Emergency Care Unit**

- This service will continue to develop in 2014/15 to expand from the existing 10 pathways to develop as a minimum a total of 20 pathways.
- There is an opportunity to work with the local provider (NWLHT) to agree a scheme where a proportion of the emergency adult patients can be appropriately managed thereby avoiding an inpatient admission.

Commissioning Intentions – Acute (cont'd)

NHS Brent Clinical Commissioning Group

- **Assessment tariff**
  - The CCG intends to review all zero and one day lengths of stay to determine scope for efficiency and potential for a reduced tariff for those referrals to acute hospitals where only low-level care (e.g. diagnostics and/or short observation for alcohol related attendances) is needed.

Readmissions

- A review of readmissions will be undertaken to assess the volume of patients, age range, source of admission and when readmitted e.g.: within 24 hours of discharge from hospital.
- This will inform the discharge planning process and clinicians will work together to reduce the occurrence of readmissions.

Planned Care

- The CCG is intent on improving provider performance against the 18 week Referral to Treatment (RTT) target for Brent patients, ensuring that patient safety and quality issues are at the forefront of decision making.
- We will work collaboratively with other providers, NHS England, the Trust Development Authority and the DH Intensive Support Team to achieve effective resolution to the barriers underpinning provider performance issues.
- GP practices are at the centre of locality based networks that are supported by integrated out of hospital services. Much of the work that has commenced in 2012/13 will continue in 2014/15 and beyond to ensuring services are provided closer to home and in the community.
- The CCG has commenced procurement processes with respect to orthopaedics, rheumatology, physiotherapy and gynaecology services with a view to achieving improved clinical outcomes and integrated care that reduces duplication.

Commissioning Intentions – Acute (cont'd)

NHS Brent Clinical Commissioning Group

Referral Facilitation Service (RFS)

- Brent CCG intends to continue RFS, recognising the benefits of reduced variation in referral practice and ensuring patients have access to the right care.
- A Brent wide approach to prospective review of referrals will be agreed with localities based on an evaluation in quarter 4 of 2013/14.

Individual Funding Requests and Planned Procedures with a Threshold

- In accordance with the most recent evidence base acupuncture services will now be commissioned through the Planned Procedures with a Threshold (PPwT) given the limited clinical effectiveness of this service for certain conditions. Historically these services have been commissioned through Individual Funding Requests (IFR) but given the volume of requests, the PPwT route for specific conditions will enable patients where this intervention is effective to access the treatment.

- IVF treatment will now be commissioned in accordance with NICE guidance, enabling same sex couples to access the treatment as well as an increasing of the age limit for eligibility.

Independent Treatment Sector Contracts

- ISTCs offering diagnostic services are currently being renegotiated by Department of Health and local commissioning organisations. Specifically, Brent CCG is working with the North West London Commissioning Support Unit to renegotiate our contract terms and conditions with In Health.

Commissioning Intentions: Community Health Services

NHS Brent Clinical Commissioning Group

Avoiding unnecessary admissions to hospital

- We will continue to commission services to avoid unnecessary admissions into hospital, ensuring that (where possible) patients are kept well at home.
- Our aim is to integrate existing services so that the patients' experience of care at home is smoother, and services work in a more cohesive way.
- We would like to develop an enhanced community respiratory pathway, which has improved access from primary care and enables patients to stay well at home.

Integrated Care Pilot

- It is the intention of BEHH CCGs to collectively review the ICP and achievement of anticipated benefits in the second half of 2013/14.
- The review will take account of the role the ICP may have as a platform for greater integrated service delivery in 2014/15 in support of the NWL Whole System Integrated Care programme.
- It will also take account of recent work within the ICP to enhance the case management approach through the use of predictive modelling.
- The review will be completed by the end of Q3 2013/14 with a decision on future investment in ICP following this review.

Community Paediatrics and services for Looked after Children

- We wish to commission a high quality community paediatric and Looked After Children service.
- We are seeking to work with existing providers with a view to service design in order that they can demonstrate they are focussed on these vulnerable patients, and are more responsive to their needs.
- We will do this in partnership with the Local Authority to ensure seamless and cohesive care.

Commissioning Intentions: Community Health Services (cont'd)

NHS Brent Clinical Commissioning Group

Integrated Nursing

- Brent CCG wishes to commission nursing within the community that works in a more integrated way with nursing in primary care, and provides a more holistic service to patients.
- We will be looking for opportunities to extend the nursing role, both within the community and primary care.

STARRS (Rapid Response)

- Brent CCG will work collaboratively with providers to develop an integrated nursing specification covering STARRS, case management, district nursing, specialist nursing and practice nursing to ensure a joined up and seamless approach to out of hospital care.
- These services will be used to support patients identified through the implementation of our local population based risk stratification processes and ensure coordinated and holistic care that is provided in an integrated way.
- Based on the outcome of the pilot at Imperial College Hospital Trust we will extend STARRS to Royal Free Hospital

Primary and community services

- The CCG is seeking to extend the range of services provided in primary care settings, including care of patients on Disease-modifying anti-rheumatic drugs (DMARDs), patients with diabetes, cardiology diagnostics, anti-coagulation services and phlebotomy services.
- The CCG intends to commission a falls service, endoscopy in community settings and improve the audiology pathway.

Commissioning Intentions – Mental Health

NHS Brent Clinical Commissioning Group

Mental health commissioning intentions for 2014/15 are aligned to delivering the Brent CCG vision and aims through:

- Developing care pathways that deliver the most appropriate treatment by the right clinician at the right time, with clear routes in and out of primary and community care
- Shifting settings of care aware from acute providers into Primary Care where appropriate.
- Maximising out of hospital care, promoting the independence of service users.
- Develop integrated care pathways between primary care, secondary care and social care to address areas such as Alcohol, Personality Disorder and Autism without reliance on acute care.
- Redesigning care pathways for agreed areas of care provision to make the most efficient use of existing resources and provide an improved pathway for patients
- Continue to repatriate service users into their local communities and reduce out of area treatments

<u>Alcohol related attendances in A&E</u>

- Brent CCG will work with Public Health and acute providers to review the numbers of admissions for observation for people with alcohol related issues only.
- The outcome of this joint approach with Public Health aims to achieve:
  - A renegotiated reduced tariff for alcohol related admissions for observation only.
  - Review of pathways for people with alcohol addiction
  - Review of integrated commissioning possibilities for provision in the community e.g. St Mungos
  - Review the number of alcohol related detox beds provided by CNWL and provision of these in more appropriate community based settings.
  - Commissioning of clear care pathways across health and social care/public health for people with alcohol related difficulties
  - Creation of clear referral and access routes, both into and out of mental health services.
  - Improve productivity of mental health services.

Commissioning Intentions – Mental Health (cont'd)

NHS Brent Clinical Commissioning Group

Personality Disorder/ADHD pathway redesign

- There is currently no specific pathway to treatment/intervention for people diagnosed with either a Personality Disorder or ADHD in the Brent services commissioned from the main mental health provider, CNWL.
- This results in patients receiving a diagnosis and being referred back to the CCG for spot purchased placements or treatment provided out of borough.
- In line with providing more cost efficient care, closer to home, Brent CCG will work with CNWL to scope the current pathway, numbers of patients and costs with the intention of redesigning the pathway to enable these patients to be managed by the existing provider.

Elderly Care

- Brent CCG will work with CNWL to review the acute bed provision for the elderly mental health population in Brent.
- The review will seek to strengthen capacity in community services such as crisis resolution home treatment services and increase service productivity and make staffing efficiencies including the rationalisation of sites if appropriate and redirecting resources into commissioning a Primary Care plus service to work across primary and secondary care settings.

Primary Care Plus

- Brent CCG will work with CNWL to design and commission a Primary care plus service to work across primary and secondary care settings to enable a stable cohort of patients to be discharged from secondary care services to be managed within primary care.
- It is expected that this development will allow a significant cohort of stable patients to be discharged back to the care of their GP. The service will also work to prevent inappropriate referrals to secondary care and enable intervention earlier before a service user reaches crisis.

Commissioning Intentions – Mental Health (cont'd)

NHS Brent Clinical Commissioning Group

IAPT (Improving Access to Psychological Therapies)

- National and local targets set for the provision of IAPT services are ambitious at achieving 15% access across the local population by 2015 and 50% of those in treatment moving to recovery. Brent's IAPT service is currently commissioned through CNWL.
- Despite substantial investment, waiting lists for counselling, in particular remains high and the provider is seeking substantial levels of additional investment to meet national and local targets by 2015.
- It is therefore the CCG's intention to consider alternative models of providing IAPT services and procurement options to achieve the targets.
- The CCG will continue to work with the current provider to maximise productivity within existing resources and seek to maximise the use of the voluntary sector wherever possible and appropriate.

Review of small contracts

- The CCG has a number of small contracts with a variety of voluntary sector providers where the fit and relevance of these contracts has not been reviewed for some years
- The CCG will undertake a comprehensive review of all existing small contracts ensure alignment of contracts to the CCG's commitment to providing care out of hospital in more cost efficient settings.
- Equality Impact Assessments will be carried out to identify any impact of commissioning decisions and associated actions required in relation to these contracts.
- Alignment with the local authorities commissioning of small contracts will be integral to this work

Repatriation of out of area placements

- CNWL and Brent CCG were awarded the commissioning efficiencies award for the Placement Efficiency Project (PEP).
- In recognition of the value of this work, the CCG will continue work collaboratively with CNWL's Placement efficiency team to ensure that placements for those with complex needs are regularly reviewed, assessed and matched to appropriate care settings.

Commissioning Intentions – Mental Health (cont'd)

NHS Brent Clinical Commissioning Group

Redesign of Autism Diagnostic Pathway

- The CCG currently has a spot purchase agreement with CNWL for referrals for diagnosis of patients on the Autistic Spectrum
- The CCG will therefore work with providers to negotiate a contract which is more reflective of demand with a view to achieving better value.

North West London Mental Health Strategy

Brent CCG will continue to work as a key member of the Mental Health Programme Board delivering the agreed work streams and working collaboratively across the 8 NWL CCG's, which includes:

- Psychiatric Liaison service
  - The CCG will commission a Psychiatric Liaison service operating to a single service specification across all 8 CCGs and sites, working to core outcomes of acute admission avoidance, facilitated enhanced/early discharge, emergency re-admission reduction, annual medication reviews and capacity building within AHTs through planned training.
- Urgent Assessment & Care
  - Through redesign with secondary providers work towards (a) extension of daytime hours to better match those in primary care (8 am – 8pm); (b) a single point of access/advice 24/7/365 for GP's and (c) increased home visiting out of hours to resolve new crises in people's homes, reducing the need for patients to travel to A&E departments
- The CCG expects continued evidence of improved involvement of patients using mental health acute inpatient services in decisions about their care and treatment; explanations about care and treatment is provided to all patients using mental health services and patients are given information on how they could receive help in a crisis after they are discharged from mental health acute inpatient services.

Commissioning Intentions – Learning Disabilities

NHS Brent Clinical Commissioning Group

- For people with learning disabilities, the CCG will work collaboratively with Brent Council to jointly commission a specific Needs Analysis of learning disabilities (pre-birth to grave); which will form the LD chapter of the JSNA, and be the basis for the commissioning strategy.

- Commission a follow-up to the initial health checks audit but broaden its scope to include more conditions and all practices in Brent.

- Once completed the results on CCG, Locality and Practice level should be the focus for in-year improvements, which include:

  – uptake of health checks
  – management of long-term [physical health] conditions (QOF registers)
  – reasonable adjustments
  – cancer Screening,
  – learning disability awareness training for all CCG staff; so that they understand why we need to specifically identify them in A&E, complaints, etc.

- Jointly commission with Brent Council advocacy services to lead on patient stories, feedback, complaints and compliments. The aim of this would be to support improved gement, raise profile of people with the condition and capture good practice.

Commissioning Intentions – Children's Services

NHS Brent Clinical Commissioning Group

The CCG's commissioning intentions with respect to children's services span the spectrum of care from community to secondary. To this end, the CCG seeks to achieve the following improvements in children's services over the next year:

CAMHS

- Commissioning a cohesive and integrated care pathway across health and social care, which includes community based services where appropriate and ensuring robust transition plans are in place for children moving into adult services

Community Nursing Teams

- Develop integrated children's nursing teams to include health visitors, practice nurses, community paediatric nurses for example for the management of complex eczema, asthma and specialist feeding management.

Children's Centres

- Alignment of GP practices to Children's Centres in order to improve integration with primary care.

Community Paediatric Clinics

- In partnership with community services, acute providers and primary care develop community based paediatric clinics to be led by acute consultants and GPs with Special Interest and paediatric nurses.

Looked After Children (LAC)

- We intend to rescind the decommissioning notice for the LAC service from Ealing ICO subject to agreement of a new service specification and sustained improved performance.

Sickle Cell Services

- The CCG will review services for children with sickle cell to ensure that they are appropriate, not fragmented and provide the best clinical outcomes for these patients.

Developing Primary Care

NHS Brent Clinical Commissioning Group

- NHS England commissions primary care services from GP practices, dentist, optometrist and pharmacists.
- Brent CCG is statutorily required to assist NHS England in the continuous improvement of the quality of primary care in Brent. Brent CCG may commission additional services from primary care contractors. For GP practices this may be from individual practices or practices working in networks. The CCG may also commission integrated care from GP networks working with providers in an integrated network.
- We recognise that achievement of Brent's commissioning strategy cannot be delivered without a corresponding change to the way that care is provided in primary and community settings.
- In 2014/15 Brent CCG intends to commission services from the four GP networks in Brent for the following services:
    - (subject to successful pilot for extended GP hours) locality hubs for 7 day GP services outside core contract hours.
    - A number of services currently commissioned through Local Enhanced Services.
- We will also consider commissioning integrated services from GP networks and other providers for:
    - Adults vulnerable to hospital admission or residential care
    - 24/7 urgent care

Developing Primary Care (cont'd)

NHS Brent Clinical Commissioning Group

Local Enhanced Services

- NW London CCGs have been working collaboratively to develop a toolkit to assist CCGs in their decision making process for the commissioning of LES services from 2014/15. The purpose of this toolkit is to assist CCGs in their decision making process for the commissioning of new locally commissioned out of hospital services, and to serve as a reference point when considering the appropriate procurement options for these services in the light of changes to the law since the Health and Social Care Act 2012 came into force.
- The CCG will need to balance the requirements of complying with the law and reducing legal challenge with the need to make effective and integrated commissioning decisions that are right for their local population. The aim of the toolkit is provide a framework that enables CCGs to do this quickly, efficiently and consistently.
- Brent CCG is considering future commissioning of all services currently commissioned through a LES. The options for the CCG are:

  (i) To cease commissioning the service

  (ii) To consider whether:

  - Only one provider is capable of providing the service
  - Only one provider or provider type is most capable of providing services
  - Benefits of competitive tendering outweigh the cost of running a competitive tender process
- Brent CCG's Primary Care Development Programme Board will evaluate the future commissioning of these services using the above decision points and will make recommendations to the Governing Body in November 2013.
- The implications of these recommendations will be published in a later version of our Commissioning Intentions.

Developing Primary Care (cont'd)

NHS Brent Clinical Commissioning Group

- The following local enhanced services are delivered by Brent Member Practices
  - Childhood surveillance for children under 5 years where their registered practices does not undertake
  - Prescribing and administration of hormone blockers for treatment of prostate cancer
  - Phlebotomy for 12 years and over
  - Insulin initiation
  - Register and plan for patients requiring palliative care
  - Register and plan for carers
  - Undertake ECG monitoring and 24 hour ambulatory blood pressure monitoring

- Out of Hospital specifications are in development for:
  - Primary Care Monitoring of long term DMARD
  - Anticoagulation
  - Wound care

- We propose to continue, subject to NHSE's approval, commissioning the following improvement incentives
  - GP commissioning including prescribing
  - Referral facilitation
  - Improving GP outcomes

Commissioning Intentions – Continuing Healthcare

NHS Brent Clinical Commissioning Group

- Continuing Healthcare will be working to develop and implement effective governance, financial and operational arrangements and review all current commissioning and contractual arrangements. The Terms of Reference for the Continuing Healthcare Panels will be reviewed jointly with our partners, together with the Operational and Dispute Resolution policies in line with the revised Department of Health guidance (April 2013).

- We will further consolidate joint working arrangements with the Local Authority with a detailed market management strategy in order to manage the provider market economy to deliver longer term efficiency savings (e.g. a preferred providers list).

- Personal Health Budgets - NHS Brent CCG has been piloting Personal Health Budgets from April 2012. Implementation of Personal budgets is part of a system-wide transformation of workforce and market development and simplified assessment processes. We are developing processes to ensure availability of a personal health budget that can be used to meet the needs of individuals with complex, long-term and/or a life-limiting condition/s from April 2014. This will be supported through Continuing Healthcare budgets and this will become a statutory right for individuals to have from October 2014.

- Nursing Homes Review – We will undertake a review of options for commissioning nurse home placements to ensure that high standards of care are provided to all Brent patients in nursing and care homes, building on the learning from the ICP Care Homes project.

- Reviews of all Continuing Healthcare activity – As part of good clinical practice, we will continue to undertake planned reviews of health-funded placements across adult care groups, i.e. older people, patients with physical disabilities, learning disabilities and adult mental health to ensure provision of appropriate, clinically effective and value for money care packages are delivered with a greater emphasis on quality and patient outcomes

Commissioning Intentions – Informatics

NHS Brent Clinical Commissioning Group

- Brent CCG is committed to developing and implementing an improved informatics infrastructure and interoperability for 2014-15 and it will be a requirement that all local providers of Brent CCG work to maximise the interoperability of IT systems and the sharing of clinical records/information to optimise the delivery of safe care across health and social care.

- The CCG will progress its interoperability programme to share clinical information to ensure that data can be exchanged between different clinical systems in a safe and secured way and will expect provider organisations to work in partnership towards the sharing of clinical records within robust information governance frameworks across the health and social care community.

- The CCG will expect providers to commit to the sharing of information where they have at least one of the following in place to support the exchange of clinical information:

  1. there is a common clinical IT system and a shared record between the GP and the care provider,
  2. respective IT systems are interoperable and in full conformance with the current Interoperability Toolkit (ITK) standards and
  3. the Summary Care Record is enabled, available and accessible particularly where patients are receiving care out of area.

- When contracting with providers in the future the CCG will insist their systems are able to communicate with the CCGs chosen solutions for interoperability (i.e. the Medical Interoperability Gateway(MIG), Docman EDT Hub, etc.) .

- Extending on the 2013/14 the Electronic Patient Discharge Summaries CQUIN the CCG will require all providers to ensure GPs receive electronic information about patient treatments, investigations and attendances at the point of discharge and to receive real-time confirmation of receipt by the recipient practice.

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Brent	**Health Partnerships Overview and Scrutiny Committee** 28th January 2014 **Report from the Assistant Chief Executive**
For Action	Wards Affected: ALL

18 Weeks Referral To Treatment Incident and Urology Serious Incident

1.0 Summary

1.1 The committee was informed at the last meeting that North West London Hospitals had discovered in February 2013 that 60% of patients on North West London Hospital Trust (NWLHT) waiting lists did not have an open care pathway and that as a result a large number of patients had been waiting longer than 18 weeks for treatment. NWLHT were asked to return to provide an update to this meeting.

1.2 The report restates the plans to expand some areas of capacity including theatres and to commission external providers in order to cope with the additional capacity required to deal with the large volume of affected patients with some additional details.

1.3 Also highlighted is a different, more recently identified, incident that has occurred in urology, where patients booked on a planned waiting list for diagnostic/cystoscopy procedures had not been offered an appointment. As at October 2013 there were 196 patients who had waited over ten weeks for a flexible cystoscopy appointment. Following an internal review NWLHT is currently collating the results of the review.

2.0 Recommendations

2.1 The committee is recommended to question officers from NWLHT on the contents of the report and in particular:

- how much research it has done into the impact on patient safety and what has been done to address any issues found and to minimise risk to

patients.

- the steps being taken to address the excess capacity needed to deal with the affected patients and return the waiting lists to a manageable size.

2.2 The committee is also recommended to question officers on the serious incident in urology including:

- how the incident arose;
- the level of impact on patient safety;
- the actions being taken to address the problem;
- what is being done to ensure that no similar incidents can occur in the future.

Contact Officers

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18 Week RTT Clinical Review Process

Background:

Following the recent IST diagnostic and publication of their findings, the Trust has identified the need to look at the large number of patients who were waiting over 18 weeks as a result of recording the correct overall waiting time.
The Trust needed to ensure that patients waiting longer than 18 weeks had a clinical review to determine whether there is a risk of harm to a patient due to the length of wait for their procedure. The review primarily focussed on any patients who had waited due to unnecessary delay rather than due to clinical or social reasons for delay such as patient choice or planned procedures.

Methodology:
The Trust agreed two methods of review with the CSU/CCGs.

Internal Process:

Patients waiting over 52 weeks: The Trust completed root cause analysis of the length of the waiting time identifying key reasons for the delay in treatment as well as a clinical view on any potential harm due to the length of wait.

Patients waiting over 18 weeks: The Trust completed a clinical view of the patients that were currently waiting over 18 weeks for their procedure during September 2013. There was a two-step process.

Step 1: A retrospective review which identified patients who as of 1st September 2013 have waited longer than 18 weeks. Clinical Directors and Clinical leads were sent the patient level data by speciality and feedback was required on patients who required clinical expediency due to the length of time waiting for their procedure, patients who were routine and still require treatment but in line with current wait, and patients who didn't require treatment due to clinical/non-clinical reasons.

Step 2: The development of a prospective review which identifies patients that move past the 18 week target on a weekly basis. This process will allow the Trust to proactivity review the types of procedures that waiting beyond the 18 week target and appropriately prioritises the patient's procedure date. The data will be reviewed during at a weekly meeting involving the Medical Director, Director of Operations and/or Head of Performance and will involve Clinical Directors and Clinical leads as required. Start date w/c 30th September 2013.

Review of mortality rates whilst on the waiting list: The Trust reviewed the number of patients who were over 18 weeks whilst waiting for a procedure and were removed from the waiting list as a result of dying. It compared the current year to previous years to understand if there are any trends that require investigation. The primary causes for a patient's death across 2012/13 and 2013/14 were reviewed to see if this is related to the procedure they were waiting for.

The Trust invited an external Medical Consultant/Director to review/assess our current processes for clinical review. The aim was to provide assurance that the Trust has put in the place appropriate measures to ensure clinical review of long waiting patients.

External process:

The Trust agreed with the local CCGs, Brent and Harrow and the CSU that it would send patient level information to GPs across all CCGs. The data was in an agreed format and the patients will be live on the system and were currently waiting on the Trust's inpatient waiting list. The patient level detail was sent via post with the request for the GP to review their patient's that were currently waiting and contact the Trust if they wished to update us on the priority for their patients.

Results review process

The clinical review process will be reviewed by the Independent review panel which is planned to meet in January 2014. The panel will assess the level of scrutiny that the Trust has undertaken as well as the results from the internal and external process.

Once assessed the results will be shared with the Trust Board and wider LHE.

Author:
Sean McCloy
Head of Performance
NWLHT

Date: 13th January 2014.

Northwest London Hospitals Trust – Capacity

1.0 Background

The Trust is currently working through an improvement programme for 18 weeks, which started with an IST diagnostic review in June 2013. Part of the work carried out by the Trust and IST identified a significant mis-match in the number of patients that are currently waiting for treatment on the Trust waiting list and a sustainable waiting list size based on the demand coming through. The Trust reported that it had 4400 patients on the admitted waiting list and this number needs to be nearer 2000 to reach a sustainable balance. The Trust also had 801 (189 undated as of 3/11/13) patients currently waiting over 18 weeks and a further 328 undated above 16 weeks.

2.0 Capacity Demand work

The Trust carried out some preliminary work in a number of key specialities[1] with technical support from the IST to understand the capacity required in these specialities to achieve a compliant pathway. This work has informed the both the internal capacity plan increase and the Trust draft trajectories for 18 weeks. For the majority of specialities, this showed a mis-match in capacity against demand.

1. General Surgery, Trauma Orthopaedics, OMFS, Opthalmology, ENT.

3.0 Trust Capacity Increase (Internal)

The Trust has historically carried out waiting list initiatives and continues to carry them out during 2013/14. From the initial review of demand and capacity the Trust has planned to increase its own internal capacity with the majority of additional work being carried out at Central Middlesex Hospital. The provisional increase in capacity is identified in Appendix 1.

4.0 OutSource Process

To support the Trust, the CCGs have agreed to fund additional capacity through an outsourcing process. The providers were chosen with the support of the CSU and CCGs. These are:

- BMI Healthcare group (BMI)
- The Hillingdon Hospitals Trust (THH)
- The Royal National Throat Nose and Ear Hospital. (RNTNEH)

The process started in November 2013 and the outline of how this was set up is explained below:

4.1 Patient Selection

The patient group will be selected from all specialities who have patients on the admitted waiting list. The exclusion criteria should be followed.

- cancer
- tertiary
- complex
- revision surgery
- dated by the Trust
- Urgent (patients requiring treatment within 4 weeks)

The Clinical Directors will be consulted on the patient procedures that are currently undated across their specialities to ensure any specific procedures are clinically contra-indicated for outsource.

The patient will be initially selected as one off large group to take into account the start of the process with a priority on the longest waiting patients (patients waiting >16 weeks) The process would then continue on a weekly basis looking at new patients added to the waiting list in the last week and those reaching 16 weeks without a date.

Patients sent from <12 weeks would expect to be treated before 18 weeks at the alternative provider.

Patients would only be selected from specialities where there are RTT performance issues.

4.2 Patient Tracking

Letter to Patients **-** The Trust will send an agreed letter to the patients identified. This will explain the process and ask the patients to contact the Trust on a dedicated phone line if they wish to keep their treatment at the Trust. The letter will be a positive response letter, ie. If patients do not respond back to the Trust, the Trust would treat this as consent to transfer to another provider. The letter will also contain information regarding the consent to transfer of the patient's information to another provider. The Trust will have a dedicated team to monitor the trackers and receive phone calls from patients. The letter is shown in Appendix 2. Any patients wishing to remain with the Trust will have the code changed back to an internal code and will remain on the waiting list not disadvantaged by this process.

Provider to provider **-** The patient tracker list will be sent to the external provider weekly in agreed formats which will be the same for all external providers. This will be updated by the external providers twice a week providing the Trust with up to date information of appointments and admission dates. The provider will contact the patient for their appointments to receive their treatment. Any patients who wish to return to the Trust or need to return for valid clinical reasons will be identified on the tracker and the code will be changed and the patient returned to the Trust waiting list, not disadvantaged by this process. The Trust will send the minimum data set and agree with external providers on the relevant medical information required by the external providers. Where possible the Trust will copy the relevant patient medical records and send by secure fax/courier. In exceptional circumstances the Trust will send the original copy of the notes. Relevant diagnostics will be shared on the inter Trust image exchange portal or direct on CD or to a secure fax.

Access Policy – The Trust's Access Policy has been revised and as soon as this has been agreed with CCGs will be shared with the providers and they will be expected to follow the same process that would happen in the Trust. This would ensure that the principles that patients should be fit, willing and able to receive their treatment are adhered to.

Admission criteria – If the external provider clinician feels that the treatment choice decided on by the Trust Consultant is not in the patients best interest at the time of the consultation at the external provider the patient should be discharged to the GP with the appropriate management plan. Where there are clinical exceptions the external provider Clinician should seek to contact the NWLHT Consultant.

4.3 Reporting

In normal circumstances the National rules concerning provider to provider allows for the 18 week pathway to be handed over the receiving Trust and that Trust counts the admission and corresponding performance. In exceptional circumstances and with commissioner support providers can agree to "manually" adjust the performance statistics sent to UNIFY2 to reflect that the performance was of the original Trust.

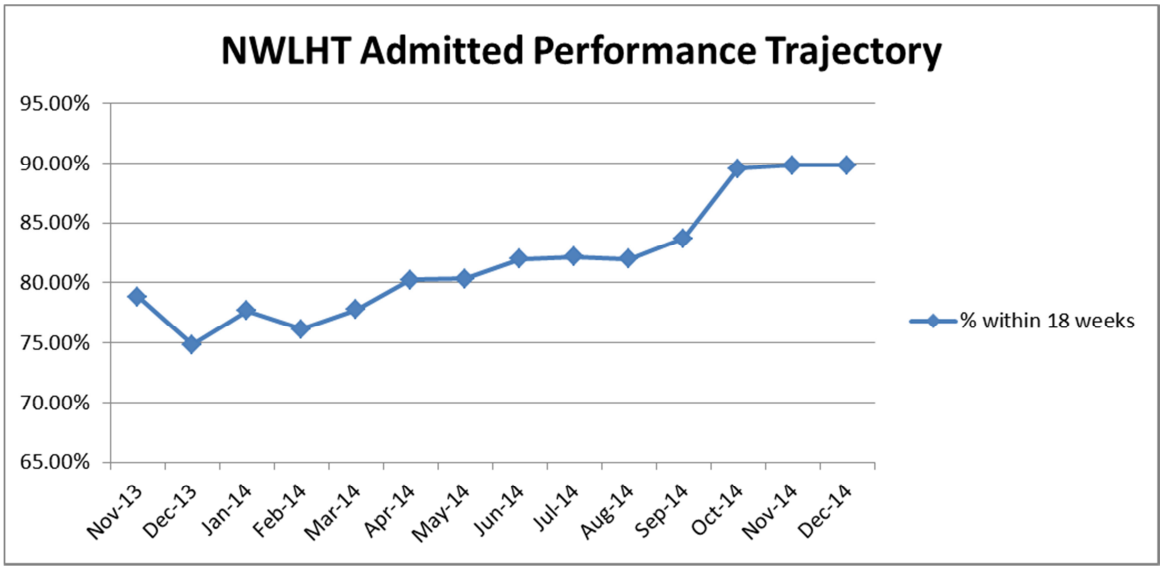
This paper proposes that the NWLHT reports the performance stats of all the outsourced patients to other providers. The CCGs, CSU and the Trust would need to ensure that both NWLHT and the providers manually update the same information so that the performance is removed from the external provider and is shown in the NWLHT UNIFY2 dataset.

5.0 Risks

A number of risks have been identified both to the success of this process and in the process itself. These have been identified in a table in Appendix 3 with the largest risk remaining with the volume of patients that are likely to be choose to be treated elsewhere, risk score 12. This was noticeable when the Trust last carried out this process in February 2012.

6.0 Trajectory

The increase in capacity has been mapped which has identified that for the majority of specialities who are currently failing the admitted performance target of 90%, a return to performance will either take a significant length of time or performance is not due to return into positive balance. Where this is the case, the Trust and CCGs are working on further plans to deliver the required capacity. This will include further expansion of CMH capacity and a review of theatre capacity at NPH for those specialities which can only operate at that site.



7.0 Progress.

To date the Trust has identified and written to 985 patients through this process. Of which 819 patient details/records have currently been sent to the providers. The providers are now in the process of booking these patients into clinics, pre-assessment and offering treatment dates. The Trust and the CSU are currently collating data regarding further detail on the process.

The Trust currently has under 3800 patients on the waiting list with under 700 patients waiting over 18 weeks.

8.0 Capacity Demand Modelling

The Trust completed some initial modelling work across a small number of specialities using the Intensive Support Team's (IST) published model. This helped form some early views that led to the increase in capacity as already identified earlier in this document. The Trust is currently working in collaboration with the CCGs on a "flow through" model which joins up capacity/demand and activity modelling across the 18 week pathway. This will help provide summary data on the available capacity to see new out-patient appointments, follow-up appointments and for patients who need treatment on waiting lists.

This work is planned to achieve model outcomes across five key specialities Orthopaedics, ENT, Gastro, General Surgery and Urology by the end of February 2014.

9.0 Conclusions

The Trust is increasing the overall capacity for theatres to manage both emergency and elective pathways. Overall the Trust is planning to increase the elective capacity by 87 theatre lists per month by the end of March 2014 however this will not meet demand across a number of specialities.

The outsource proposal allows the Trust to reduce the overall sizes of the waiting lists across the specialities by utilising capacity at other centres. The Trust will report both the positive and negative performance results from this activity undertaken on its behalf. Good

progress has been made to date with a small level of attrition resulting from contacting patients. However this is expected to increase as providers contact the patients.
There will be a positive reduction in the overall size of the waiting list which will depend on the success on the outsource process and the Trust will have maintained its existing theatre schedules through booking the volume of work not outsourced on the waiting list. This is already starting to be evidenced in section 7 of the paper.

Author:
Sean McCloy, Head of Performance
NWLHT.
13/1/14

Appendix 1 –
Admitted Capacity Increase

October 21st 2013 Location CMH.	Extra lists/ 4 week month	Est. Increase in Patient per month	Achieved (Y/N)
ENT	2	6	(capacity used in by Gen Surg and Urol up to end of November.
OMFS	3	9	Y
Ortho	8* * previously CEPOD and trauma	12	Y

Capacity to be delivered:

Plan start date 4th November 2013 **Location CMH**	**Extra lists/ 4 week month**	**Est. Increase in Patient per month**	**Achieved (Y/N)**
Ophthalmology	8	32	Y

Plan start date 15th December 2013 **Location NPH**	**Extra lists/ 4 week month**	**Est. Increase in Patient per month**	**Achieved (Y/N)**
Colorectal	4	10	N

Plan start date 31st January 2013 **Location CMH**	**Extra lists/ 4 week month**	**Est. Increase in Patient per month**	**Achieved (Y/N)**
ENT	10	30	
OMFS	4	12	
Ortho	26	52	
Gen Surg	8	24	
Vasc	2	6	
Urology	4	12	

Plan start date 15th March 2014 **Location NPH**	**Extra lists/ 4 week month**	**Est. Increase in Patient per month**	**Achieved (Y/N)**
OMFS	4	12	
Gen Surg	4	12	

Appendix 2

Patient letter template.pdf

Appendix 3

Risk	Likelihood	Consequence	Score	Mitigation	Residual
Small numbers of patients will take up opportunity to transfer	4	4	16	Utilisation of same Consultant at BMI, Provider staff telephoning, greater awareness of patient rights.	12
Patients will complain that their data has been shared with another provider	3	4	12	Letter to contain information on intent to data share. Patient has to communicate in order to retract this.	6
Patients information will be lost from the Trust waiting list therefore patient wont be contacted by either provider delaying their care.	2	4	8	Pathway supports staff data entry, only trained staff to use Trust ICS system. Senior staff oversee process.	2
The Trust will lose visibility of the patients once they are transferred to another provider risking that a patient could fall in a gap of communication delaying their treatment.	2	4	8	The Trust will introduce a separate patient tracking list for outsourced patient which will track patients moving forward. It will identify the specific cohorts in this group using freetext to uniquely identify them. The Trust will also have a tracker with external providers tracking updates on patients.	2

Summary – Urology serious incident

Northwest London Hospitals Trust uses a "planned" waiting list as part of the processes used to manage patients waiting for procedures. This is in line with National guidance and rules for the 18 week referral to treatment (RTT) target. The planned list is used for patients who need procedures that cannot clinically be carried out until a period of time elapses or other processes are required to be done first. The planned list is often used to manage patients who require surveillance procedures which occur over years. Through validation of the RTT pathways for the Trust, personnel in the Access Centre confirmed that a number of patients under Urology had been booked onto a planned waiting list for a diagnostic/cystoscopy procedure, but that they had never been offered/given a date. Following a review of Urology patients on the planned waiting list in October 2013 there were a total of 196 patients identified as waiting over 10 weeks for a flexible cystoscopy appointment. This is the group of patients that were reviewed by clinicians in Urology for either urgent follow up in the department or update on PAS to reflect their correct clinical status.

Review process

An internal Consultant agreed to lead the review process supported by experienced Registrar level medical staff.

1. Clinical review lead – Mr Rajesh Kavia, Consultant Urology (Year 2)
   Clinical reviewer – Ms Hazel Ecclestone, Specialist Registrar Urology ST5
   Clinical reviewer – Mr Iqbal Sahibzada, Specialty Trust Doctor Urology (ST4 equivalent)
   Patient data provided by Ms Catherine Endeley-Brown, General Manager

2. Quality assurance checks were managed by Mr Rajesh Kavia who had oversight of the data files used to manage the clinical feedback for the patients identified through this process

3. The clinical reviewers cross-referenced the information from the data file to that of ICS PAS and the Generic ICS system. This enabled patients to be validated from the clinical data available on GCIS against the status held for them on PAS. Where this information was insufficient, there was a request to bring the patient back to an outpatient clinic for further clinical review. All patients were reviewed by the clinical team and any decisions taken regarding their outcomes was based on the clinical information available at the time of review.

Results

The Trust is currently collating the results of the review process and clinics that were set up to see the identified patients. These will be reviewed through the Independent panel to provide assurance that the clinical review was appropriate with a final report to the Trust Board.

CCG Position

Cllr Daly Question: How is this capacity issue going to tie in with changes and current under-utilisation of CMH and how can CMH best be used to address this?

Brent CCG Response: Brent CCG supports the development of an elective centre at CMH for Ealing and NWLHT surgery. In addition Brent CCG supports the development of an elective orthopaedic centre at CMH. Both initiatives will ensure theatres at CMH are used to

full capacity and protect elective activity from emergency pressures that can occur where an A and E is on site.

Cllr Daly Question: (with input from SaHF if needed): Can you explain why/how there will still be capacity once there have been an extra 900 hospital beds closed across NW London.

Brent CCG Response: The demand and capacity study for elective activity will help the CCG and Trust to appropriately plan for sufficient capacity to meet demand at NWLHT. The CCG is committed to commissioning sufficient capacity to meet demand. The Trust is establishing the right balance between outpatients, theatre and bed capacity. The planning for implementation of SAHF ensures that no changes take place without ensuring there is sufficient capacity across the health economy to where services will be relocated.

Brent	**Health Partnerships Overview and Scrutiny Committee** 28th January 2014 **Report from the Assistant Chief Executive**
For Action	Wards Affected: ALL
Plans for Central Middlesex Hospital	

1.0 Summary

1.1 Members of the committee will be aware that under the "Shaping a Healthier Future" reconfiguration of hospital services in North West London, there was some doubt as to the exact plans for Central Middlesex Hospital. This report outlines the proposals for the future services to be delivered at CMH. These proposals will form the basis for the Strategic Outline Case which will be presented to the Future of CMH Partnership Board on 4th February and to the SaHF Implementation Programme Board on 6th February.

1.2 Under the SaHF plans, CMH will be a local and elective hospital. The site has been underutilised for some time and currently operates at around £11m a year loss.

1.3 The key services now being proposed for CMH are:

- "Hub Plus" for primary care and community care services for Brent. This will include the relocation of rehabilitation beds from Willesden Centre for Health, which could have an impact on the Willesden Centre.
- Elective Orthopaedic Centre;
- Mental Health Services: Transferred from Park Royal;
- Regional Genetics Services: relocated from Northwick Park Hospital;
- 24/7 Urgent Care Centre.

2.0 Recommendations

2.1 The committee is recommended to question officers on the viability of its plans and the timescale for their implementation, as well as on what contingency plans are in place in case any of the proposals turn out not to be possible or feasible.

Contact Officers

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Shaping a Healthier Future and Central Middlesex Hospital Report for Brent HOSC on 28th January 2014

Executive Summary

This report provides Brent HOSC with a further update (previous update 4th December 2013) on the work taking place to review opportunities to resolve the future of Central Middlesex Hospital, to provide a sustainable long term solution.

1. Introduction

Shaping a Healthier Future (SaHF) set out a vision for the future of how services are delivered across North West London (NWL). This vision has been consulted upon, a recommendation has been approved and these proposals are now being implemented. However, this strategy was not intended to and has not resolved all the issues in NWL. An ongoing issue is Central Middlesex Hospital (CMH), which was an underutilised site before SaHF and remains so now, and will produce a financial deficit indefinitely if steps are not taken to resolve this. Work has now commenced to build upon the SaHF plans for Central Middlesex Hospital to be a local and elective hospital. As a local and elective hospital the services delivered at CMH are planned to include a 24/7 Urgent Care Centre (UCC), outpatients services, diagnostics, elective services and primary care. The proposed closure of the A&E department at CMH will mean that as a local and elective hospital, CMH will be supported by a level 2 intensive care unit and associated high dependency beds. Maximising utilisation of the CMH site has implications for the utilisation of sites in Brent, including Willesden Centre for Health, which is also included in the report and requires resolution.

2. The proposals & impact to patients

The intention is that a range of additional services will be provided at the CMH site to fully utilise this facility for the benefit of Brent and the NWL wide population, ensuring the long term clinically viable and financially sustainable future of CMH. A Strategic Outline Case (SOC) is being developed during January with a stakeholder workshop on 14th January to support the case for a range of additional services at the CMH site. This will provide Brent residents with additional and improved healthcare services as well as the relocation of some services already provided at other sites in Brent including the Willesden Centre for Health. Work is therefore also taking place to scope a range of additional services that can go into the Willesden Centre for Health as this is also an underutilised site in Brent and will become further underutilised if the rehabilitation beds and outpatient services at Willesden Centre for Health are moved to CMH.

Travel analysis on affected patient/carer journeys has been undertaken on the range of services affected and there are no significant impacts that would prevent the inclusion of the range of services being considered for CMH. Similarly, equalities impact consideration has highlighted no significant impacts that would prevent the range of services being progressed.

3. Decision making process

The intention is for the SOC to be developed and completed during January so that it can make a recommendation to the Future of Central Middlesex Hospital Partnership Board on 4th February, which will then make a recommendation to SaHF Implementation Programme Board on 6th February. Following this, an approvals process through the affected statutory organisations and providers will take place during February and March to proceed to Outline Business Case stage. The intention is to have the additional services in place in 2015. See slide 7 for further detail on the decision making process.

A Brent stakeholder engagement session was carried out on 12th December and the feedback was very positive. There was broad support for plans to put additional services onto the CMH site. The range of services being proposed now require focused patient and public engagement alongside further clinical and financial evaluation and we would like your views on how this should be approached. Any proposals developed into an Outline Business Case will be progressed subject to any necessary or appropriate consultation.

4. Importance of decisions

Financial evaluation and identification of the risk of the options including Willesden, is currently being undertaken. The results are not yet available for inclusion in this paper. The potential cost to Brent CCG of increasing empty space at Willesden and the requirement to subsidise rental costs for new services at both CMH and Willesden is high. The CMH site currently runs at an annual loss of £10.8M and the impact of moving services from Willesden increases the underutilised space on that site. Brent CCG is pursing a number of initiatives to mitigate these potential increased costs to Brent, in partnership with NWL CCGs and providers as we expect the pressure to be absorbed across a number of organisations. Nonetheless the future decisions on CMH and Willesden have major service and financial considerations for Brent CCG and residents for many years to come.

5. Next Steps

Following the stakeholder workshop on 14th January, a Strategic Outline Case (SOC) is being developed and will be completed during January. This SOC will be presented to the Future of CMH Partnership Board on 4th February who will make a recommendation to SaHF Implementation Programme Board on 6th February. At this stage it will then go through a formal approvals process through the affected statutory organisations during February and March. For Brent CCG the SOC will be presented to the Governing Body on 5th March (see slide 21 for SOC approvals process). If the SOC is supported by Brent CCG and the other statutory organisations support the SOC, then this work will proceed to Outline Business Case (OBC) stage. Each stage of the process (SOC, OBC, Full Business Case) will require formal approval and support through the statutory organisations (with assurance of the process as appropriate).

Throughout the process Brent CCG will engage with stakeholders and patients and public representatives to ensure that plans for services are tailored to the local population and an

effective outcome for patients is achieved. A further Brent stakeholder event to discuss these plans is being organised for February and will be communicated shortly when the date has been confirmed. We would welcome views of Brent HOSC on the options and support and advice on engagement in this process.

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SaHF, Central Middlesex Hospital and Willesden Centre for Health

Update for Brent HOSC

28th January 2014

Shaping a healthier future – brief summary to date

- SaHF is a clinician led programme which set out to develop a vision for how we want health services to be developed and improved in North West London.
- Increasing care delivered closer to home will better coordinate services and improve quality. SaHF will save at least 130 lives per year.
- Local services will be co-designed by clinicians and local residents around the specific needs of the population.
- Staff will gain improved specialist knowledge specific to their role and services will be integrated across the system.
- A full public consultation ran from July to October 2012 where the team ran over 200 meetings, sent 73,000 consultation documents and received 17,000 responses.
- In February 2013 the Joint Committee of Primary Care Trusts agreed the programme recommendations, which has now been supported in full by the Independent Reconfiguration Panel and Secretary of State for Health.

Secretary of State for Health quote: "Changes to A&E at Central Middlesex and Hammersmith hospitals should be implemented as soon as practicable"

- Work is currently being progressed to plan service changes to ensure a safe transition of services for patients
- This includes consideration of:
  - *Ensuring neighbouring A&Es ready for transition*
  - *Central Middlesex and Hammersmith Urgent Care Centres operating to agreed North West London wide specifications*
  - *Emerging Government policy; Keogh review*
- We are looking to make these changes as soon as practicably possible, in line with the Secretary of State for Health's decision.
- Details of the changes to A&E services will be communicated appropriately with affected residents in advance of any change

Current Services at CMH

•All services of an acute hospital with the exception of emergency surgery and paediatrics

Current services include:

•Sickle cell – adult and paediatric outpatients and day cases

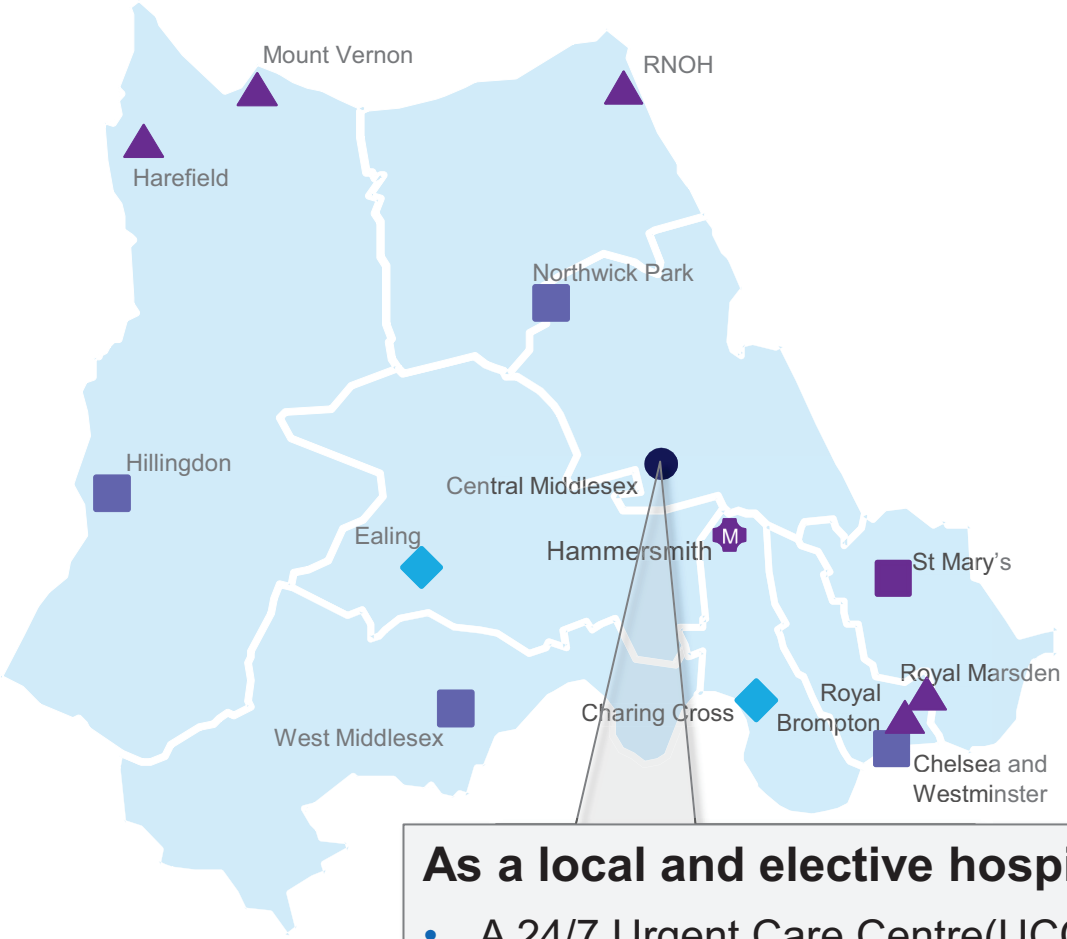
•Dialysis (outreach provided by Imperial)

Services at CMH following closure of A&E department

•Emergency admissions and acute medicine will no longer take place at CMH when the A&E department closes in 2014

•Sickle cell and Dialysis services will be retained at CMH (as above)

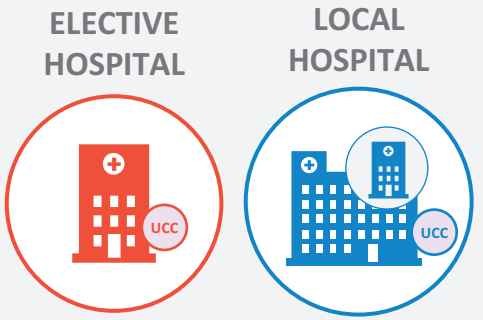
We are working to deliver changes to health



- Specialist hospital
- Local and Specialist hospital with obstetric-led maternity unit and UCC
- Local and Elective hospital with UCC
- Local and Major hospital with A&E and UCC
- Local and Major hospital and specialist eye hospital and Hyper Acute Stroke Unit with A&E and UCC
- Local hospital with A&E

As a local and elective hospital, CMH would have:

- A 24/7 Urgent Care Centre(UCC)
- Outpatients services
- Diagnostics
- Elective services
- Primary Care

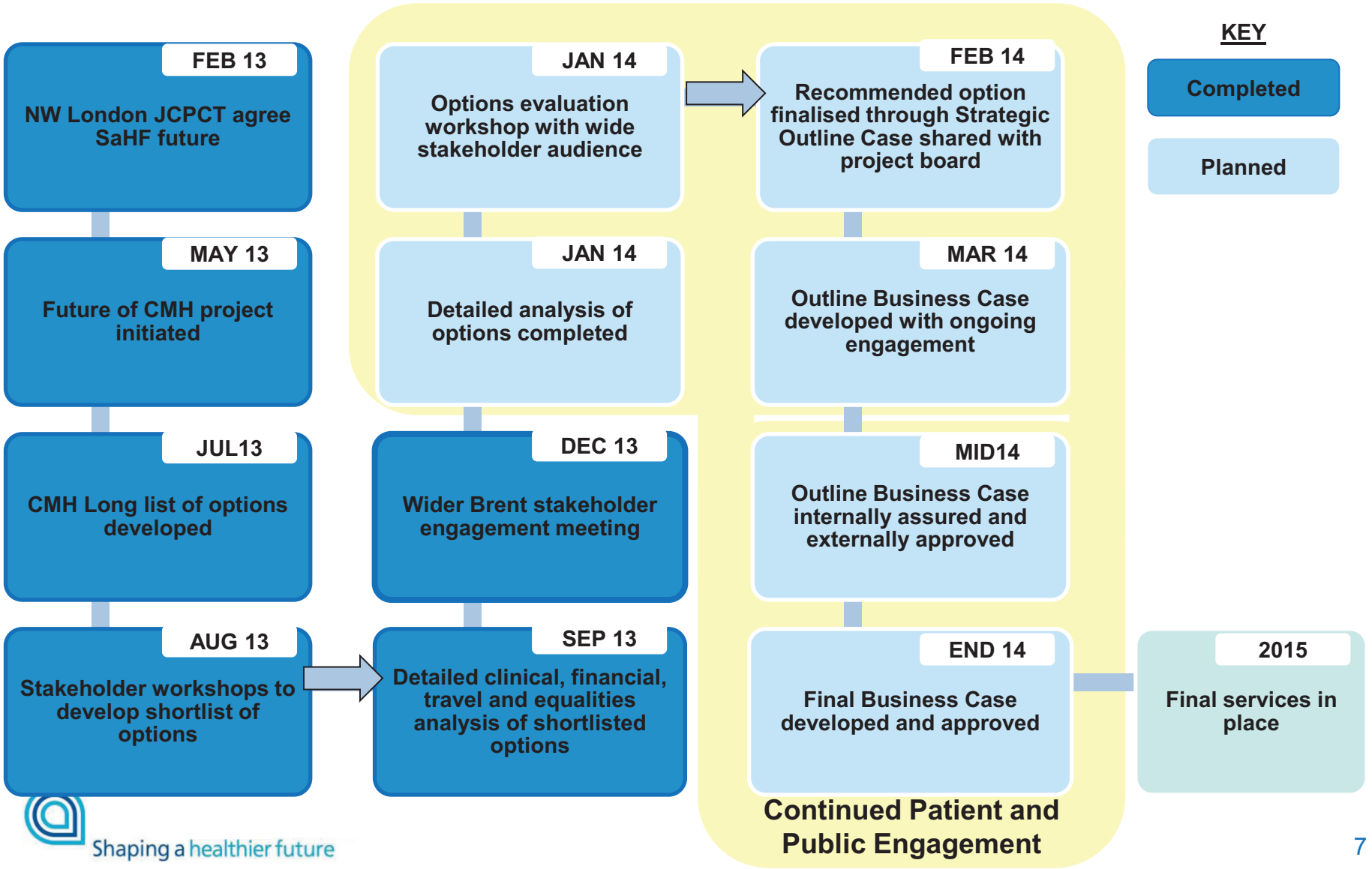


Shaping a healthier future

Options for additional services at Central Middlesex

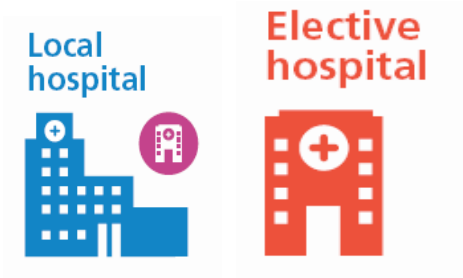
- *Under the Shaping a healthier future* proposals the site would only be 35% full and would make a large financial loss. The site has excellent facilities and we committed to undertake further work to identify a range of services that would make best use of them.
- To fulfil our commitment a project has been established to look at what services could be delivered at CMH to fully utilise the site for the benefit of local residents and ensure it is financially sustainability for the long term.
- The project has considered four key areas to allow evaluation of different services:
  1. **Clinical evaluation** – quality of care, deliverability, research and education
  2. **Estates and Finance Analysis** – affordability and value for money
  3. **Transport Analysis** – access to care and impact of changed patient journeys
  4. **Equalities Analysis** – any impact on protected patient groups
- We have also undertaken provider engagement across NWL to establish who would like to provide potential services on site.
- We are now at the stage of being able to engage with the wider community to hear your feedback and input to these early proposals.

Process for developing a clinically sustainable and financially viable future for CMH



Three overall options have been considered for CMH

Option 1 — *DMBC base case "no change" option



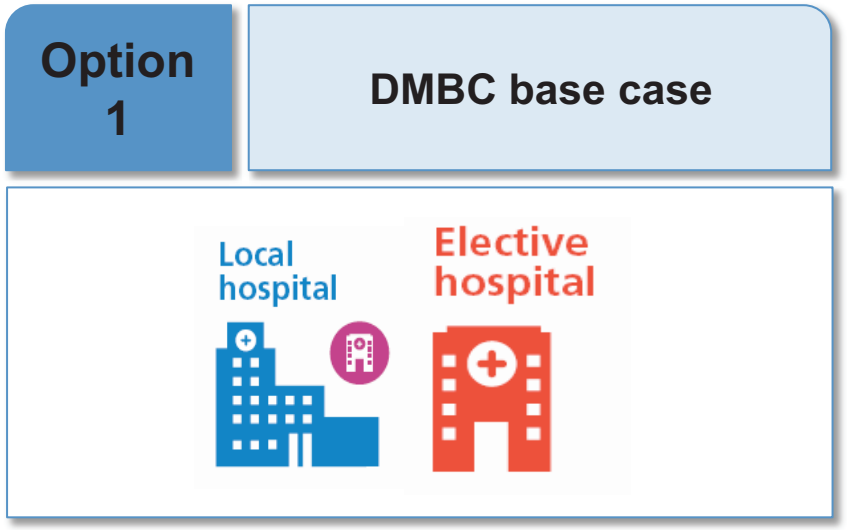
Option 2 — Bundle of Services from multiple providers on CMH site

Option 3 — Close and transfer services to other sites

- Closure of the CMH site is considered to provide a comparator for the other options

*DMBC – decision-making business case approved by the JCPCTs

Option 1 was insufficient in itself as it didn't fully utilise CMH

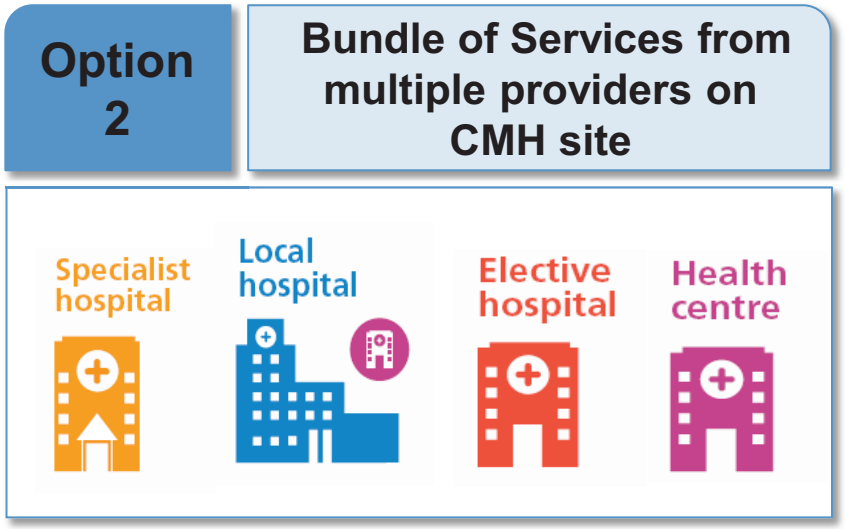


- Option 1 is the base case described in the DMBC.
- **Services would include:**
  - 24/7 Urgent Care Centre
  - Diagnostics
  - Acute and community outpatients
  - Elective inpatients and level 2 ITU
  - Hub facility for primary and community services

- Even after transferring appropriate elective activity from Northwick Park, Ealing and Imperial sites, and retaining the services above, only 35% of the site is utilised
- This results in the site running at an £11million recurring deficit
- Closure of the CMH site was considered to provide a comparator for quality as well as money

For these reasons Brent CCG have built on Option 1, as agreed by the JCPCT, to develop a sustainable option for the future

Option 2 considered a ‘long list’ of all the potential services that could be safely and practically provided at CMH



‘Bundle’ of services could include:

1. **Hub Plus for Brent** – using CMH as a major hub for primary and community services including 24/7 Urgent Care Centre.
2. **Elective Orthopaedic Centre** – a joint venture for local providers.
3. **Specialist Rehabilitation Services** moving from NPH.
4. **Rehousing Mental Health Services** from Park Royal Centre for Mental Health.
5. **Relocating some or all of St Marks Hospital**.

We clinically evaluated each of these options

1 Hub Plus for Brent

- CMH becomes a larger hub for primary and community care services, including General Practice, Urgent Care Centre, outpatients, diagnostics and intermediate care.
- This option has a sub-option of Hub 'Plus Plus' which includes Willesden rehabilitation beds
- The Hub ++ option has a greater impact as it uses more of the CMH estate and potentially increases quality more than Hub + and provides better support to inpatient rehab beds and allows the development of larger teams to support, orthopaedics, rehab and community services
- This option has an impact on the viability of Willesden Hospital and this will need greater assessment.

Evaluation Domain		Sub - domain	Estimate	Key reasoning
1	**Clinical Quality**	Clinical Quality	+	Rehab beds co-located with a wider range of services and support
		Patient Experience		
4	**Deliverability**	Workforce	+	Building larger team of AHPs on one site.
		Expected Time to Deliver	-	Reconfiguration at CMH cf. continued use of Willesden
		Wider Co-Dependencies	-	Creates vacancy at Willesden Site
5	**Research and Education**	Education and Research		

2 Elective centre for NW London

- After discussion it has been recommended that an orthopaedic centre similar to the South West London Elective Orthopaedic Centre (SWLEOC) be developed as a joint venture between Northwick Park, Ealing, St Mary's and Charing Cross (Imperial).
- Alongside the orthopaedic work SaHF includes current CMH elective activity and a proportion of the elective work that will move from Ealing Hospital. To reduce risk of infection this general surgical work should be separated from the orthopaedic work.
- The Orthopaedic centre should learn from and adopt the service delivery model from SWLEOC (South West London Elective Orthopaedic Centre), requiring 24/7 consultant led HDU to enable rapid recovery, reduced complications and reduced LOS.

Evaluation Domain		Sub - domain	Estimate	Key reasoning
1	**Clinical Quality**	Clinical Quality	++	Dedicated elective care, with improved LoS, low infection and complication rate
		Patient Experience	++	Very high satisfaction of SWLEOC model
4	**Deliverability**	Workforce		Challenges of joint venture model
		Expected Time to Deliver	o*	Reconfiguration at CMH for EOC requires some rebuild
		Wider Co-Dependencies	+	Helps support NWL/EHT merger
5	**Research and Education**	Education and Research	+	SWLEOC undertakes considerable research and training

* The expected time to deliver was scored as o as it had already been considered in the DMBC and all scoring has been against those original proposals

3 Specialist Rehabilitation Services

- The Regional Rehab Unit (RRU) at Northwick Park is constrained by space and there are patients in more distant units and waits for admission. The unit is commissioned by Specialised Commissioning at NHS England. It is the only level 1 hyper-acute rehabilitation unit in London.
- The patients have complex needs. The National Guidelines for these services recommend they be located an acute hospital site. An audit of activity at the RRU showed a very wide range of inputs from diagnostics and specialists from the acute services at NPH.

Evaluation Domain		Sub - domain	Estimate	Key reasoning
1	**Clinical Quality**	Clinical Quality	--	The service needs substantial support from the acute hospital services
		Patient Experience	+	Greater space at NPH could reduce waits to enter the service
4	**Deliverability**	Workforce	-	Changes to this specialist unit would be likely to disruption to the workforce
		Expected Time to Deliver	-	Reconfiguration at CMH cf. continued use of NPH
		Wider Co-Dependencies	--	This would be in contradiction to the National Service Specification
5	**Research and Education**	Education and Research	-	The current unit is active in E&R

Because of the negative clinical evaluation the clinical review recommended that further evaluation of this option should not be pursued.

4 Mental Health Service transfer from Park Royal

- The Park Royal Hospital is almost adjacent to the CMH site, provided by CNWL FT. It contains a range of services and office facilities including a mother and baby unit, an acute assessment service and treatment wards. It has a small number of beds for low-security patients. Current accommodation does not comply with modern facility specifications.
- Re-locating services (excluding the low-secure unit) into CMH on the ground floor may be a cost effective option.
- CNWL are also considering developing a single pharmacy service for their range of services. If this were to be based at CMH then this service could also support the other services at the site.

Evaluation Domain		Sub - domain	Estimate	Key reasoning
1	**Clinical Quality**	Clinical Quality	+	Providing services in facilities that reach best standards will reduce risk and optimise care
		Patient Experience	+	Rebuilt mother+baby unit and modern pharmacy services
4	**Deliverability**	Workforce		
		Expected Time to Deliver	+	Reconfiguration at CMH would be quicker than a decant and rebuild at the current Park Royal site.
		Wider Co-Dependencies		
5	**Research and Education**	Education and Research		

5 Moving all or part of St Marks

- St Marks is a specialist gastroenterology hospital co-located with Northwick Park. It provides regional specialist diagnostics and services for inflammatory bowel disease, familial polyposis coli, and the full range of GI conditions. It also provides colorectal screening services.
- The service is currently constrained at the NPH site which limits the necessary expansion of the colorectal screening services for example.
- The surgical and medical teams provide clinical support to the general hospital (for example emergency endoscopy).

Evaluation Domain	Sub - domain	Estimate	Key reasoning
1 **Clinical Quality**	Clinical Quality	--	Co-dependencies with NPH acute service. Effective single MDT team with screening service. Acute GI admissions denied St Marks skills.
	Patient Experience		Specialist site hospitals typically score highly. Disruption of combined MDT will lower experience
4 **Deliverability**	Workforce	-	Duplication of key staff at both CMH and NPH
	Expected Time to Deliver	-	Reconfiguration at CMH cf. continued use of NPH
	Wider Co-Dependencies	+	Moving Screening services would allow expansion
5 **Research and Education**	Education and Research	-	St Marks research and teaching would be disrupted

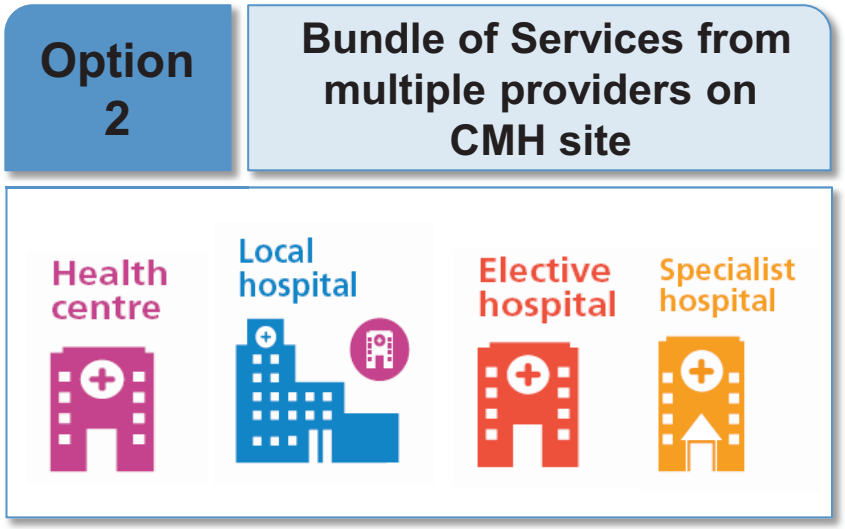
Because of the negative clinical evaluation the clinical review recommended that further evaluation of this option should not be pursued.

5b Relocation of Regional Genetics service from NPH to CMH

- This is a specialised service that provides outreach services across North West London and surrounding counties. It is supported by two laboratories which analyse samples from wide range of units. The labs are not interdependent with the general labs for NPH, which are provided by a private provider.
- The service needs a new IT infrastructure. This is not interdependent with other IT services at NPH.
- No co-dependencies with the acute service at NPH were identified.
- Moving the service from NPH would allow other services to be developed at NPH.

Evaluation Domain		Sub - domain	Estimate	Key reasoning
1	**Clinical Quality**	Clinical Quality	+	Moving from NPH could allow other services to develop at that site
		Patient Experience		This is an outpatient service, mostly at distant sites.
4	**Deliverability**	Workforce		
		Expected Time to Deliver	-	Reconfiguration at CMH cf. continued use of NPH
		Wider Co-Dependencies		
5	**Research and Education**	Education and Research	+	New IT and labs would facilitate research.

The clinical evaluation resulted in an optimised proposed list of services that will make full use of CMH



- This 'bundle' of services option is the most viable option to provide the best range of health services for Brent residents and to maximise the use of the CMH site.
- These services would require a significant investment to be made on the site, which is being detailed in the estates and finance workstream.

Hub Plus for Brent – major hub for primary care and community services including additional out-patient clinics and relocation and expansion of community rehabilitation beds from Willesden

+

Elective Orthopaedic Centre – a joint venture for local providers delivering modern elective orthopaedic services

+

Brent's Mental Health Services from Park Royal Centre for Mental Health

+

Regional genetics service relocated from Northwick Park Hospital

+

24/7 UCC with a wide range of outpatients and diagnostics and specialist support to other services such as sickle cell

Shaping a healthier future

Impact of potential services that 'bundle' option offers

Hub Plus

- ✓ Improved quality – rehabilitation beds co-located with wider range of services and support
- ✓ More primary care and community services available on site
- ✓ Diagnostics services – improved direct access
- ✓ More out-patients clinics provided on site
- ✓ Co-located services support integration
- x Implication for Willesden Health Centre

Rehousing Mental Health Services

- ✓ Modern mental health facilities to ensure best practice care
- ✓ Improved mother and baby unit
- ✓ Shared pharmacy facilities between community acute and mental health

Elective Orthopaedic

- ✓ Dedicated planned/elective care with reduced length of stay and low infection and complication rate
- ✓ Proven model of care – SWLEOC receiving high patient satisfaction

Relocating regional genetics

- ✓ Moving lab services allows Northwick Park to expand major hospital services

Enhancing services on the CMH site has an effect on the utilisation of sites in Brent, including Willesden

- Willesden, as part of Brent CCGs out of hospital strategy is a hub, providing extended community services for South Brent.
- Under suggested proposals rehabilitation beds move to CMH, Willesden continues to offer
  - 2 GP practices (as today)
  - Locality hub for extended services including outpatients and diagnostics
- This creates opportunities for other services to move into the building – options currently being considered are:
  - Respite - Pembridge Unit from St Charles – *deemed not suitable for relocation
  - Mental Health - consolidate CAMHS services into a single (new) hub
  - Medical Respite Service for the homeless – newly commissioned DH pilot – *now going to Finchley Memorial Hospital
  - Kilburn Square - community services relocation (mainly office space)
  - Static Breast Screening Unit - Replacement of existing mobile service
  - Relocating some GP practices within a 1 mile radius (discussions underway with practices)
  - Understanding the implications of Willesden operating as an under utilised site
  - Understanding options around partial disposal and full disposal if the building cannot be fully utilised.

Current Services at Willesden

Adult Services

Cardiology

*Care Co-ordination

Diabetes

Dietetics

District Nursing

In-patient unit

*STARRS (Intermediate Care)

Musculo-skeletal

Phlebotomy

Podiatry

Respiratory Service

Children's Services

Health Visiting

School Nursing

Paediatric Occupational Therapy

Paediatric Physiotherapy

Paediatric Speech and Language Therapy

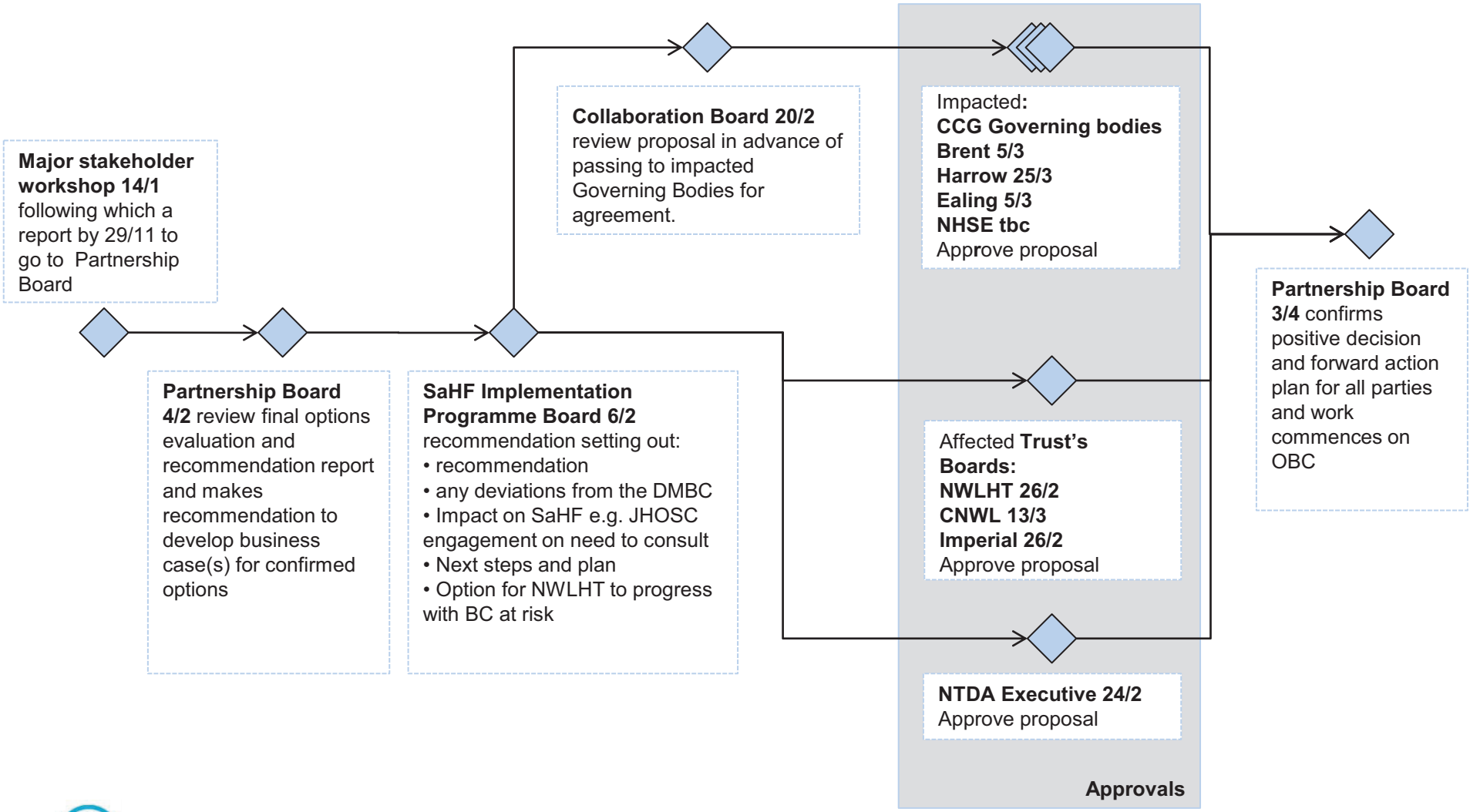
Proposals:

*Care Co-ordination, STARRS and rehabilitation beds would move to CMH

Cardiology, Ophthalmology, Musculo-skeletal, Gynaecology Outpatients, plain x-ray and ultrasound would be provided at Willesden

Approvals process For SOC

Awaiting confirmation of affected organisations using 80% rule (aligned to approvals process being used for SaHF major hospital OBCs)



Shaping a healthier future

Plans for engagement/consultation

- Assessment of the proposals for the bundle of services that could go onto the CMH site presents the opportunity to work with the local and NW London wide population to ensure that patients and the public are involved in the development of the options.
- This opportunity will ensure the proposed services are tailored to meet the needs of the population and to ensure utilisation of the services is maximised.

Question: Do you have any advice on what this engagement should look like?

Question: Are there any concerns that should be raised through engagement to ensure a successful outcome?

Feedback from 12th December stakeholder meeting

- Supportive of plans
- CMH offers good transport
- With this project having a tight timescale we need to ensure that it is delivered on time and avoid service quality being compromised
- Mental health treatment and care should be a key consideration for future CMH development
- The STARRS service provides excellent home based care

Feedback from 9th January meeting with Brent CCG Clinical Leaders

- Broad support for the proposals
- For many patients going to CMH and Willesden this would result in very little change from now, noting that many patients would choose to go to Wembley/Sudbury, CMH and Willesden for their outpatients and diagnostics appointments if the provider of choice was present on the sites
- Achievable if transport links could be improved for those patients closest to Barnet, NPH and Imperial
- Outpatients and diagnostics centre at CMH and other hubs would be successful if supported by effective Choose and Book, ie details of all services were available and waiting times were short
- Preference order of options for Willesden were:

  1. Maximise full use of site, if possible

  2. Fill site, as far as possible, and then partial disposal of part of site, if possible, so there is limited call on CCG funds to increase the cost of funding empty space at Willesden

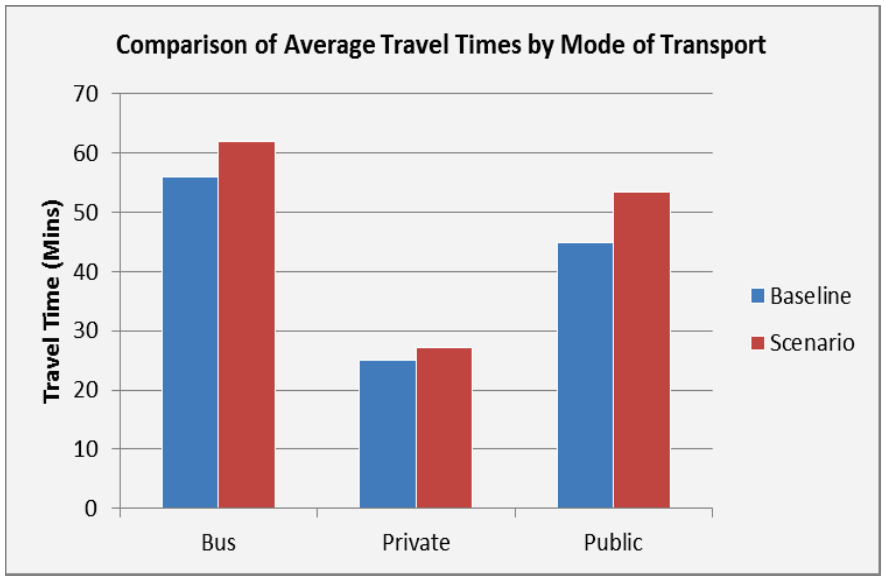
  3. Only in extremis to consider option of buying out the PFI site only if partial disposal is not possible and we cannot secure any new tenants to replace the wards. 2 primary care practices would need to be relocated in Willesden

Travel Considerations

Travel Conclusions:

- Only three options involve major shifts of treatment location
- A thorough analysis of journeys for the **Elective Orthopaedic Centre** option shows only small changes in journey times which, in our judgement, do not constitute a significant diminution of patient access
- Analysis of the major inpatient and outpatient flows in **Closure** option suggests that the average travel time is marginally improved which strongly suggests there are no new barriers to access in this option
- Analysis of the major flows relating to the **Brent Hub Plus** suggest that it also marginally improves the average patient journey time so cannot be considered to create significant access issues. A separate analysis may be required for routine GP activity based at Willesden and this is likely to require analysis of patient preferences not just activity.
- No other options require travel analysis

The changes in average travel times for those orthopaedic patients moving to CMH are not large

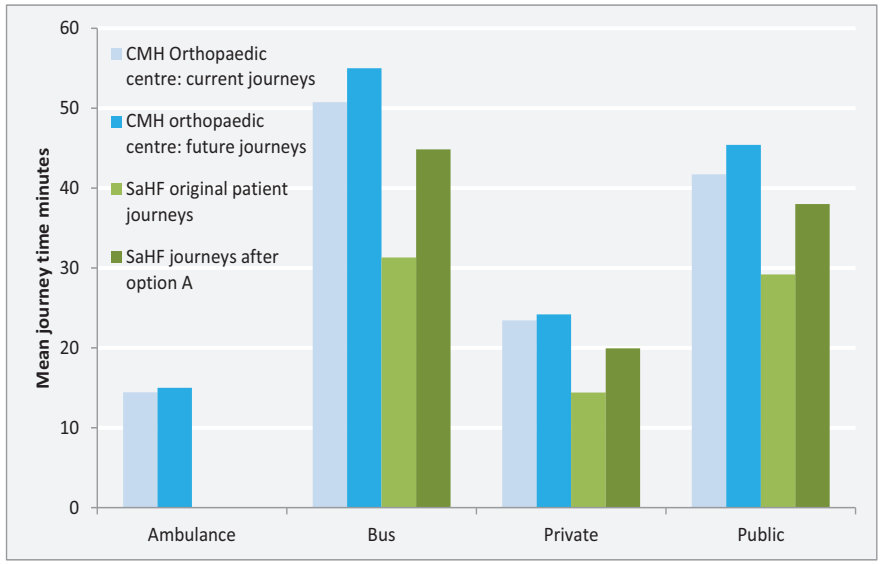


Our worst-case analysis takes the journey times of the patients to their current provider and compares it to the journey times to CMH. We test times for 3 key modes of transport, though in reality a mix of methods will be used (this has the advantage of being a worst-case for travel time).

Note that in some options for the Orthopaedic Centre at CMH, patient transport is provided by the centre so this analysis is irrelevant and there are no relevant issues potentially reducing patient access.

These are small changes in travel time and do not show significant affects on patient access.

Comparisons of orthopaedic centre option with the effect of SaHF changes shows the incremental change is much smaller



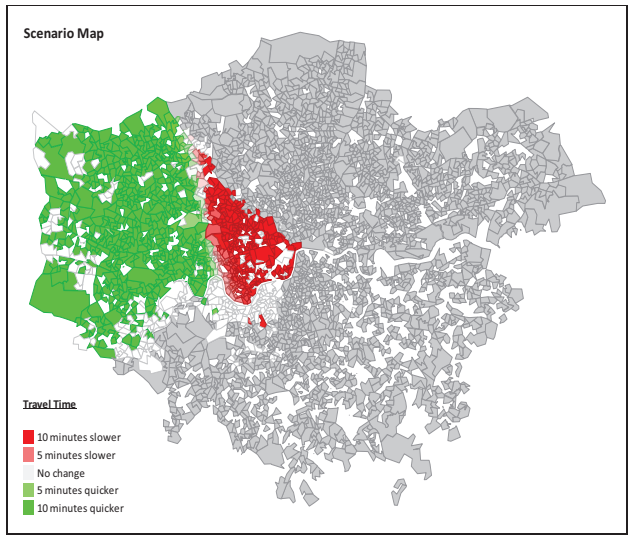
The changes of treatment location as a result of the original SaHF plans were not regarded as creating significant problems for patient access. We show here a comparison of the incremental changes in average journey times for the CMH orthopaedic option compared to the equivalent analysis for SaHF.

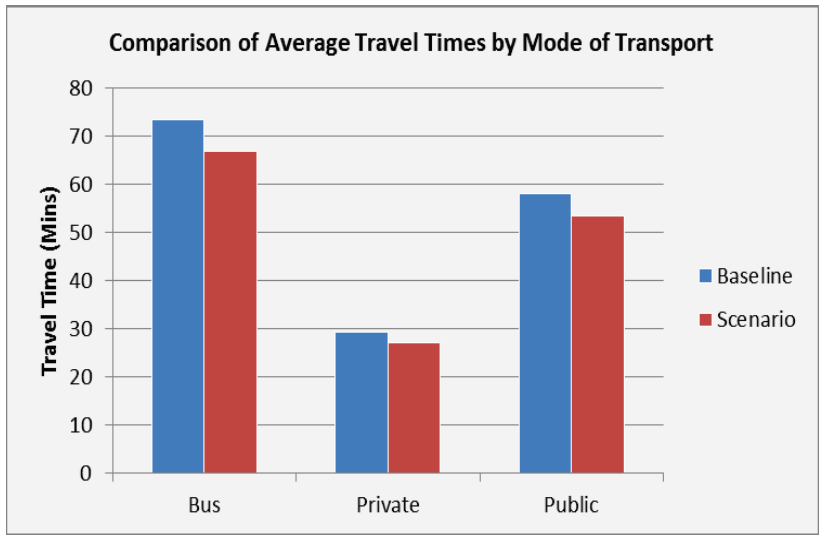
The average impacts can be seen to be much lower than the previous results which were themselves not though to be a significant barrier to access.

NB the SaHF results are not significant in the context of the average patient journey times before the changes. Calculations are not directly comparable and involve different locations and case mixes.

CMH primary care hub: travel times relating to significant activity *improve* with this option

Average travel times for most NWL population improve slightly and this is reflected in analysis of patient journeys

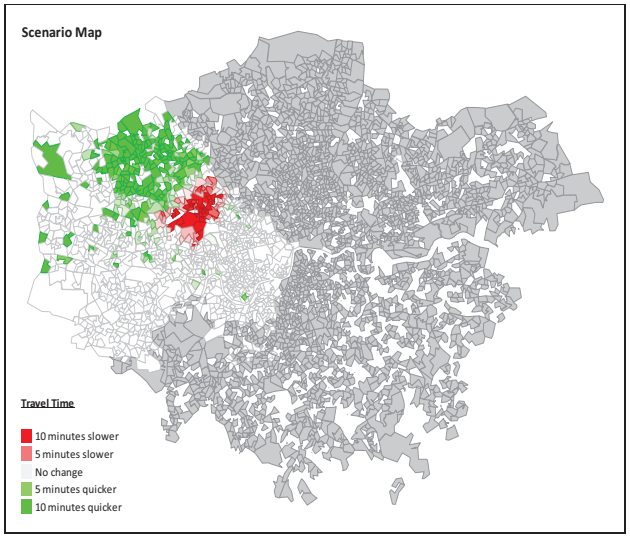


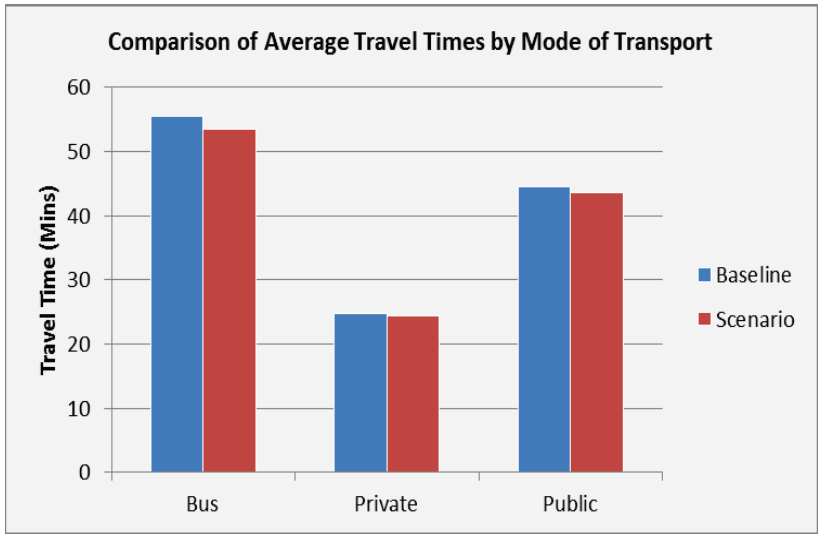


Simple interpretation of this shows that anyone who was closer to Willesden than CMH is now worse off but the vast majority would benefit from the shift.

Closure – Travel time change is marginally positive suggesting no new barriers to access are created by this option

The overall impact of closure option is small on average travel times and is marginally positive as, on balance, the locations of treatment are now closer to the resident location:





Detailed analysis shows that some patients living close to CMH have longer journeys but this is not a significant impact overall. Many individuals who live closer to Northwick Park but would have previously been sent to CMH could benefit if they are treated closer to home.

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Health Partnerships OSC

Work Programme 2013-14

Meeting Date	Item	Issue
Jan 2014	Diabetes	Report on the diabetes services currently provided in Brent and future plans for services.
Jan 2014	CCG Finances	Report from the CCG on their finances and specific funding allocations.
Jan 2014	18 Weeks RTT update	Update on the 18 weeks RTT incident previously reported to the committee.
Jan 2014	Plans for Central Middlesex	Following decisions taken at, and after, the stakeholder meeting: an update on the plans for services at Central Middlesex Hospital.
March 2014	Violence against Women Task Group	Report from the Violence Against Women Task Group with the group's findings recommendations.
March 2014	Mental Health services	Full report on current services provided by: CNWL, CCG, Social Care (council).
March 2014	Sexual Health	• Teenage pregnancy and the services offered; • Abortion services in Brent including a report on repeat abortions and what is being to done to combat this; • HIV services.
Ongoing	CCG: Wave 2 Commissioning	Update on Wave 2 Commissioning including the Service Specification.

TBC	Maternity Services	Maternity care in Brent, including proposed changes proposed under Shaping a Healthier Future
Recurring	Emergency Services	Current issues around emergency services/A&E at North West London Hospitals and immediate, mid and long term plans to address current problems and improve services.
TBC	NWLHT and EHT Merger	Update on the merger between North West London Hospitals Trust and Ealing Hospitals Trust and on current progress against financial targets.
TBC	Public Health	Report on the progress of transition of and integration of Public Health into the council.
TBC	Out of hospital care strategy	As part of the Shaping a Healthier Future work, Brent will be preparing an Out of Hospital Care Strategy. The committee will consider the strategy and respond to the consultation.
TBC	Diabetes Task Group	Update on progress of the Diabetes Task Group recommendations.